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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR CHILDREN, YOUTH & FAMILIES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4455 1-800-852-3345 Ext. 4455
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www.dhhs.nh.gov/dcyf

Jeffrey A. Meyers
Commissioner

Joseph E. Ribsam, Jr.
Director

December 20, 2018

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Children, Youth and Families, to **retroactively** exercise a renewal option to an existing **sole source** agreement with Mary Hitchcock Memorial Hospital (Vendor ID# 177160), 1 Medical Center Drive, Lebanon, NH 03756, to support the continued delivery of adoption preparation and preservation services, by increasing the price limitation by $208,845 from $2,156,447 to an amount not to exceed $2,365,292 and extending the contract completion date from January 1, 2019 to September 30, 2019 **retroactive** to January 1, 2019 upon Governor and Executive Council approval. 100% Federal Funds.

This agreement was originally approved by the Governor and Executive Council on March 12, 2014, Item #21.

Funds are available in the following account for State Fiscal Year (SFY) 2019, and are anticipated to be available in SFY 2020, upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust encumbrances between State Fiscal Years through the Budget Office without further approval from the Governor and Executive Council, if needed and justified.

05-95-42-421010-89030000 HEALTH AND HUMAN SERVICES DEPT OF, HHS: HUMAN SERVICES, CHILD PROTECTION, ADOPTION TRAUMA GRANT

Fiscal Year	Class / Account	Class Title	Activity Number	Current Budget	Increased (Decreased) Amount	Revised Modified Budget
2014	102-50731	Contracts for Prgm Srvcs	42100300	$293,335	$0	$293,335
2015	102-50731	Contracts for Prgm Srvcs	42100300	$461,958	$0	$461,958
2016	102-50731	Contracts for Prgm Srvcs	42100300	$438,245	$0	$438,245
2017	102-50731	Contracts for Prgm Srvcs	42100300	$424,763	$0	$424,763
2018	102-50731	Contracts for Prgm Srvcs	42100300	$429,920	$0	$429,920
2019	102-50731	Contracts for Prgm Srvcs	42100300	$108,226	$118,361	$226,587
2020	102-50731	Contracts for Prgm Srvcs	42100300	$0	$90,484	$90,484
			Totals	**$2,156,447**	**$208,845**	**$2,365,292**

EXPLANATION

This request is **retroactive** because in order to meet federal requirements for the carry-forward funding, the contract must not have a gap in service. The original contract with the Trustees of Dartmouth College was assigned to Mary Hitchcock Memorial Hospital, effective October 1, 2018. The change in responsibilities resulted in increased processing time for this request.

This request is **sole source** because the grant application for the Children's Bureau Promoting Well Being and Adoption after Trauma required the Department to identify and justify any agencies or organizations that would be critical to successfully implementing the Department's proposal to improve permanency and wellbeing outcomes for children adopted through the Department. Further, the Department was required to assert whether any partners identified were implementation ready. Due to the partnership and work of the Dartmouth Trauma Intervention and Research Center, the Trustees of Dartmouth College (original Contractor) was identified as the vendor who was implementation ready. The Trauma Intervention and Research Center has since been moved under a new entity, Mary Hitchcock Memorial Hospital, but has continued to provide the contracted services under this entity.

The purpose of this request is to continue with the adoption preparation and preservation services in effect since October 1, 2013. The Contractor will continue the dissemination of the new model of caring for children who have experienced early trauma. The Contractor will assist with providing training to DCYF staff, in-home therapy providers and foster and adoptive parents Statewide.

In addition, the Contractor will continue providing ongoing consultation to the Department regarding the wellbeing and mental health of children who have been impacted by trauma. Utilizing knowledge gained during the project, the Contractor will also provide consultation on the identification and development of new screening measures for trauma and mental health used by the Department that better align with the Families First Prevention and Services Act of 2017.

The Exhibit B, Method and Conditions Precedent to Payment, of the original Contract contains language that allows the Department the right to renew the Agreement for up to two (2) additional years, subject to continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

Should the Governor and Executive Council not approve this request, it may result in the loss of highly needed resources that are utilized to meet the needs of our pre- and post-adoptive population. Without this service, New Hampshire will continue to have a lack of pre-adoptive families that can meet the needs of the waiting children. Further, the children in state care will continue to have placement disruptions in foster homes and there will be a decline in the wellbeing outcomes of adopted children. In addition, New Hampshire will experience a decrease in the wellbeing outcomes of children adopted through the child welfare system, a decrease in the number of adoptive homes available in the state and a decrease in the number of children adopted from foster care.

Area served: Statewide

Source of funds: 100% Federal Funds from the US Department of Health and Human Services Adoption Trauma Grant, CFDA # 93.652, Federal Award Identification Number (FAIN) 90CO1115.

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

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the Dartmouth Trauma Intervention and Research Center Contract to Improve Permanency and Well-Being Outcomes for Children Adopted through NH DCYF

This 1st Amendment to the Dartmouth Trauma Intervention and Research Center Contract to Improve Permanency and Well-Being Outcomes for Children Adopted through NH DCYF contract (hereinafter referred to as "Amendment #1") dated this 11th day of October, 2018, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital (formerly the Trustees of Dartmouth College, Dartmouth College, Office of Sponsored Projects, (hereinafter referred to as "the Contractor"), a corporation with a place of business at 1 Medical Center Drive, Lebanon, NH 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on March 12, 2014 (Item 21), assigned to Mary Hitchcock Memorial Hospital (Vendor ID #177160), effective 10/1/18, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract upon written agreement of the parties and approval from the Governor and Executive Council; and

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

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

1. Form P-37 General Provisions, Subject to read:

   Adoption Preparation and Preservation

2. Form P-37 General Provisions, Block 1.3, Contractor Name to read:

   Mary Hitchcock Memorial Hospital

3. Form P-37 General Provisions, Block 1.4, Contractor Address to read:

   1 Medical Center Drive, Lebanon, NH 03756

4. Form P-37 General Provisions, Block 1.5, Contractor Phone Number to read:

   603-650-5000

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

   September 30, 2019

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

   $2,365,292

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

   Nathan D. White, Director

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

   603-271-9631

9. Delete Exhibit A, Scope of Services, in its entirety and replace with:

   Exhibit A – Amendment #1, Scope of Services.

10. Delete Exhibit B, Method and Conditions Precedent to Payment, in its entirety and replace with:

    Exhibit B – Amendment #1, Method and Conditions Precedent to Payment.

11. Delete Exhibit B-2 Budget in its entirety and replace with:

    Exhibit B-2 Budget – Amendment #1.

12. Delete Exhibit C-1, Revisions to General Provisions, and replace with:

    Exhibit C-1 – Amendment #1, Revisions to Standard Contract Language.

13. Add Exhibit K, DHHS Information Security Requirements (v5, 10/09/18).

This amendment shall be effective upon the date of Governor and Executive Council approval.
IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/21/18
Date

Joseph E. Ribsam, Jr.
Director

Mary Hitchcock Memorial Hospital

12/18/18
Date

Name: Daniel P. Jantzen
Title: Chief Financial Officer

Acknowledgement of Contractor's signature:

State of New Hampshire, County of Grafton on December 18 2018, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

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

My Commission Expires: April 19 2022

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

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

OFFICE OF THE ATTORNEY GENERAL

Date: 1/2/19

Name: Megan A. Yap
Title: Attorney

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor 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.

1.2. Notwithstanding any other provision of the Contract to the contrary, no services shall continue after June 30, 2019, and the Department shall not be liable for any payments for services provided after June 30, 2019, unless and until an appropriation for these services has been received from the state legislature and funds encumbered for the SFY 2020-2021 biennium.

2. Scope of Services

2.1. The Contractor shall provide consultation to the Department for the development of a new screening or assessment tool on well-being, behavioral health and trauma related issues; to better meet new federal requirements for the Family First Prevention Services Act of 2017.

2.2. The Contractor shall utilize knowledge and information gained from the implementation of mental health and family functioning screens during the first five (5) years of the contract to help inform the implementation of a new screening or assessment tool.

2.3. The Contractor, shall provide expert consultation to Department staff on topics related to behavioral health and well-being of children who have experienced trauma including, but not limited to:

2.3.1. Symptoms and treatment of mental health in children;

2.3.2. Trauma related issues; and

2.3.3. Skills to assist Department staff on collaboration and communication with mental health providers and agencies.

2.4. The Contractor shall develop a Dissemination Plan to assist the Department with dissemination of a family and system level intervention program to work with children who have experienced early trauma.

2.5. The Contractor shall ensure the intervention is disseminated to Department staff and in-home therapeutic treatment providers, including but not limited to:

2.5.1. Individual Service Option Services; and

2.5.2. Home Based Therapeutic Services.

2.6. The Contractor shall meet all requirements set forth by the Administration for Children including, but not limited to:

2.6.1. Planning and Implementation Plans; and

2.6.2. Scheduling all travel and planning for key staff required at Administration for Children mandatory meetings.

3. Reporting

3.1. The Contractor shall update the Dissemination Plan on a monthly basis.

3.2. The Contractor shall develop and submit a semi-annual report that ensures compliance with the measures required by the Administration for Children to the Department in April and October of the contract period.

4. Deliverables

4.1. The Contractor shall meet with Department leadership onsite at State Offices to review and report on the screening or assessment tool measures and progress on a monthly basis.

4.1. The Contractor shall submit the Dissemination Plan to the Department by December 31, 2018.

Exhibit B - Amendment #1

Method and Conditions Precedent to Payment

1) The State shall pay the Contractor an amount not to exceed the Form P-37, Block 1.8, Price Limitation for the services provided by the Contractor pursuant to Exhibit A – Amendment #1, Scope of Services.

   1.1. This contract is funded with 100% Federal Funds from the Administration for Children and Families, Children's Bureau, Adoption Trauma Grant, CFDA #93.652, Federal Award Identification Number (FAIN) 90CO1115.

   1.2. The Contractor shall provide the services in Exhibit A – Amendment #1, Scope of Services in compliance with funding requirements. Failure to meet the scope of services may jeopardize the funded contractor's current and/or future funding.

2) Payment for said services shall be made monthly as follows:

   2.1. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this agreement, and shall be in accordance with Exhibits B-1 and B-2 Budget – Amendment #1.

   2.2. The Contractor shall submit an invoice in a form satisfactory to the State by the twentieth (20th) working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The invoices must be completed, signed, dated and returned to the Department in order to initiate payment.

   2.3. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available. Contractors will keep detailed records of their activities related to DHHS-funded programs and services.

   2.4. The final invoice shall be due to the State no later than forty (40) days after the contract Form P-37, Block 1.7 Completion Date.

   2.5. Invoices shall be mailed to:

   Financial Administrator
   Department of Health and Human Services
   Division of Children, Youth and Families
   129 Pleasant Street
   Concord, NH 03301

   2.6. Payments may be withheld pending receipt of required reports or documentation as identified in Exhibit A – Amendment #1, Scope of Services.

3) 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.

4) Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting encumbrances between State Fiscal Years, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B - Amendment #1

5) When the Contract Price limitation is reached, the Contractor shall continue to perform services at no charge to the Department for the duration of the Contract Period.

Exhibit B-2 Budget - Amendment #1
Adoption Preparation and Preservation Project

		SFY15	SFY16	SFY17	SFY18	SFY19	SFY20
Kay Jankowski	$ 86,549.00	$ 35,904	$ 36,779	$ 37,883	$ 39,020	$ 38,589	$ 21,988
Erin Barnett	$ 72,540.00	$ 30,092	$ 30,826	$ 31,751	$ 32,704	$ 27,364	$ 14,622
Cathleen Yackley	$ 72,540.00	$ 20,061	$ 20,551	$ 21,168	$ 21,802	$ 5,491	
TBD	$ 60,000.00	$ 82,966	$ 84,992	$ 87,541	$ 90,168	$ 40,843	$ 13,864
CPDE-TBD (Center for Program, Design and Evaluation at Dartmouth)	$ 71,936.00	$ 42,231	$ 41,139	$ 42,214	$ 50,605	$ 20,701	$ 5,632
Karen Schifferdecker	$ 96,428.00	$ 20,001	$ 20,489	$ 21,103	$ 21,737	$ 5,474	
Budget total for Personnel		$ 231,254	$ 234,776	$ 241,660	$ 256,035	$ 138,461	$ 56,106
Description:							
All staff listed are committed to project 12 months/year x 5 years							
6.c - Travel							
Budget total for Travel		$ 19,348	$ 26,378	$ 27,167	$ 27,983	$ 10,320	$ 2,502
Description:							
1. Annual Meeting: (Each Year) Trip to Washington, DC for 3 people @ 3 days, 2 nights stay in hotel, airfare, per diem							
2. Entrance Conference: REMOVED							
3. Travel for Staff to run Focus Groups: (4 Groups meeting 2 times/year) average evaluators)							
7. Staff travel to State offices, avg 160 miles/roundtrip * .565/mile for approximately							
8. Consumer Participation, avg 160 miles/roundtrip * .565/mile for approximately 30							
3. Mileage reimbursement for attendees, $2,260.00, Avg 160 miles/person roundtrip							
6.d - Equipment							
Budget total for Equipment		$ 39,494	$ 7,899	$ 8,136	$ 8,380	$ 2,110	$ -
Description:							
1. Computer for Coordinator - Year 1 only: $2,890.00							
2. Data Collection: Tablets, 10 Tablets at $620.00/tablet, Year 1 only: $6,200.00							
3. Data Collection: Programming of Tablets & General Data Instructions at							
6.e - Supplies							
Budget total for Supplies		$ 920	$ 948	$ 976	$ 1,006	$ 253	$ -
Description:							
Project materials, supplies and duplication, $75.00/month							
6.f - Contractual							
Budget for Contractual		$ 4,850	$ 3,800	$ 3,563	$ 3,800	$ 9,451	$ 6,499
Description:							
(TBN) Adoption Consultants, 3 consultants, $100/hour - 15 hours year 1 & 7 hours years 2-5							
2. Intervention Evaluators: Dept of Psychiatry's Data Safety & Monitoring Board requires intervention studies to be evaluated by outside consultants, $650.00/year							
6.h - Other							
Budget for Other		$ 47,597	$ 52,032	$ 34,307	$ 22,439	$ 7,872	$ 2,166
Description:		Less $1.00	Less $1.00	Plus $236.00	Less $1.00	Plus $1.00	
1. Training Meetings: (6 meetings/year) Meeting room rental, $300.00/meeting							
2. Training Meetings: (6 meetings/year) Food and beverages, $500.00/meeting ($20.00/person, 25 people)							
Meeting with Adoption Consultants (food/beverage & room rental), $485/year							
Evaluation:							
4. Focus Groups Stipends: (4 Groups meeting 2 times/year) 8 participants at							
5. Food for Focus Groups: (4 Groups meeting 2 times/year) at $100.00/meeting							
6. Phone Charges: Conference Calls, 24-60 minute calls/year with 5 callers/call at							
7. Stipends: Consumer Participation Payments, $100.00 stipends for 30 consumers							
8. SAFE Training: (Structured Analysis Family Evaluation), 2 day training at $700.00/person; 36 people in year 2, 13 people year 3, & 13 people year 4							
9. "Train the Trainers" Workshops, Years 2 & 3 only							
10. "Train the Trainers" Continuation Workshops, Years 4 & 5 only							
State Addl Set Aside							
6.i - Total Direct Charges		$ 343,463	$ 325,833	$ 315,809	$ 319,643	$ 168,467	$ 67,274
6.j - Indirect Charges		$ 118,495	$ 112,412	$ 108,954	$ 110,277	$ 58,121	$ 23,210
6.k - Total (Budget includes inflation at 103.0%)		$ 461,958	$ 438,245	$ 424,763	$ 429,920	$ 226,587	$ 90,484

REVISIONS TO STANDARD CONTRACT LANGUAGE

1. Revisions to Form P-37, General Provisions

1.1. Section 4, 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.

1.2. Section 10, 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.

2. Renewal

2.1. The Department reserves the right to extend this agreement for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, written agreement of the parties and approval of the Governor and Executive Council.

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

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

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

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

II. METHODS OF SECURE TRANSMISSION OF DATA

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

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

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

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

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

A. Retention

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

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

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

B. Disposition

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

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

IV. PROCEDURES FOR SECURITY

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

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

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

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

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

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

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

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

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

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

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

health information and as applicable under State law.

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

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer, and additional email addresses provided in Section VI, of any security breach within 24-hours of the time that the Contractor learns of its occurrence. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

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

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

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

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches within 24- hours of the time that the Contractor learns of their occurrence.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with– the HIPAA, Privacy and Security Rules. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

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

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

VI. PERSONS TO CONTACT

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

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

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

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

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that MARY HITCHCOCK MEMORIAL HOSPITAL is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 07, 1889. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **68517**

Certificate Number: **0004082905**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 17th day of April A.D. 2018.

William M. Gardner

Secretary of State

Dartmouth-Hitchcock

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 Financial 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. Daniel P. Jantzen is the Chief Financial 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 18th day of December.

Anne-Lee Verville, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 18th day of December, 2018, by Anne-Lee Verville.

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

Notary Public
My Commission Expires: April 19, 2022

CERTIFICATE OF INSURANCE

DATE: 09/25/2018

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

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

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

COVERAGES

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

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

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

Certificate of Insurance issued as evidence of insurance.

CERTIFICATE HOLDER

DHHS
129 Pleasant Street
Concord, NH 03301

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

AUTHORIZED REPRESENTATIVES

Paul D Monahan

DARTHIT-01 DMCDONALD

CERTIFICATE OF LIABILITY INSURANCE

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

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

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

PRODUCER License # 1780862 HUB International New England 100 Central Street, Suite 201 Holliston, MA 01746	CONTACT NAME: Dan McDonald PHONE (A/C, No, Ext): (508) 808-7293 FAX (A/C, No): (866) 235-7129 E-MAIL ADDRESS: dan.mcdonald@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

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

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N ☐	N/A		AGC4059104	07/01/2018	07/01/2019	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

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

Our Vision

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

Values

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

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2018 and 2017

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2018 and 2017

Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2018 and June 30, 2017, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the financial statements of Alice Peck Day Hospital, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 2.8% of consolidated total assets at June 30, 2017 and total revenues of 3.3% of consolidated total revenue for the year then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Alice Peck Day Hospital, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2018 and June 30, 2017, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 7, 2018

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
Years Ended June 30, 2018 and 2017

(in thousands of dollars)	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ 200,169	$ 68,498
Patient accounts receivable, net of estimated uncollectibles of $132,228 and $121,340 at June 30, 2018 and 2017 (Note 3)	219,228	237,260
Prepaid expenses and other current assets	97,502	89,203
Total current assets	516,899	394,961
Assets limited as to use (Notes 4 and 6)	706,124	662,323
Other investments for restricted activities (Notes 4 and 6)	130,896	124,529
Property, plant, and equipment, net (Note 5)	607,321	609,975
Other assets	108,785	97,120
Total assets	$ 2,070,025	$ 1,888,908
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 9)	$ 3,464	$ 18,357
Current portion of liability for pension and other postretirement plan benefits (Note 10)	3,311	3,220
Accounts payable and accrued expenses (Note 12)	95,753	89,160
Accrued compensation and related benefits	125,576	114,911
Estimated third-party settlements (Note 3)	41,141	27,433
Total current liabilities	269,245	253,081
Long-term debt, excluding current portion (Note 9)	752,975	616,403
Insurance deposits and related liabilities (Note 11)	55,516	50,960
Interest rate swaps (Notes 6 and 9)	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion (Note 10)	242,227	282,971
Other liabilities	88,127	90,548
Total liabilities	1,408,090	1,314,879
Commitments and contingencies (Notes 3, 5, 6, 9, and 12)		
Net assets		
Unrestricted (Note 8)	524,102	424,947
Temporarily restricted (Notes 7 and 8)	82,439	94,917
Permanently restricted (Notes 7 and 8)	55,394	54,165
Total net assets	661,935	574,029
Total liabilities and net assets	$ 2,070,025	$ 1,888,908

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, 2018 and 2017

(in thousands of dollars)	2018	2017
Unrestricted revenue and other support		
Net patient service revenue, net of contractual allowances and discounts	$ 1,899,095	$ 1,859,192
Provision for bad debts (Note 1 and 3)	47,367	63,645
Net patient service revenue less provision for bad debts	1,851,728	1,795,547
Contracted revenue (Note 2)	54,969	43,671
Other operating revenue (Note 2 and 4)	148,946	119,177
Net assets released from restrictions	13,461	11,122
Total unrestricted revenue and other support	2,069,104	1,969,517
Operating expenses		
Salaries	989,263	966,352
Employee benefits	229,683	244,855
Medical supplies and medications	340,031	306,080
Purchased services and other	291,372	289,805
Medicaid enhancement tax (Note 3)	67,692	65,069
Depreciation and amortization	84,778	84,562
Interest (Note 9)	18,822	19,838
Total operating expenses	2,021,641	1,976,561
Operating income (loss)	47,463	(7,044)
Non-operating gains (losses)		
Investment gains (Notes 4 and 9)	40,387	51,056
Other losses	(2,908)	(4,153)
Loss on early extinguishment of debt	(14,214)	-
Loss due to swap termination	(14,247)	-
Contribution revenue from acquisition	-	20,215
Total non-operating gains, net	9,018	67,118
Excess of revenue over expenses	$ 56,481	$ 60,074

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, 2018 and 2017

(in thousands of dollars)	2018	2017
Unrestricted net assets		
Excess of revenue over expenses	$ 56,481	$ 60,074
Net assets released from restrictions	16,313	1,839
Change in funded status of pension and other postretirement benefits (Note 10)	8,254	(1,587)
Other changes in net assets	(185)	(3,364)
Change in fair value of interest rate swaps (Note 9)	4,190	7,802
Change in interest rate swap effectiveness	14,102	-
Increase in unrestricted net assets	99,155	64,764
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	13,050	26,592
Investment gains	2,964	1,677
Change in net unrealized gains on investments	1,282	3,775
Net assets released from restrictions	(29,774)	(12,961)
Contribution of temporarily restricted net assets from acquisition	-	103
(Decrease) increase in temporarily restricted net assets	(12,478)	19,186
Permanently restricted net assets		
Gifts and bequests	1,121	300
Investment gains in beneficial interest in trust	108	245
Contribution of permanently restricted net assets from acquisition	-	30
Increase in permanently restricted net assets	1,229	575
Change in net assets	87,906	84,525
Net assets		
Beginning of year	574,029	489,504
End of year	$ 661,935	$ 574,029

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, 2018 and 2017

(in thousands of dollars)	2018	2017
Cash flows from operating activities		
Change in net assets	$ 87,906	$ 84,525
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Change in fair value of interest rate swaps	(4,897)	(8,001)
Provision for bad debt	47,367	63,645
Depreciation and amortization	84,947	84,711
Contribution revenue from acquisition	-	(20,348)
Change in funded status of pension and other postretirement benefits	(8,254)	1,587
(Gain) loss on disposal of fixed assets	(125)	1,703
Net realized gains and change in net unrealized gains on investments	(45,701)	(57,255)
Restricted contributions and investment earnings	(5,460)	(4,374)
Proceeds from sales of securities	1,531	809
Loss from debt defeasance	14,214	381
Changes in assets and liabilities		
Patient accounts receivable, net	(29,335)	(35,811)
Prepaid expenses and other current assets	(8,299)	7,386
Other assets, net	(11,665)	(8,934)
Accounts payable and accrued expenses	19,693	(17,820)
Accrued compensation and related benefits	10,665	10,349
Estimated third-party settlements	13,708	7,783
Insurance deposits and related liabilities	4,556	(5,927)
Liability for pension and other postretirement benefits	(32,399)	8,935
Other liabilities	(2,421)	11,431
Net cash provided by operating and non-operating activities	136,031	124,775
Cash flows from investing activities		
Purchase of property, plant, and equipment	(77,598)	(77,361)
Proceeds from sale of property, plant, and equipment	-	1,087
Purchases of investments	(279,407)	(259,201)
Proceeds from maturities and sales of investments	273,409	276,934
Cash received through acquisition	-	3,564
Net cash used in investing activities	(83,596)	(54,977)
Cash flows from financing activities		
Proceeds from line of credit	50,000	65,000
Payments on line of credit	(50,000)	(101,550)
Repayment of long-term debt	(413,104)	(48,506)
Proceeds from issuance of debt	507,791	39,064
Repayment of interest rate swap	(16,019)	-
Payment of debt issuance costs	(4,892)	(274)
Restricted contributions and investment earnings	5,460	4,374
Net cash provided by (used in) financing activities	79,236	(41,892)
Increase in cash and cash equivalents	131,671	27,906
Cash and cash equivalents		
Beginning of year	68,498	40,592
End of year	$ 200,169	$ 68,498
Supplemental cash flow information		
Interest paid	$ 18,029	$ 23,407
Net assets acquired as part of acquisition, net of cash aquired	-	16,784
Non-cash proceeds from issuance of debt	137,281	-
Use of non-cash proceeds to refinance debt	(137,281)	-
Building construction in process financed by a third party	-	8,426
Construction in progress included in accounts payable and accrued expenses	1,569	14,669
Equipment acquired through issuance of capital lease obligations	17,670	-
Donated securities	1,531	809

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

1. Organization and Community Benefit Commitments

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

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

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

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

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

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

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

- *Subsidized health services* are services provided by the Health System, resulting in financial losses that meet the needs of the community and would not otherwise be available to participate unless the responsibility was assumed by the government.
- *Research support and other grants* represent costs in excess of awards for numerous health research and service initiatives awarded to the organizations within the Health System.
- *Community health-related initiatives* occur outside of the organization(s) through various financial contributions of cash, in-kind, and grants to local organizations.
- *Community-building activities* include cash, in-kind donations, and budgeted expenditures for the development of programs and partnerships intended to address social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement. Community benefit operations includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.
- *Charity care (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2018 and 2017, the Health System provided financial assistance to patients in the amount of approximately $39,446,000 and $29,934,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2018 and 2017 was approximately $15,559,000 and $12,173,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.
- *Government-sponsored healthcare services* are provided to Medicaid and Medicare patients at reimbursement levels that are significantly below the cost of the care provided.
- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2017 was approximately $126,867,000. The 2018 Community Benefits Reports are expected to be filed in February 2019.

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, 2017:

(Unaudited, in thousands of dollars)

Government-sponsored healthcare services	$	287,845
Health professional education		33,197
Subsidized health services		30,447
Charity care		11,070
Community health services		6,829
Research		3,308
Community building activities		1,487
Financial contributions		1,417
Community benefit operations		913
Total community benefit value	$	376,513

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, 2018 and 2017, the Health System reported a provision for bad debt expense of approximately $47,367,000 and $63,645,000, respectively.

2. Summary of Significant Accounting Policies

Basis of Presentation

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

Use of Estimates

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

Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include the excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisitions, loss on early extinguishment of debt, loss due to swap termination, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as non-operating gains (losses).

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

Charity Care 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 3).

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 3).

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

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

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

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds and pooled/comingled funds, and all investments in debt securities are considered to be trading securities reported at fair value with changes in fair value included in the excess 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 6).

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

Certain 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 permanently restricted assets were invested in these pooled funds by purchasing units based on the fair value of the pooled funds at the end of the month prior to receipt of any new additions to the funds. Interest, dividends, and realized and unrealized gains and losses earned on pooled funds are allocated monthly based on the weighted average units outstanding at the prior month-end.

Investment income or losses (including change in unrealized and realized gains and losses on unrestricted investments, change in value of equity method investments, interest, and dividends) are included in the excess of revenue over expenses and classified as non-operating gains and losses, unless the income or loss is restricted by donor or law (Note 8).

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

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

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

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

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

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

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

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

Trade Names
The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $2,462,000 and $2,700,000 as intangible assets associated with its affiliations as of June 30, 2018 and 2017, respectively.

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

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

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

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

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

Recently Issued Accounting Pronouncements
In May 2014, the FASB issued ASU 2014-09 - *Revenue from Contracts with Customers* and in August 2015, the FASB amended the guidance to defer the effective date of this standard by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Health System is in the process of completing an evaluation of the requirements of the new standard, which became effective on July 1, 2018. In addition, the Health System is in the process of drafting the new disclosures required post implementation. The Health System plans to use a modified retrospective method of application to adopt ASU 2014-09 on July 1, 2018. The Health System will use a portfolio approach to apply the new model to classes of payers with similar characteristics and analyze cash collection trends over an appropriate collection look-back period depending on the payer. Adoption of ASU 2014-09 will result in changes to the presentation for and disclosure of revenue related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of the provision for doubtful accounts related to self-pay patients, as well as co-pays and deductibles owed to the Health System by patients. Under ASU 2014-09, the estimated uncollectible amounts due from these patients are generally considered a direct reduction to net operating revenues and, correspondingly, result in a material reduction in the amounts presented separately as provision for doubtful accounts. The Health System is also in the process of completing an assessment of the impact of the new standard on other operating revenue and various reimbursement programs that represent variable consideration. These include supplemental state Medicaid programs, disproportionate share payments and settlements with third party payers. The payment mechanisms for these types of programs vary by state. While the adoption of ASU 2014-09 will

have a material effect on the presentation of net operating revenues in the Health System's consolidated statements of operations and changes in net assets, and will impact certain disclosures, it will not materially impact the financial position, results of operations or cash flows.

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

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

In August 2016, the FASB issued ASU 2016-14 - *Presentation of Financial Statements for Not-for-Profit Entities*. The new pronouncement amends certain financial reporting requirements for not-for-profit entities, including revisions to the classification of net assets and expanded disclosure requirements concerning expenses and liquidity. The ASU is effective for the Health System for the year ending June 30, 2019. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

3. 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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Gross patient service revenue	$ 5,180,649	$ 4,865,332
Less: Contractual allowances	3,281,554	3,006,140
Provision for bad debt	47,367	63,645
Net patient service revenue	$ 1,851,728	$ 1,795,547

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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Receivables		
Patients	$ 94,104	$ 90,786
Third-party payors	250,657	263,240
Nonpatient	6,695	4,574
	$ 351,456	$ 358,600

The allowance for estimated uncollectibles is $132,228,000 and $121,340,000 as of June 30, 2018 and 2017.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2018 and 2017:

	2018	2017
Medicare	43 %	43 %
Anthem/Blue Cross	18	18
Commercial insurance	20	20
Medicaid	13	13
Self-pay/other	6	6
	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, 2018 and 2017 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 this 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, subject to 2% sequestration, for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. They are reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. The nursing home and Rehabilitation distinct part units are not impacted by CAH designation. Medicare reimburses both services based on an acuity driven prospective payment system with no retrospective settlement.

Certain of the Health System's affiliates qualify as Home Health and Hospice Providers. Providers of home health services to clients eligible for Medicare home health benefits are paid on a prospective basis, with no retrospective settlement. The prospective payment is based on the scoring attributed to the acuity level of the client at a rate determined by federal guidelines. Hospice services to clients eligible for Medicare hospice benefits are paid on a per diem basis, with no retrospective settlement, provided the aggregate annual Medicare reimbursement is below a predetermined aggregate capitated rate. Revenue is recognized as the services are performed based on the fixed rate amount.

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, 2018 and 2017, the Health System recorded State of NH Medicaid Enhancement Tax (MET) and State of VT Provider Tax of $67,692,000 and $65,069,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain net patient revenues in accordance with instructions received from the States. The provider taxes are included in Medicaid enhancement tax in the consolidated statements of operations and changes in net assets.

During fiscal year 2016, Vermont state legislation passed changes to the tax base for home health providers from 19.30% of core home health care services (primarily Medicaid services) with a cap of 6% of net patient service revenue to 3.63% of net patient revenue for fiscal year 2017 and fiscal year 2018. Home health provider tax paid, which is included in purchased services and other in the consolidated statements of operations and changes in net assets, was $737,000 and $645,000 in 2018 and 2017, respectively.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax "SB 369". As part of this 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.

In May of 2018, the State of NH and NH Hospitals reached a new seven-year agreement through 2024. Under the terms of this agreement, the hospitals agreed to accept approximately $28 million less in DSH payments to which they are entitled in fiscal year 2018 and fiscal year 2019 in exchange for greater certainty about both future DSH payments and increases in Medicaid reimbursement rates. The new agreement contains a number of safeguards. In the event of adverse federal legislative or administrative changes to the DSH program, the agreement provides for alternative payments (e.g., other Medicaid supplemental payments or rate increases that will compensate the hospitals for any loss of DSH revenue). Additionally, the hospitals have filed a declaratory judgment petition based on the terms of the 2018 agreement, to which the State of NH has consented and on which a court order has been entered. If the State of NH breaches any term of the 2018 agreement, the hospitals are entitled to recoup the balance of DSH payments forfeited in fiscal year 2018 and fiscal year 2019.

Pursuant to this agreement, the State of NH made DSH payments to D-HH member hospitals in NH in the aggregate amount of approximately $66,383,000 for fiscal year 2018. In fiscal year 2017, D-HH member hospitals in NH received approximately $59,473,000.

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. The Health System has recognized meaningful use incentives of $344,000 and $1,156,000 for both the Medicare and Vermont Medicaid programs during the years ended June 30, 2018 and 2017, 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.

Non-acute 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 (2013 - 2018). 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 2018 and 2017, changes in prior estimates related to the Health System's settlements with third-party payors resulted in (decreases) increases in net patient service revenue of ($5,604,000) and $2,000,000 respectively, in the consolidated statements of operations and changes in net assets.

4. Investments

The composition of investments at June 30, 2018 and 2017 is set forth in the following table:

(in thousands of dollars)	2018	2017
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 8,558	$ 9,923
U.S. government securities	50,484	44,835
Domestic corporate debt securities	109,240	100,953
Global debt securities	110,944	105,920
Domestic equities	142,796	129,548
International equities	106,668	95,167
Emerging markets equities	23,562	33,893
Real Estate Investment Trust	816	791
Private equity funds	50,415	39,699
Hedge funds	32,831	30,448
	636,314	591,177
Investments held by captive insurance companies (Note 11)		
U.S. government securities	30,581	18,814
Domestic corporate debt securities	16,764	21,681
Global debt securities	4,513	5,707
Domestic equities	8,109	9,048
International equities	7,971	13,888
	67,938	69,138
Held by trustee under indenture agreement (Note 9)		
Cash and short-term investments	1,872	2,008
Total assets limited as to use	706,124	662,323
Other investments for restricted activities		
Cash and short-term investments	4,952	5,467
U.S. government securities	28,220	28,096
Domestic corporate debt securities	29,031	27,762
Global debt securities	14,641	14,560
Domestic equities	20,509	18,451
International equities	17,521	15,499
Emerging markets equities	2,155	3,249
Real Estate Investment Trust	954	790
Private equity funds	4,878	3,949
Hedge funds	8,004	6,676
Other	31	30
Total other investments for restricted activities	130,896	124,529
Total investments	$ 837,020	$ 786,852

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

The following tables summarize the investments by the accounting method utilized, as of June 30, 2018 and 2017. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 6.

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

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

Investment income is comprised of the following for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Unrestricted		
Interest and dividend income, net	$ 12,324	$ 4,418
Net realized gains on sales of securities	24,411	16,868
Change in net unrealized gains on investments	4,612	30,809
	41,347	52,095
Temporarily restricted		
Interest and dividend income, net	1,526	1,394
Net realized gains on sales of securities	1,438	283
Change in net unrealized gains on investments	1,282	3,775
	4,246	5,452
Permanently restricted		
Change in net unrealized gains on beneficial interest in trust	108	245
	108	245
	$ 45,701	$ 57,792

For the years ended June 30, 2018 and 2017 unrestricted investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $960,000 and $1,039,000 and as non-operating gains of approximately $40,387,000 and 51,056,000, 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, 2018 and 2017, the Health System has committed to contribute approximately $137,219,000 and $119,719,000 to such funds, of which the Health System has contributed approximately $91,942,000 and $81,982,000 and has outstanding commitments of $45,277,000 and $37,737,000, respectively.

5. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Land	$ 38,058	$ 38,058
Land improvements	42,295	37,579
Buildings and improvements	876,537	818,831
Equipment	818,902	766,667
Equipment under capital leases	20,966	20,495
	1,796,758	1,681,630
Less: Accumulated depreciation and amortization	1,200,549	1,101,058
Total depreciable assets, net	596,209	580,572
Construction in progress	11,112	29,403
	$ 607,321	$ 609,975

As of June 30, 2018, construction in progress primarily consists of the building renovations taking place at the birthing pavilion in Lebanon, NH as well as the information systems PeopleSoft project for APD and Cheshire. The estimated cost to complete the birthing pavilion at June 30, 2018 is $200,000 and the estimated cost to complete the PeopleSoft project is $2,775,000.

The construction in progress for the Hospice & Palliative Care building reported as of June 30, 2017 was completed during the second quarter of fiscal year 2018 and APD's medical office building was completed in the fourth quarter of fiscal year 2018.

Depreciation and amortization expense included in operating and non-operating activities was approximately $84,947,000 and $84,711,000 for 2018 and 2017, respectively.

6. Fair Value Measurements

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

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

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

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

Interest Rate Swaps
The fair value of interest rate swaps, are determined using the present value of the fixed and floating legs of the swaps. Each series of cash flows are discounted by observable market interest rate curves and credit risk. All interest rate swaps held by the Health System were extinguished as part of Series 2018A and Series 2018B bond issuance (Note 9).

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, 2018 and 2017:

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

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

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

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

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

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2018 and 2017.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Healthcare services	$ 19,570	$ 32,583
Research	24,732	25,385
Purchase of equipment	3,068	3,080
Charity care	13,667	13,814
Health education	18,429	17,489
Other	2,973	2,566
	$ 82,439	$ 94,917

Permanently restricted net assets consist of the following at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Healthcare services	$ 23,390	$ 22,916
Research	7,821	7,795
Purchase of equipment	6,310	6,274
Charity care	8,883	6,895
Health education	8,784	10,228
Other	206	57
	$ 55,394	$ 54,165

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

8. Board Designated and Endowment Funds

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

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

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

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2018 and 2017.

Endowment net asset composition by type of fund consists of the following at June 30, 2018 and 2017:

	2018			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 31,320	$ 46,877	$ 78,197
Board-designated endowment funds	29,506	-	-	29,506
Total endowed net assets	$ 29,506	$ 31,320	$ 46,877	$ 107,703

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

Changes in endowment net assets for the year ended June 30, 2018:

	2018			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at beginning of year	$ 26,389	$ 29,701	$ 45,756	$ 101,846
Net investment return	3,112	4,246	-	7,358
Contributions	-	-	1,121	1,121
Transfers	5	(35)	-	(30)
Release of appropriated funds	-	(2,592)	-	(2,592)
Balances at end of year	$ 29,506	$ 31,320	46,877	$ 107,703

Balances at end of year	46,877
Beneficial interest in perpetual trust	8,517
Permanently restricted net assets	$ 55,394

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

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

Balances at end of year	45,756
Beneficial interest in perpetual trust	8,409
Permanently restricted net assets	$ 54,165

9. Long-Term Debt

A summary of long-term debt at June 30, 2018 and 2017 is as follows:

(in thousands of dollars)	2018	2017
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2036 (1)	$ 83,355	$ -
Series 2016A, principal maturing in varying annual amounts, through August 2046 (3)	-	24,608
Series 2015A, principal maturing in varying annual amounts, through August 2031 (4)	-	82,975
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	-
Series 2017A, principal maturing in varying annual amounts, through August 2039 (2)	122,435	-
Series 2017B, principal maturing in varying annual amounts, through August 2030 (2)	109,800	-
Series 2016B, principal maturing in varying annual amounts, through August 2046 (3)	10,970	10,970
Series 2014A, principal maturing in varying annual amounts, through August 2022 (6)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (6)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (7)	-	71,700
Series 2012B, principal maturing in varying annual amounts, through August 2031 (7)	-	39,340
Series 2012, principal maturing in varying annual amounts, through July 2039 (11)	25,955	26,735
Series 2010, principal maturing in varying annual amounts, through August 2040 (9)	-	75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (10)	-	57,540
Total variable and fixed rate debt	$ 697,107	$ 430,358

A summary of long-term debt at June 30, 2018 and 2017 is as follows (continued):

(in thousands of dollars)	2018	2017
Other		
Revolving Line of Credit, principal maturing through March 2019 (5)	$ -	$ 49,750
Series 2012, principal maturing in varying annual amounts, through July 2025 (8)	-	136,000
Series 2010, principal maturing in varying annual amounts, through August 2040 (12)*	15,498	15,900
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment*	646	811
Note payable to a financial institution with entire principal due June 2029 that is collateralized by land and building. The note payable is interest free*	380	437
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046*	2,697	2,763
Obligations under capital leases	18,965	3,435
Total other debt	38,186	209,096
Total variable and fixed rate debt	697,107	430,358
Total long-term debt	735,293	639,454
Less: Original issue discounts and premiums, net	(26,862)	862
Bond issuance costs, net	5,716	3,832
Current portion	3,464	18,357
	$ 752,975	$ 616,403

*Represents nonobligated group bonds

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

(in thousands of dollars)	2018
2019	$ 3,464
2020	10,495
2021	10,323
2022	10,483
2023	7,579
Thereafter	692,949
	$ 735,293

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

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

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

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

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

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. A loss on the extinguishment of debt of approximately $13,636,000 was recognized in non-operating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

(3) Series 2016A and 2016B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2016A and 2016B in July 2016 through a private placement with a financial institution. The Series 2016A Revenue Bonds were primarily used to refund Series 2013A and Series 2013B and the Series 2016B Revenue Bonds were used to finance 2016 projects. Interest is equal to the sum of .70 times one month LIBOR plus .70 times the spread. The variable rate as of June 30 2017 was 1.48% The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2046. The Series 2016A Revenue Bonds were refunded in February 2018.

(4) Series 2015A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2015A in September 2015 through a private placement with a financial institution. The Series 2015A Revenue Bonds were primarily used to refinance a portion of the Series 2011 Revenue Bonds and to cover cost of issuance. The Series 2015A Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The Series 2015A Revenue Bonds were refunded in February 2018.

(5) Revolving Line of Credit

The DHOG entered into a Revolving Line of Credit with TD Bank, N.A. (TD Bank). Interest on the TD Bank loan accrues variably and matures at various dates through March 2019. The Revolving Line of Credit was refunded in February 2018.

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

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

(7) Series 2012A and 2012B Revenue Bonds

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. The Series 2012A and Series 2012B Revenue Bonds were refunded in December 2017.

(8) Series 2012 Bank Loan

The DHOG issued the Bank of America, N.A. Series 2012 note, in July 2012. The proceeds from the Series 2012 note were used to prefund the D-H defined benefit pension plan. Interest on the Series 2012 note accrues at a fixed rate of 2.47% and matures at various dates through 2025. The Series 2012 Bank Loan was refunded in February 2018.

(9) Series 2010 Revenue Bonds

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. The Series 2010 Revenue Bonds were defeased in December 2017.

(10)Series 2009 Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 5.00% and 6.00% and mature at various dates through August 2038. The Series 2009 Revenue Bonds were defeased in December 2017.

(11)Series 2012 Revenue Bonds

The NHHEFA issued $29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%). Principal is payable in annual installments ranging from $780,000 to $1,750,000 through July 2039. The Series 2012 Revenue Bonds were refunded in February 2018.

Outstanding joint and several indebtedness of the DHOG at June 30, 2018 and 2017 approximates $697,107,000 and $616,108,000, respectively.

Non Obligated Group Bonds

(12)Series 2010 Revenue Bonds

The Business Finance Authority (BFA) of the State of NH issued Revenue Bonds, Series 2010. Interest is based on an annual percentage rate equal to the sum of (a) 69% of the 1-Month LIBOR rate plus (b) 1.8975/5. APD may prepay certain of these bonds according to the terms of the loan and trust agreement. The bonds are redeemable at any time by APD at par value plus any accrued interest. The bonds are also subject to optional tender for purchase (as a whole) in November 2020 at par plus accrued interest.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $1,872,000 and $2,008,000 at June 30, 2018 and 2017, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 4). The debt service reserves are mainly comprised of escrowed funds held for future interest payments for the Cheshire debt.

For the years ended June 30, 2018 and 2017 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 $18,822,000 and $19,838,000 and is included in other non-operating losses of $2,793,000 and $3,135,000, respectively.

Swap Agreements

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

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

- A Fixed Payor Swap designed as a cash flow hedge of the NHHEFA Series 2011 Revenue Bonds. The Swap had an initial notional amount of $91,040,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 4.56% in exchange for the counterparty's payment of 67% of USD-LIBOR-BBA. The Swap's term matches that of the associated bonds. The 2011 interest rate swap was not integrated with the 2011 bonds. When the 2011 bonds were refinanced, the swap became associated with the 2015 bond. The Fixed Payor Swap was terminated in February 2018.

- 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. The Interest Rate Swap was terminated in February, 2018.

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

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

As of June 30, 2018, there was no liability for interest rate swaps as all remaining swaps were terminated in February 2018. For the year ended June 30, 2018, the Health System recognized a non-operating loss due to swap termination of $14,247,000 relating to the swap termination. As of June 30, 2017, the fair value of the Health System's interest rate swaps was a liability of $20,916,000. The change in fair value during the years ended June 30, 2018 and 2017 was a decrease of $4,897,000 and $8,002,000, respectively. For the years ended June 30, 2018 and 2017 the Health System recognized a non-operating gain of $145,000 and $124,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

10. Employee Benefits

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

All of the defined benefit plans within the Health System have been frozen or had been approved by the applicable Board of Trustees to be frozen by January 31, 2017.

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

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

Defined Benefit Plans

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Service cost for benefits earned during the year	$ 150	$ 5,736
Interest cost on projected benefit obligation	47,190	47,316
Expected return on plan assets	(64,561)	(64,169)
Net prior service cost	-	109
Net loss amortization	10,593	20,267
Special/contractural termination benefits	-	119
One-time benefit upon plan freeze acceleration	-	9,519
	$ (6,628)	$ 18,897

The following assumptions were used to determine net periodic pension expense as of June 30, 2018 and 2017:

	2018	2017
Discount rate	4.00 % – 4.30 %	4.20 % – 4.90 %
Rate of increase in compensation	N/A	Age Graded - N/A
Expected long-term rate of return on plan assets	7.50 % – 7.75 %	7.50 % – 7.75 %

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,122,615	$ 1,096,619
Service cost	150	5,736
Interest cost	47,190	47,316
Benefits paid	(47,550)	(43,276)
Expenses paid	(172)	(183)
Actuarial (gain) loss	(34,293)	6,884
One-time benefit upon plan freeze acceleration	-	9,519
Benefit obligation at end of year	1,087,940	1,122,615
Change in plan assets		
Fair value of plan assets at beginning of year	878,701	872,320
Actual return on plan assets	33,291	44,763
Benefits paid	(47,550)	(43,276)
Expenses paid	(172)	(183)
Employer contributions	20,713	5,077
Fair value of plan assets at end of year	884,983	878,701
Funded status of the plans	(202,957)	(243,914)
Less: Current portion of liability for pension	(45)	(46)
Long term portion of liability for pension	(202,912)	(243,868)
Liability for pension	$ (202,957)	$ (243,914)

For the years ended June 30, 2018 and 2017 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 include approximately $418,971,000 and $429,782,000 of net actuarial loss as of June 30, 2018 and 2017, respectively.

The estimated amounts to be amortized from unrestricted net assets into net periodic pension expense in fiscal year 2019 for net actuarial losses is $10,357,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,087,991,000 and $1,123,010,000 at June 30, 2018 and 2017, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2018 and 2017:

	2018	2017
Discount rate	4.20 % – 4.50 %	4.00 % – 4.30 %
Rate of increase in compensation	N/A	N/A - 0.00 %

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, 2018 and 2017, it is expected that the LDI strategy will hedge approximately 60% and 55%, respectively, of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

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

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

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

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

The hierarchy and inputs to valuation techniques to measure fair value of the Plans' assets are the same as outlined in Note 6. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in these funds rather than in securities underlying each fund and, therefore, are

generally required to consider such investments as Level 2 or 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2018 and 2017:

	2018					
(In thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 142	$ 35,817	$ -	$ 35,959	Daily	1
U.S. government securities	46,265	-	-	46,265	Daily–Monthly	1–15
Domestic debt securities	144,131	220,202	-	364,333	Daily–Monthly	1–15
Global debt securities	470	74,676	-	75,146	Daily–Monthly	1–15
Domestic equities	158,634	17,594	-	176,228	Daily–Monthly	1–10
International equities	18,656	80,803	-	99,459	Daily–Monthly	1–11
Emerging market equities	382	39,881	-	40,263	Daily–Monthly	1–17
REIT funds	371	2,686	-	3,057	Daily–Monthly	1–17
Private equity funds	-	-	23	23	See Note 6	See Note 6
Hedge funds	-	-	44,250	44,250	Quarterly–Annual	60–96
Total investments	$ 369,051	$ 471,659	$ 44,273	$ 884,983		

	2017					
(In thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 23	$ 29,792	$ -	$ 29,815	Daily	1
U.S. government securities	7,875	-	-	7,875	Daily–Monthly	1–15
Domestic debt securities	140,498	243,427	-	383,925	Daily–Monthly	1–15
Global debt securities	426	90,389	-	90,815	Daily–Monthly	1–15
Domestic equities	154,597	16,938	-	171,535	Daily–Monthly	1–10
International equities	9,837	93,950	-	103,787	Daily–Monthly	1–11
Emerging market equities	2,141	45,351	-	47,492	Daily–Monthly	1–17
REIT funds	362	2,492	-	2,854	Daily–Monthly	1–17
Private equity funds	-	-	96	96	See Note 6	See Note 6
Hedge funds	-	-	40,507	40,507	Quarterly–Annual	60–96
Total investments	$ 315,759	$ 522,339	$ 40,603	$ 878,701		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2018 and 2017:

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

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

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2018 and 2017 were approximately $14,743,000 and $7,965,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2018 and 2017.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2018 and 2017.

The weighted average asset allocation for the Health System's Plans at June 30, 2018 and 2017 by asset category is as follows:

	2018	2017
Cash and short-term investments	4 %	3 %
U.S. government securities	5	1
Domestic debt securities	41	44
Global debt securities	9	10
Domestic equities	20	20
International equities	11	12
Emerging market equities	5	5
Hedge funds	5	5
	100 %	100 %

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

The Health System is expected to contribute approximately $20,480,000 to the Plans in 2019 however actual contributions may vary from expected amounts.

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

(in thousands of dollars)

2019	$ 49,482
2020	51,913
2021	54,249
2022	56,728
2023	59,314
2024 – 2027	329,488

Defined Contribution Plans

The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $38,563,000 and $33,375,000 in 2018 and 2017, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by affiliate and plan. No employer contributions were made to any of these plans in 2018 and 2017 respectively.

Postretirement Medical and Life Benefits

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

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Service cost	$ 533	$ 448
Interest cost	1,712	2,041
Net prior service income	(5,974)	(5,974)
Net loss amortization	10	689
	$ (3,719)	$ (2,796)

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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Change in benefit obligation		
Benefit obligation at beginning of year	$ 42,277	$ 51,370
Service cost	533	448
Interest cost	1,712	2,041
Benefits paid	(3,174)	(3,211)
Actuarial loss (gain)	1,233	(8,337)
Employer contributions	-	(34)
Benefit obligation at end of year	42,581	42,277
Funded status of the plans	$ (42,581)	$ (42,277)
Current portion of liability for postretirement medical and life benefits	$ (3,266)	$ (3,174)
Long term portion of liability for postretirement medical and life benefits	(39,315)	(39,103)
Liability for postretirement medical and life benefits	$ (42,581)	$ (42,277)

For the years ended June 30, 2018 and 2017 the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic postretirement medical and life benefit income and included in the change in unrestricted net assets are as follows:

(in thousands of dollars)	2018	2017
Net prior service income	$ (15,530)	$ (21,504)
Net actuarial loss	3,336	2,054
	$ (12,194)	$ (19,450)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement income in fiscal year 2019 for net prior service cost is $5,974,000.

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2019 and thereafter:

(in thousands of dollars)	
2019	$ 3,266
2020	3,298
2021	3,309
2022	3,315
2023	3,295
2024-2027	15,156

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.50% in 2018 and an assumed healthcare cost trend rate of 6.00%, trending down to 4.75% in 2021 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2018 and 2017 by $1,088,000 and $1,067,000 and the net periodic postretirement medical benefit cost for the years then ended by $81,000 and $110,000, 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, 2018 and 2017 by $996,000 and $974,000 and the net periodic postretirement medical benefit cost for the years then ended by $72,000 and $96,000, respectively.

11. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College, Cheshire, NLH and MAHHC are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2017 VNH is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. D-H and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

APD are covered for malpractice claims under a modified claims-made policy purchased through New England Alliance for Health (NEAH). While APD remain in the current insurance program under this policy, the coverage year is based on the date the claim is filed; subject to a medical incident arising after the retroactive date (includes prior acts). The policy provides modified claims-made coverage for former insured providers for claims that relate to the employee's period of employment at APD 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, 2018 and 2017 are summarized as follows:

	2018		
(in thousands of dollars)	HAC *(audited)*	RRG *(unaudited)*	Total
Assets	$ 72,753	$ 2,068	$ 74,821
Shareholders' equity	13,620	50	13,670
Net income	-	(751)	(751)

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

12. 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 $14,096,000 and $15,802,000 for the years ended June 30, 2018 and 2017, respectively.

Minimum future lease payments under noncancelable operating leases at June 30, 2018 were as follows:

(in thousands of dollars)

2019	$ 12,393
2020	10,120
2021	8,352
2022	5,175
2023	3,935
Thereafter	10,263
	$ 50,238

Lines of Credit
The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $2,000,000 up to $30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 29, 2019. There was no outstanding balance under the lines of credit as of June 30, 2018 and 2017. Interest expense was approximately $232,000 and $915,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

13. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Program services	$ 1,715,760	$ 1,662,413
Management and general	303,527	311,820
Fundraising	2,354	2,328
	$ 2,021,641	$ 1,976,561

14. Subsequent Events

The Health System has assessed the impact of subsequent events through November 7, 2018, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

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

APD and APD LifeCare Center (LifeCare) were jointly liable for their Series 2010 Revenue Bonds; $26,000,000 outstanding as of June 30, 2018. As described in Note 9 to the financial statements, APD's portion was approximately $15,500,000 as of June 30, 2018. LifeCare's outstanding portion of approximately $10,500,000 was appropriately excluded from the consolidated financial statements as LifeCare was not affiliated with any of the members of the Health System as of June 30, 2018. On August 15, 2018, APD joined the DHOG and simultaneously issued NHHEFA Revenue Bonds, Series 2018C. The Series 2018C Revenue Bonds were used primarily to refinance the joint (APD and LifeCare) Series 2010 Revenue Bonds.

Consolidating Supplemental Information – Unaudited

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets										
Current assets										
Cash and cash equivalents	$ 134,634	$ 22,544	$ 6,588	$ 9,419	$ 6,604	$ -	$ 179,889	$ 20,280	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,055	-	207,521	11,707	-	219,228
Prepaid expenses and other current assets	11,964	143,893	6,551	5,253	2,313	(72,361)	97,613	4,766	(4,877)	97,502
Total current assets	146,598	343,418	30,422	22,974	13,972	(72,361)	485,023	36,753	(4,877)	516,899
Assets limited as to use	8	616,929	17,438	12,821	10,829	-	658,025	48,099	-	706,124
Notes receivable, related party	554,771	-	-	-	-	(554,771)	-	-	-	-
Other investments for restricted activities	-	87,613	8,591	2,881	6,238	-	105,423	25,473	-	130,896
Property, plant, and equipment, net	36	443,154	66,759	42,438	17,356	-	569,743	37,578	-	607,321
Other assets	24,863	101,078	1,370	5,906	4,280	(10,970)	126,527	3,604	(21,346)	108,785
Total assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025
Liabilities and Net Assets										
Current liabilities										
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 187	$ -	$ 2,600	$ 864	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	3,311	-	-	3,311
Accounts payable and accrued expenses	54,995	82,061	20,107	6,705	3,029	(72,361)	94,536	6,094	(4,877)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,796	-	118,498	7,078	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	-	38,693	2,448	-	41,141
Total current liabilities	57,997	217,299	26,647	19,419	8,637	(72,361)	257,638	16,484	(4,877)	269,245
Notes payable, related party	-	527,346	-	27,425	-	(554,771)	-	-	-	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,270	(10,970)	724,231	28,744	-	752,975
Insurance deposits and related liabilities	-	54,616	465	155	240	-	55,476	40	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	242,227	-	-	242,227
Other liabilities	-	85,577	1,107	1,405	-	-	88,089	38	-	88,127
Total liabilities	702,517	1,170,412	57,788	49,583	25,463	(638,102)	1,367,661	45,306	(4,877)	1,408,090
Commitments and contingencies										
Net assets										
Unrestricted	23,759	334,882	61,828	32,897	19,812	-	473,178	72,230	(21,306)	524,102
Temporarily restricted	-	54,666	4,964	493	1,540	-	61,663	20,816	(40)	82,439
Permanently restricted	-	32,232	-	4,147	5,860	-	42,239	13,155	-	55,394
Total net assets	23,759	421,780	66,792	37,537	27,212	-	577,080	106,201	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 134,634	$ 23,094	$ 8,621	$ 9,982	$ 6,654	$ 12,144	$ 5,040	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,109	7,996	3,657	-	219,228
Prepaid expenses and other current assets	11,964	144,755	5,520	5,276	2,294	4,443	488	(77,238)	97,502
Total current assets	146,598	344,830	31,324	23,560	14,057	24,583	9,185	(77,238)	516,899
Assets limited as to use	8	635,028	17,438	12,821	11,862	9,812	19,355	-	706,124
Notes receivable, related party	554,771	-	-	-	-	-	-	(554,771)	-
Other investments for restricted activities	-	95,772	25,873	2,981	6,238	32	-	-	130,896
Property, plant, and equipment, net	36	445,829	70,607	42,920	19,065	25,725	3,139	-	607,321
Other assets	24,863	101,235	7,526	5,333	1,886	130	128	(32,316)	108,785
Total assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,607	$ (664,325)	$ 2,070,025
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 245	$ 739	$ 67	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	54,995	82,613	20,052	6,714	3,092	3,596	1,929	(77,238)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,831	5,814	1,229	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	2,448	-	-	41,141
Total current liabilities	57,997	217,851	26,592	19,428	8,793	12,597	3,225	(77,238)	269,245
Notes payable, related party	-	527,346	-	27,425	-	-	-	(554,771)	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,593	25,792	2,629	(10,970)	752,975
Insurance deposits and related liabilities	-	54,616	465	155	241	-	39	- -	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	- -	5,316	-	-	-	242,227
Other liabilities	-	85,577	1,117	1,405	-	28	-	-	88,127
Total liabilities	702,517	1,170,964	57,743	49,592	25,943	38,417	5,893	(842,979)	1,408,090
Commitments and contingencies									
Net assets									
Unrestricted	23,759	356,518	65,069	33,383	19,764	21,031	25,884	(21,306)	524,102
Temporarily restricted	-	60,836	19,196	493	1,539	415	-	(40)	82,439
Permanently restricted	-	34,376	10,760	4,147	5,862	219	30	-	55,394
Total net assets	23,759	451,730	95,025	38,023	27,165	21,665	25,914	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025

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

(in thousands of dollars)	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 27,328	$ 10,645	$ 7,797	$ 6,662	$ -	$ 52,432	$ 16,066	$ -	$ 68,498
Patient accounts receivable, net	193,733	17,723	8,539	4,659	-	224,654	12,606	-	237,260
Prepaid expenses and other current assets	93,816	6,945	3,650	1,351	(16,585)	89,177	8,034	(8,008)	89,203
Total current assets	314,877	35,313	19,986	12,672	(16,585)	366,263	36,706	(8,008)	394,961
Assets limited as to use	580,254	19,104	11,784	9,058	-	620,200	42,123	-	662,323
Other investments for restricted activities	86,398	4,764	2,833	6,079	-	100,074	24,455	-	124,529
Property, plant, and equipment, net	448,743	64,983	43,264	17,167	-	574,107	35,868	-	609,975
Other assets	89,650	2,543	5,965	4,095	(11,520)	90,733	27,674	(21,287)	97,120
Total assets	$ 1,519,922	$ 126,657	$ 83,832	$ 49,071	$ (28,105)	$ 1,751,377	$ 166,826	$ (29,295)	$ 1,888,908
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ 16,034	$ 780	$ 737	$ 80	$ -	$ 17,631	$ 726	$ -	$ 18,357
Line of credit	-	-	-	550	(550)	-	-	-	
Current portion of liability for pension and other postretirement plan benefits	3,220	-	-	-	-	3,220	-	-	3,220
Accounts payable and accrued expenses	72,362	19,715	5,356	2,854	(16,585)	83,702	13,466	(8,008)	89,160
Accrued compensation and related benefits	99,638	5,428	2,335	3,448	-	110,849	4,062	-	114,911
Estimated third-party settlements	11,322	-	7,265	1,915	-	20,502	6,931	-	27,433
Total current liabilities	202,576	25,923	15,693	8,847	(17,135)	235,904	25,185	(8,008)	253,081
Long-term debt, excluding current portion	545,100	26,185	26,402	10,976	(10,970)	597,693	18,710	-	616,403
Insurance deposits and related liabilities	50,960	-	-	-	-	50,960	-	-	50,960
Interest rate swaps	17,606	-	3,310	-	-	20,916	-	-	20,918
Liability for pension and other postretirement plan benefits, excluding current portion	267,409	8,761	-	6,801	-	282,971	-	-	282,971
Other liabilities	77,622	2,636	1,426	-	-	81,684	8,864	-	90,548
Total liabilities	1,161,273	63,505	46,831	26,624	(28,105)	1,270,128	52,759	(8,008)	1,314,879
Commitments and contingencies									
Net assets									
Unrestricted	258,887	58,250	32,504	15,247	-	364,888	81,344	(21,285)	424,947
Temporarily restricted	68,473	4,902	345	1,363	-	75,083	19,836	(2)	94,917
Permanently restricted	31,289	-	4,152	5,837	-	41,278	12,887	-	54,165
Total net assets	358,649	63,152	37,001	22,447	-	481,249	114,067	(21,287)	574,029
Total liabilities and net assets	$ 1,519,922	$ 126,657	$ 83,832	$ 49,071	$ (28,105)	$ 1,751,377	$ 166,826	$ (29,295)	$ 1,888,908

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 1,166	$ 27,760	$ 11,601	$ 8,280	$ 6,968	$ 8,129	$ 4,594	$ -	$ 68,498
Patient accounts receivable, net	-	193,733	17,723	8,539	4,681	8,878	3,706	-	237,260
Prepaid expenses and other current assets	3,884	94,305	5,899	3,671	1,340	4,179	518	(24,593)	89,203
Total current assets	5,050	315,798	35,223	20,490	12,989	21,186	8,818	(24,593)	394,961
Assets limited as to use	-	596,904	19,104	11,782	9,889	8,168	16,476	-	662,323
Other investments for restricted activities	6	94,210	21,204	2,833	6,079	197	-	-	124,529
Property, plant, and equipment, net	50	451,418	68,921	43,751	18,935	23,447	3,453	-	609,975
Other assets	23,866	89,819	8,586	5,378	1,812	283	183	(32,807)	97,120
Total assets	$ 28,972	$ 1,548,149	$ 153,038	$ 84,234	$ 49,704	$ 53,281	$ 28,930	$ (57,400)	$ 1,888,908
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 16,034	$ 780	$ 737	$ 137	$ 603	$ 66	$ -	$ 18,357
Line of credit	-	-	-	-	550	-	-	(550)	-
Current portion of liability for pension and other postretirement plan benefits	-	3,220	-	-	-	-	-	-	3,220
Accounts payable and accrued expenses	5,996	72,806	19,718	5,365	2,946	5,048	1,874	(24,593)	89,160
Accrued compensation and related benefits	-	99,638	5,428	2,335	3,480	2,998	1,032	-	114,911
Estimated third-party settlements	6,165	11,322	-	7,265	1,915	766	-	-	27,433
Total current liabilities	12,161	203,020	25,926	15,702	9,028	9,415	2,972	(25,143)	253,081
Long-term debt, excluding current portion	-	545,100	26,185	26,402	11,356	15,833	2,697	(10,970)	616,403
Insurance deposits and related liabilities	-	50,960	-	-	-	-	-	-	50,960
Interest rate swaps	-	17,606	-	3,310	-	-	-	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion	-	267,409	8,761	-	6,801	-	-	-	282,971
Other liabilities	-	77,622	2,531	1,426	-	8,969	-	-	90,548
Total liabilities	12,161	1,161,717	63,403	48,840	27,185	34,017	5,669	(36,113)	1,314,879
Commitments and contingencies									
Net assets									
Unrestricted	16,367	278,695	60,758	32,897	15,319	18,965	23,231	(21,285)	424,947
Temporarily restricted	444	74,304	18,198	345	1,363	265	-	(2)	94,917
Permanently restricted	-	33,433	10,679	4,152	5,837	34	30	-	54,165
Total net assets	16,811	386,432	89,635	37,394	22,519	19,264	23,261	(21,287)	574,029
Total liabilities and net assets	$ 28,972	$ 1,548,149	$ 153,038	$ 84,234	$ 49,704	$ 53,281	$ 28,930	$ (57,400)	$ 1,888,908

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2018

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Unrestricted revenue and other support										
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ -	$ 1,804,550	$ 94,545	$ -	$ 1,899,095
Provisions for bad debts	-	31,358	10,967	1,554	1,440	-	45,319	2,048	-	47,367
Net patient service revenue less provisions for bad debts	-	1,443,956	205,769	58,932	50,574	-	1,759,231	92,497	-	1,851,728
Contracted revenue	(2,305)	97,291	-	-	2,169	(42,870)	54,285	715	(32)	54,969
Other operating revenue	9,799	134,461	3,365	4,169	1,814	(10,554)	143,054	6,978	(1,086)	148,946
Net assets released from restrictions	658	11,605	620	52	44	-	12,979	482	-	13,461
Total unrestricted revenue and other support	8,152	1,687,313	209,754	63,153	54,601	(53,424)	1,969,549	100,673	(1,118)	2,069,104
Operating expenses										
Salaries	-	806,344	105,607	30,360	24,854	(21,542)	945,623	42,035	1,605	989,263
Employee benefits	-	181,833	28,343	7,252	7,000	(5,385)	219,043	10,221	419	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,055	-	329,836	10,195	-	340,031
Purchased services and other	8,509	215,073	33,055	13,587	13,960	(19,394)	264,800	29,390	(2,818)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,744	-	65,517	2,175	-	67,692
Depreciation and amortization	23	66,073	10,217	3,934	2,030	-	82,277	2,501	-	84,778
Interest	8,684	15,772	1,004	981	224	(8,882)	17,783	1,039	-	18,822
Total operating expenses	17,216	1,627,466	217,599	64,934	52,867	(55,203)	1,924,879	97,556	(794)	2,021,641
Operating (loss) margin	(9,064)	59,847	(7,845)	(1,781)	1,734	1,779	44,670	3,117	(324)	47,463
Non-operating (losses) gains										
Investment (losses) gains	(26)	33,628	1,408	1,151	858	(196)	36,821	3,566	-	40,387
Other, net	(1,364)	(2,599)	-	1,276	266	(1,581)	(4,002)	733	361	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	(14,214)	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	(14,247)	-	-	(14,247)
Total non-operating (losses) gains, net	(1,390)	(2,673)	1,408	2,122	1,124	(1,779)	(4,358)	4,299	361	9,018
(Deficiency) excess of revenue over expenses	(10,454)	62,720	(6,437)	341	2,858	-	49,028	7,416	37	56,481
Unrestricted net assets										
Net assets released from restrictions (Note 7)	-	16,038	-	4	252	-	16,294	19	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	8,254	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-	-
Additional paid in capital	-	-	-	-	-	-	-	58	(58)	-
Other changes in net assets	-	-	-	-	-	-	-	(185)	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	4,190	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	14,102	-	-	14,102
Increase in unrestricted net assets	$ 7,337	$ 75,995	$ 3,578	$ 393	$ 4,565	$ -	$ 91,868	$ 7,308	$ (21)	$ 99,155

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2018

(In thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ 71,458	$ 23,087	$ -	$ 1,899,095
Provisions for bad debts	-	31,358	10,967	1,554	1,440	1,680	368	-	47,367
Net patient service revenue less provisions for bad debts	-	1,443,956	205,769	58,932	50,574	69,778	22,719	-	1,851,728
Contracted revenue	(2,305)	98,007	-	-	2,169	-	-	(42,902)	54,969
Other operating revenue	9,799	137,242	4,061	4,166	3,188	1,697	453	(11,640)	148,946
Net assets released from restrictions	658	11,984	620	52	44	103	-	-	13,461
Total unrestricted revenue and other support	8,152	1,691,189	210,450	63,150	55,955	71,578	23,172	(54,542)	2,069,104
Operating expenses									
Salaries	-	806,344	105,607	30,360	25,582	29,215	12,082	(19,937)	989,253
Employee benefits	-	181,833	28,343	7,252	7,182	7,406	2,653	(4,966)	229,683
Medical supplies and medications	-	289,327	31,293	8,181	3,057	8,484	1,709	-	340,031
Purchased services and other	8,512	218,690	33,431	13,432	14,354	19,220	5,945	(22,212)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,743	2,178	-	-	67,692
Depreciation and amortization	23	68,073	10,357	3,939	2,145	1,831	410	-	84,778
Interest	8,684	15,772	1,004	981	223	975	65	(8,882)	18,822
Total operating expenses	17,219	1,631,083	218,105	64,784	54,276	69,307	22,864	(55,997)	2,021,841
Operating (loss) margin	(9,067)	60,106	(7,655)	(1,634)	1,679	2,271	308	1,455	47,483
Non-operating (losses) gains									
Investment (losses) gains	(26)	35,177	1,954	1,097	787	203	1,393	(188)	40,387
Other, net	(1,364)	(2,599)	(3)	1,276	273	(223)	952	(1,220)	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	-	-	(14,247)
Total non-operating (losses) gains, net	(1,390)	4,422	1,951	2,068	1,060	(20)	2,345	(1,418)	9,018
(Deficiency) excess of revenue over expenses	(10,457)	64,528	(5,704)	434	2,739	2,251	2,653	37	56,481
Unrestricted net assets									
Net assets released from restrictions (Note 7)	-	18,058	-	4	251	-	-	-	18,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-
Additional paid in capital	58	-	-	-	-	-	-	(58)	-
Other changes in net assets	-	-	-	-	-	(185)	-	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	-	-	14,102
Increase in unrestricted net assets	$ 7,392	$ 77,823	$ 4,311	$ 486	$ 4,445	$ 2,066	$ 2,653	$ (21)	$ 99,155

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

(in thousands of dollars)	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ 1,447,961	$ 214,265	$ 59,928	$ 48,072	$ (19)	$ 1,770,207	$ 88,985	$ -	$ 1,859,192
Provisions for bad debts	42,963	14,125	2,010	1,705	-	60,803	2,842	-	63,645
Net patient service revenue less provisions for bad debts	1,404,998	200,140	57,918	46,367	(19)	1,709,404	86,143	-	1,795,547
Contracted revenue	88,620	-	-	1,861	(41,771)	48,710	(4,995)	(44)	43,671
Other operating revenue	104,611	3,045	3,839	1,592	(1,148)	111,939	6,418	820	119,177
Net assets released from restrictions	9,550	639	116	61	-	10,366	756	-	11,122
Total unrestricted revenue and other support	1,607,779	203,824	61,873	49,881	(42,938)	1,880,419	88,322	776	1,969,517
Operating expenses									
Salaries	787,644	102,769	30,311	23,549	(21,784)	922,489	42,327	1,536	966,352
Employee benefits	202,178	26,632	7,071	5,523	(5,322)	236,082	8,392	381	244,855
Medical supplies and medications	257,100	30,692	6,143	2,905	(273)	296,567	9,513	-	306,080
Purchased services and other	208,671	28,068	12,795	13,224	(17,325)	245,433	45,331	(959)	289,805
Medicaid enhancement tax	50,118	7,800	2,923	1,620	-	62,461	2,608	-	65,069
Depreciation and amortization	66,067	10,238	3,881	2,138	-	82,324	2,238	-	84,562
Interest	17,352	1,127	819	249	(209)	19,338	500	-	19,838
Total operating expenses	1,589,130	207,326	63,943	49,208	(44,913)	1,864,694	110,909	958	1,976,561
Operating margin (loss)	18,649	(3,502)	(2,070)	673	1,975	15,725	(22,587)	(182)	(7,044)
Non-operating gains (losses)									
Investment gains (losses)	42,484	1,378	1,570	884	(209)	46,207	4,849	-	51,056
Other, net	(3,003)	-	(879)	570	(1,767)	(5,079)	740	186	(4,153)
Contribution revenue from acquisition	-	-	-	-	-	-	20,215	-	20,215
Total non-operating gains (losses), net	39,481	1,378	691	1,554	(1,976)	41,128	25,804	186	67,118
Excess (deficiency) of revenue over expenses	58,130	(2,124)	(1,379)	2,227	(1)	56,853	3,217	4	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 7)	983	-	9	442	-	1,434	405	-	1,839
Change in funded status of pension and other postretirement benefits	(5,297)	4,031	-	(321)	-	(1,587)	-	-	(1,587)
Net assets transferred (from) to affiliates	(18,380)	900	143	986	-	(16,351)	16,351	-	-
Additional paid in capital	-	-	-	-	-	-	6,359	(6,359)	-
Other changes in net assets	-	-	-	(2,286)	-	(2,286)	(1,078)	-	(3,364)
Change in fair value on interest rate swaps	6,418	-	1,337	47	-	7,802	-	-	7,802
Increase in unrestricted net assets	$ 41,854	$ 2,807	$ 110	$ 1,095	$ (1)	$ 45,865	$ 25,254	$ (6,355)	$ 64,764

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	MLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,447,961	$ 214,265	$ 59,928	$ 48,072	$ 65,835	$ 23,150	$ (19)	$ 1,859,192
Provisions for bad debts	-	42,963	14,125	2,010	1,705	2,275	567	-	63,645
Net patient service revenue less provisions for bad debts	-	1,404,998	200,140	57,918	46,367	63,560	22,583	(19)	1,795,547
Contracted revenue	(5,802)	89,427	-	-	1,881	-	-	(41,815)	43,671
Other operating revenue	673	106,775	3,264	3,837	3,038	1,537	381	(328)	119,177
Net assets released from restrictions	-	10,200	639	116	81	108	-	-	11,122
Total unrestricted revenue and other support	(5,129)	1,611,400	204,043	61,871	51,327	65,203	22,964	(42,162)	1,969,517
Operating expenses									
Salaries	1,009	787,844	102,769	30,311	24,273	29,397	11,197	(20,248)	966,352
Employee benefits	293	202,178	28,632	7,071	5,688	5,532	2,404	(4,941)	244,855
Medical supplies and medications	-	257,100	30,692	6,143	2,905	7,760	1,753	(273)	306,080
Purchased services and other	18,021	212,414	29,902	12,653	13,626	16,564	6,907	(18,282)	289,805
Medicaid enhancement tax	-	50,118	7,600	2,923	1,620	2,608	-	-	65,069
Depreciation and amortization	26	66,067	10,396	3,886	2,242	1,532	413	-	84,562
Interest	-	17,352	1,127	819	249	467	33	(209)	19,838
Total operating expenses	17,349	1,592,873	209,318	63,806	50,601	63,860	22,707	(43,953)	1,976,561
Operating (loss) margin	(22,478)	18,527	(5,275)	(1,935)	726	1,343	257	1,791	(7,044)
Non-operating gains (losses)									
Investment (losses) gains	(321)	44,746	2,124	1,516	1,045	439	1,718	(209)	51,058
Other, net	-	(3,003)	-	(879)	581	(161)	888	(1,579)	(4,153)
Contribution revenue from acquisition	20,215	-	-	-	-	-	-	-	20,215
Total non-operating gains, net	19,894	41,743	2,124	637	1,626	278	2,604	(1,788)	67,118
(Deficiency) excess of revenue over expenses	(2,584)	60,270	(3,151)	(1,298)	2,352	1,621	2,861	3	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 7)	-	1,075	-	9	442	158	155	-	1,839
Change in funded status of pension and other postretirement benefits	-	(5,297)	4,031	-	(321)	-	-	-	(1,587)
Net assets transferred (from) to affiliates	(3,864)	(18,380)	900	143	986	-	20,215	-	-
Additional paid in capital	6,359	-	-	-	-	-	-	(6,359)	-
Other changes in net assets	-	-	-	-	(2,286)	(1,078)	-	-	(3,364)
Change in fair value on interest rate swaps	-	6,418	-	1,337	47	-	-	-	7,802
(Decrease) increase in unrestricted net assets	$ (89)	$ 44,086	$ 1,780	$ 191	$ 1,220	$ 701	$ 23,231	$ (6,356)	$ 64,784

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Supplemental Consolidating Information
June 30, 2018 and 2017

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in unrestricted net assets of D-HH and subsidiaries. All intercompany accounts and transactions between D-HH and subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

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

BOARDS OF TRUSTEES & BOARD OFFICERS | Effective: June 23, 2018

Jeffrey A. Cohen, MD MHMH/DHC Trustee *Chair, Dept. of Neurology*	**Robert A. Oden, Jr., PhD** MHMH/DHC/D-HH Boards' Vice Chair *Retired President, Carleton College*
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Paul P. Danos, PhD MHMH/DHC/D-HH Trustee *Dean Emeritus; Laurence F. Whittemore Professor of Business Administration, Tuck School of Business at Dartmouth*	**Pamela Austin Thompson, MS, RN, CENP, FAAN** MHMH/DHC/D-HH Trustee *Chief executive officer emeritus of the American Organization of Nurse Executives (AONE)*
Senator Judd A. Gregg MHMH/DHC Trustee *Senior Advisor to SIFMA*	**Anne-Lee Verville** MHMH/DHC/D-HH Boards' Chair *Retired senior executive, IBM*
Laura K. Landy, MBA MHMH/DHC/D-HH Trustee *President and CEO of the Fannie E. Rippel Foundation*	**Jon Wahrenberger, MD** MHMH/DHC (Lebanon Physician) Trustee Cardiologist
	Marc B. Wolpow, JD, MBA MHMH/DHC/D-HH Trustee *Co-Chief Executive Officer of Audax Group*

BIOGRAPHICAL SKETCH

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

NAME: Mary K. Jankowski

eRA COMMONS USER NAME (credential, e.g., agency login): [redacted]

POSITION TITLE: Associate Professor of Psychiatry

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

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
Pomona College, Claremont CA	B.A.	1990	Psychology
University of Vermont, Burlington, VT	Ph.D.	1999	Clinical Psychology
Geisel School of Medicine at Dartmouth, Hanover, NH	Post-doctoral Fellow	2001	

A. Personal Statement: Jankowski has worked for the past 20 years in the field of trauma and its effects, with the last 12 specifically in the area of child and adolescent trauma. She has directed many projects, including developing and testing new treatment interventions, implementing trauma informed best practices, disseminating evidence-based practices into "real world settings", and transforming child serving systems to bring a more trauma-informed approach to care for children, youth and their families. I have worked closely for the past 8 years with both child serving state systems and community-based agencies across the State of NH to better address the needs of traumatized children and families through improving referral practices, identification and screening, improving collaboration across stakeholders and increasing availability of evidence based trauma treatment practices. I am a certified trainer for Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and have trained clinicians across New England for more than a decade. I also have served as a faculty lead for a state sponsored learning collaborative to create a more trauma informed child welfare system in the State of CT. Most recently, I have become interested in understanding the effects of the opioid crisis on children and families, and improving the quality of care to meet the needs of these children and families. As an experienced child and adolescent psychologist, I also maintain a small practice treating traumatized children, adolescents and adults.

B. Positions:

2016 -present Director, Dartmouth Trauma Interventions Research Center
2014 - 2016 Associate Director, Dartmouth Trauma Interventions Research Center
2005- present Licensed Clinical Psychologist, Dartmouth Hitchcock Medical Center
2004-present Assistant Professor of Psychiatry, Geisel School of Medicine at Dartmouth
2001-2004 Instructor in Psychiatry, Geisel School of Medicine at Dartmouth
1990-1993 Research Assistant, Department of Epidemiology, Dana-Farber Cancer Institute

Honors:

2015 Margaret M. Riggs NH Psychological Association's Distinguished Psychologist Award
1995 Child and Adolescent Psychology Training and Research award

C. Contributions to Science:

My earlier work focused on adapting psychosocial treatments for PTSD for particularly vulnerable populations. I worked with K. Mueser and S. Rosenberg to adapt a CBT model for treating PTSD in severely mentally ill adult populations. Our team developed a model that emphasized cognitive restructuring and did not include an exposure component, and then tested it in a RCT in NH. I then received funding to further adapt the treatment model we developed for use with traumatized adolescents with PTSD. Although at the time there were well tested CBT models for use with children, they had not been tested with adolescents. Moreover, they all included an exposure component, and many clinicians and clients will not adhere to a model with exposure. For that reason, having effective, alternative models is important. This work has been important because it has demonstrated the feasibility and effectiveness of treating PTSD in populations with high exposure to trauma and increased rates of PTSD, but often excluded from standard EBP models.

Mueser, K.T., Rosenberg, S.D., Xie, H., Jankowski, M.K., Bolton, E.E., et al. (2008). A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. Journal of Consulting and Clinical Psychology, 76, 259-271.

Jankowski, M.K. and Hamblen, J.L. (2004). Cognitive-behavioral treatment for PTSD in people with severe mental illness: Three case studies. Psychiatric Rehabilitation Skills, 7, 147-170.

Rosenberg, H., Jankowski, MK, Fortuna, L, Rosenberg, S, Mueser, K. (2011) "A Pilot Study of a Cognitive Restructuring Program for Treating Posttraumatic Disorders in Adolescents", Psychological Trauma: Theory, Research and Policy, 3(1) 94-99.

Jankowski, M.K., Rosenberg, H.J., Sengupta, A., Rosenberg, S.D, Wolford, G. (2007). Development of a screening tool to identify adolescents engaged in multiple problem behaviors: The adolescent risk behavior screen (ARBS). Journal of Adolescent Health, 40, 180.e19-180.e26.

My more recent work has centered on two primary related areas: disseminating EBPs for child trauma to real world settings; and installing, implementing and evaluating trauma-informed practices in child serving systems. Since 2005, first under the leadership of S. Rosenberg, and then beginning in 2012 as Principal Investigator myself, our team has been awarded federal funding to bring trauma focused EBPs to the child mental health system in NH, and have installed universal screening of children and youth entering the child welfare and juvenile justice systems, and trained nearly the entire child welfare and juvenile justice workforce in trauma-informed care. I have particular experience and interest in implementation issues related to engaging adolescents into trauma-focused treatment, and was Co-Investigator and Site P.I. on a NIH funded Randomized Controlled Trial to examine the feasibility of delivering TF-CBT to juvenile justice involved youth in residential treatment facilities (J. Cohen, P.I.).

Over the past six years, I have been directing two large demonstration projects funded by federal DHHS Administration for Children, Youth and Families, which are aimed at improving well-being outcomes for children in child welfare and juvenile justice, and promoting successful adoption after trauma. This work has highlighted the important role of trauma in the lives of these vulnerable children and youth, and

highlight the need for increased early identification, workforce development, more targeted referral, improved collaboration and system linkage, and increased access and availability of EBP treatments for these children and families.

Jankowski, MK, Schifferdecker, KE, Butcher, RL, Foster-Johnson, L, Barnett, ER. (2018). Effectiveness of a Trauma Informed Care Initiative in a State Child Welfare System: A Randomized Study. Child Maltreatment.

Jankowski, M.K., Butcher, R.E., Barnett, E.R. and Camelo, A. (2018). Effecting system change in the real world: Implementing and sustaining trauma informed practices in a stressed child welfare system. For APSAC Advisor Special Issue.

Barnett, ER, Jankowski, MK, Butcher, RL, Meister, C, Parton, RR, Drake, RE. (2018). Foster and Adoptive Parent Perspective on Needs and Services: A Mixed Methods Study. Journal of Behavioral Health Services Research, 45 (1), 74-89.

Cohen, J. A., Mannarino, A. P., Jankowski, M. K., Rosenberg, S., Kodya, S., & Wolford, G. L. (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential treatment facilities. Child Maltreatment, 21(2) 156-167.

The rise of the opioid crisis in New Hampshire has contributed to a significant increase in the number of children placed in foster care and excess burden on the child welfare and community mental health workforce. From 2012-2017, NH DCYF has seen a 35% increase in the number of children in placement and a 53% increase in the average daily population (Source: NH DCYF, April 2018). My current research focuses on better understanding the impacts that NH's opioid crisis has been having on children and families, as well as the needs of the System and the child serving workforce more broadly. We recently completed a qualitative study in which we conducted interviews with diverse stakeholders from schools, primary care, community mental health, law enforcement, and child- and family-serving agencies focused on how the opioid crisis has impacted DCYF and other statewide child-serving systems, and the degree to which these systems have felt prepared to handle the impact. The results of the interviews informed the second phase of the study, namely the development and administration of a survey of staff and providers working in the five service sectors noted above. The survey measures current practices and attitudes related to screening and identification of parental substance misuse (and opioid misuse specifically). The survey also collects self-reported knowledge and training interests related to screening, assessment and service provision of children and families affected by substance misuse.
Finally, in order to define and understand the impact of the opioid crisis on NH DCYF, we are examining parental substance abuse indicators collected by staff at DCYF, matched to child-level data for youth screened in the PFC project with the Mental Health Screening Tool (MHST) to better understand the association of parental substance abuse to children's trauma exposure, related symptoms and overall well-being.

D. Research Support

Ongoing Research Support

90C01099
Jankowski (PI) 10/01/12 – 9/30/19
New Hampshire Partners for Change Project: Improving Child Well-being in New Hampshire's Child Welfare System. US Department Health and Human Services, Administration for Children and Families (ACF). The goal of this study is to improve well-being outcomes in children involved in the child welfare system in New Hampshire.

42100300

Mullen (PI) 10/01/13 – 9/30/19
The New Hampshire Adoption Preparation and Preservation Project. Federally funded through US Department of Health and Human Services Administration for Children and Families (ACF). The goal of this project is to improve adoption outcomes through installation of evidence-based services for children adopted through the child welfare system.
Role: Director of Project; Grant awarded to NH DCYF, but all funds go to Geisel School of Medicine at Dartmouth.

1H79SM081151-01
Barnett (PI) 10/1/18-9/30/21
US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
Upstream Upper Valley: Increasing early childhood mental health and trauma awareness among community healthand service providers
The *Upstream* project will provide evidence-based mental health and trauma training and consultation to health, community, and service professionals serving young children and families across 3 counties in NH and VT. Our primary goal is to increase the capacity for identification of trauma and mental health needs in young children and link families to needed services
Role: Evaluator

2018-V3-GX-0078
Barnett (PI) 10/1/18-9/30/21
US Department of Justice, Office of Justice Programs, Office for Victims of Crime
Moving Upstream: Building a Trauma-Informed Community Response for Our Youngest Victims of the Opioid Crisis in Cheshire County
Our overall goal is to enhance our community response to children ages 0-8 years victimized by our opioid crisis through expert training, consultation and coalition activities that implement trauma-sensitive practices across multiple sectors serving young children and families across the county.
Role: Trainer

Completed Research Support

R01 492435 Cohen (PI)
2011-2015 TF-CBT for Adjudicated Youth in Residential Treatment. The goal of this study was to evaluate the feasibility of delivering TF-CBT, a well-researched treatment model for PTSD in children and adolescents, to juvenile justice involved youth in residential settings.

7/2015 – 6/2016 The Use of Technology to Engage Traumatized Adolescents in Trauma-Focused Treatment. P.I. The Department of Psychiatry Gary Tucker Award.

BIOGRAPHICAL SKETCH

NAME: Barnett, Erin R

eRA COMMONS USER NAME (credential, e.g., agency login): [redacted]

POSITION TITLE: Assistant Professor of Psychiatry and The Dartmouth Institute for Health Policy and Clinical Practice

EDUCATION/TRAINING INSTITUTION AND LOCATION	DEGREE	COMPLETION DATE	FIELD OF STUDY
University of Nebraska-Omaha	BA	05/2004	Psychology
University of Missouri-St. Louis	PhD	08/2009	Clinical Psychology
Dartmouth Medical School	Internship	06/2009	Child Clinical Psychology
Dartmouth Medical School	Fellowship	07/2010	Child Clinical Psychology

Dr. Barnett is an Assistant Professor of Psychiatry and Health Policy and Clinical Practice and a faculty member at the Dartmouth Trauma Interventions Research Center. Dr. Barnett has been the Principal Investigator for three grants, each aiming to develop and test tools and strategies to improve patient-centered clinical decision making for children with mental health needs and their families. All three of these investigator-initiated projects have been guided by a core team of consumers, including parents and youth formerly involved with the child welfare system and/or with mental health needs. She has executed Community-Based Participatory Research approaches within these projects and first-authored several peer-reviewed journal articles related to these initiatives. She has excellent organizational, communication, and social skills to help her effectively collaborate with partnering agencies and the research team and to manage all aspects of the grant. Dr. Barnett has also led numerous trauma-informed training and workforce initiatives within various child-serving sectors, including residential treatment facilities, child welfare, schools, and homeless shelters. She co-led a state-wide train-the-trainer program (TIECS) aiming to improve trauma-informed knowledge and skills among early childhood care providers. She is certified in two evidence-based psychotherapies for child trauma and provides direct clinical services at a local community mental health center, which keeps her very familiar with the culture and needs of the population served. Further, she has supervised four research trainees, two project coordinators, and numerous mental health clinicians within community mental health and other regional mental health centers in evidence-based psychotherapies for children over the past 8 years since becoming licensed in 2010.

Positions and Employment

2017-current Assistant Professor of The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth

2013-current Assistant Professor of Psychiatry, Geisel School of Medicine at Dartmouth and Dartmouth-Hitchcock Medical Center

2010-2013 Research Associate, Dartmouth Medical School, Department of Psychiatry and Psychologist, National Center for PTSD

2009-2010 Postdoctoral Fellow, Dartmouth Medical School, Department of Psychiatry and National Center for PTSD

2008-2009 Pre-doctoral Clinical Psychology Intern, Dartmouth Medical School, Department of Psychiatry

Other Experience and Professional Memberships

2012–current Co-lead NH SafeRx: Division of Children Youth and Families Psychotropic Medication Oversight Program

2014-2016 Co-developed a state-wide train-the-trainer program in early childhood trauma

2014-2016 Co-developed youth residential facility trauma-informed care program

2013 Primary content developer for PTSD Coach Online, an interactive, online self-help tool developed by the VA's National Center for PTSD

2009-2012 Led a weekly Trauma Seminar for pre-doctoral psychology interns

Honors

2012 Exceptional Contributions to Research and Education, VA's National Center for PTSD

2013 Exceptional Contributions to Research and Education, VA's National Center for PTSD

2007 Jayne E. Stake Clinical Training Award, UM–St. Louis
2007 Lou Sherman Graduate Student Award, UM–St. Louis

Publications

Original articles:

Barnett, E. R., Jankowski, M. K., & Trepman, A. (under review). State-wide implementation of evidence-based psychotherapies for youth exposed to trauma. Psychological Trauma: Theory, Research, Practice, and Policy

Jankowski, M. K., Schifferdecker, K. E., Butcher, R. L., Foster-Johnson, L., **Barnett, E. R.** (in press). Effectiveness of a Trauma Informed Care Initiative in a State Child Welfare System: A Randomized Study *Child Maltreatment.*

Barnett, E. R., Yackley, C. R., & Licht, E. S. (2018). Evaluating a trauma-informed care program in a youth residential treatment center and special needs school. *Journal of Residential Treatment for Youth.*

Cleary, S. E., **Barnett, E. R.,** Butcher, R. L., Huckins, J., & Jankowski, M. K. (2018). A comparison of foster and adoptive parent satisfaction and commitment. *Children & Youth Services Review. Pubmed ID:* 29723028

McLaren, J. L., **Barnett, E. R.,** Concepcion-Zayas, M. T., Lichtenstein, J., Acquilano, S. C., Schwartz, L. M., Woloshin, S., Drake, R. E. (2018). Psychotropic medications for highly vulnerable children. *Expert Opinion on Pharmacotherapy.* PMID: 29596008

Barnett, E. R., Cleary, S. E., & Donnelly, C. L. (2018). Psychotropic medications for youth in child welfare: Developing and pilot-testing a field guide for team decision-making. *Journal of Public Child Welfare.*

Barnett, E. R., Cleary, S. E., Butcher, R. L., & Jankowski, M. K. (in press). Child behavior problems and satisfaction of foster and adoptive parents: Do trauma-informed services make a difference? *Psychological Trauma: Theory, Research, and Practice.*

Barnett, E. R., Jankowski, M. K., Butcher, R. L., Meister, C., Parton, R. L., & Drake, R. E. (2017). Foster and Adoptive Parent Perspectives of Needs and Services: A Mixed Methods Study. *Journal of Behavioral Health Services & Research.*

Barnett, E. R., Boucher, E. A., Daviss, W. B., Drake, R. E., Elwyn, G. (2017). Supporting Shared Decision Making for Children's Complex Behavior Problems: Development and User-Testing of an Option Grid Decision Aid. *Community Mental Health Journal.*

Barnett, E. R., Boucher, E.A., Neubacher, K., & Carpenter-Song, E. A. (2016). Decision-Making around Psychotropic Medications for Children in Foster Care: Perspectives from Foster Parents. *Children & Youth Services Review, 70,* 206-213.

Barnett, E., R., Butcher, R., Neubacher, K., Jankowski, M. K., Daviss, W. B., Carluzza, K., & Yackley. C. (2016). Psychotropic medications in child welfare: From federal mandate to direct care. *Children & Youth Services Review, 66,* 9-17.

Barnett, E. R., Bernardy, N., Jenkyn, A., Lund, B., Alexander, B., & Friedman, M. (2014). Prescribing clinician's perspectives on evidence-based psychotherapies for post-traumatic stress disorder. *Behavioral Sciences, 4(4), 410-22.*

Barnett, E. R., Rosenberg, H., Osofsky, J., Rosenberg, S., & Wolford, G. (2014). Dissemination and implementation of Child-Parent Psychotherapy in Rural Public Health Settings. *Child and Adolescent Mental Health, 19(3), 215-18.*

Systematic Reviews:

Barnett, E. R., Concepcion-Zayas, M. T., Zisman-Ilani, Y., Bellonci, C. (in press). Psychiatric care for youth in foster care: A systematic and critical review of patient-centered care. *Journal of Public Child Welfare.*

Zisman-Ilani, Y., Harik, J. M., **Barnett, E. R.**, Pavlov, A., & O'Connell, M. (2017). Expanding the Concept of Shared Decision Making in Mental Health: Systematic Search and Scoping Review of Interventions. *The Mental Health Review Journal.*

Book chapters:

Barnett, E. R., Cleary, S., Neubacher, K., Daviss, W. B. (2017). Post-traumatic Stress Disorder and Attention Deficit Hyperactivity disorder. In W. B.Daviss (Ed.), *Moodiness in Patients with ADHD: Optimizing Assessment and Treatment.* Springer Press.

Hamblen, J. L., **Barnett, E. R.**, Hermann, B., Schnurr, P. (2013). Overview of PTSD treatment research: The impact of trial design. In J. G. Beck & D. M. Sloan (Eds.), *The Oxford Handbook of Traumatic Stress Disorders.*

Hamblen, J. L., **Barnett, E. R.**, & Norris, F. H. (2012). Long term mental health treatment for adult disaster survivors. In, J. Framingham and M. Teasley (Eds.), *Behavioral health response to disasters (pp. 301-318).* CRC Press.

Greco, L. A., **Barnett, E. R.**, Blomquist, K. K., & Gevers, A. (2008). Body image, acceptance, and health in adolescence. In L. A. Greco & S. C. Hayes (Eds.), *Acceptance and mindfulness Interventions for children, adolescents, and families.* Reno, NV: Context Press-New Harbinger.

Editorials

Daviss, W. B., **Barnett, E.R.**, Neubacher, K., Drake, R.E. (2016). Use of antipsychotics for non-psychotic children. *Psychiatric Services, 67(3):* 339-41.

Research Support

Patient-Centered Outcomes Research Institute **Barnett** **8/1/17 – 7/31/2018**
5093717-012
Developing Patient-Driven Research to Improve the Psychiatric Care of Youth in Foster Care, Tier 2
The goal of this PCORI project is to build community engagement and capacity toward the generation of comparative effectiveness research ideas that build and evaluate patient-driven psychiatric practices for youth in foster care. Pipeline to Proposal: Tier II. Role: PI

NH Innovation Research Center, Granite State Tech Innov Grant **Stanger** **11/1/17 – 6/30/2018**
UNH 18-014
Integrating Coaches to Promote Engagement with an M-Health Collaborative Care App
The present research collaboration seeks to test such a modification of an existing m-health collaborative care app (Proxi) to include Mobile Coaches (MCs) to promote user engagement and maximize its utility for use with youth aging out of foster care. Role: co-I

Patient-Centered Outcomes Research Center **Barnett** **8/1/17 – 4/30/2017**
Developing Patient-Driven Research to Improve the Psychiatric Care of Youth in Foster Care, TIER 1
The goal of this PCORI project is to build community engagement and capacity toward the generation of comparative effectiveness research ideas that build and evaluate patient-driven psychiatric practices for youth in foster care. Role: PI

DHHS Administration for Children and Families **Mullen** **10/1/13 – 9/30/2019**
90C01115/01
The NH Adoption Preparation and Preservation Project
The goal of this 5-year demonstration grant is to improve adoption stability for youth in NH through trauma-informed workforce development. Role: co-I

DHHS Administration for Children and Families **Jankowski** **10/1/12 – 9/30/2019**
90CO1099/01
The Partners for Change Project: Improving Well-Being for Youth in the NH Child Welfare System
The goal of this 5-year demonstration grant is to improve the well-being of children in the NH child welfare and juvenile justice system through trauma-informed workforce development with child welfare and mental health staff. Role: co-I

Gary Tucker Jr Award, Psychiatry, Dartmouth **Barnett** **7/1/15 – 6/30/2016**
Our Minds Our Choice: Developing and Piloting an Option Grid around Interventions for Complex Behavior Problems in Children
The goal of this project was to develop - with parents, clinicians, and stakeholders - and pilot-test a 1 page Option Grid decision aid to improve decision-making related to the use of various classes of medications and therapy for children's complex behavior problems. Role: PI

Neil and Louise Tillotson Foundation **Barnett** **7/1/16 – 6/30/2017**
Building a model of coordinated care toward safe and effective psychotropic medications for vulnerable children in Coos County
The goal of the study is to develop and pilot-test a protocol that facilitates team discussions and decisions centered on individual children regarding the use of psychotropic medications and other wellness topics. Role: PI

Clinical Support
Clinical services at West-Central Behavioral Health providing child and family assessments and therapeutic services.

BIOGRAPHICAL SKETCH

NAME Butcher, Rebecca L.	POSITION TITLE Assistant Director, Center for Program Design & Evaluation at Dartmouth
eRA COMMONS USER NAME (credential, e.g., agency login) [redacted]	

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

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY
University of Vermont, Burlington, VT	BS	1989	Physical Therapy
Boston University, Boston, MA	MS	1995	Applied Movement Science
University of New Hampshire, Manchester, NH	MPH	2012	Public Health

A. Personal Statement

With over 20 years as a clinician, consultant and assistant professor in healthcare service delivery, and experience in the past seven years designing and leading mixed methods evaluations for a wide range of programs, I am well qualified to lead the Evaluation of this and other projects. I have led evaluations of state- and community-based policy initiatives and multi-level interventions, including two federally funded (DHHS/ACF) System-change projects to install trauma screening and family functioning assessment in NH's child welfare and community mental health systems. I have led Realist and impact evaluations of quality improvement programs aimed at improving health in a variety of contexts including the Veterans Health Administration, higher education institutions, urban and rural settings, and developing countries. Many of my projects include multiple sites, varied stakeholder types, knowledge and practice change initiatives, as well as system-level and context measures. I work closely with PIs and other project leaders to provide timely and ongoing feedback to assist in designing methods, collecting data, and for the analysis and reporting of findings related to program goals.

B. Positions and Honors

2018-current Assistant Director, Center for Program Design & Evaluation at Dartmouth, The Dartmouth Institute of Health Policy & Clinical Practice, Lebanon, NH
2013-2017 Senior Research Associate, Center for Program Design & Evaluation at Dartmouth, The Dartmouth Institute of Health Policy & Clinical Practice, Lebanon, NH
2011-2012 Research Associate, Center for Program Design & Evaluation at Dartmouth, Community and Family Medicine, Geisel School of Medicine, Lebanon, NH
2002-2011 Physical Therapist, Senior Clinical Research Staff, Wentworth Homecare & Hospice, Dover, NH
1999-2008 Consultant and Educator, The Dogwood Institute, Atlanta, GA
1995-2002 Clinical Assistant Professor, Sargent College of Allied Health Professions, Boston University, Boston, MA
1991-1994 Physical Therapist, Staff and Senior Level, Portsmouth Regional Hospital, Portsmouth, NH
1989-1991 Physical Therapist, Elliot Hospital, Manchester, NH

C. Peer-Reviewed Publications

1. Butcher, R. L., Carluzzo, K. L., Watts, B. V., & Schifferdecker, K. E. (2018). A Guide to Evaluation of Quality Improvement and Patient Safety Educational Programs: Lessons From the VA Chief Resident

in Quality and Safety Program. *American Journal of Medical Quality.* https://doi.org/10.1177/1062860618798697

2. Jankowski, M.K., Butcher, R.L., Barnett, E.R., Carmelo, A. (2018). Effecting System Change in the Real World: Implementing and Sustaining Trauma-Informed Practices in a Stressed Child Welfare System. *APSAC Advisor*, 30: 3, 8-14.

3. Jankowski, M.K., Schifferdecker, K. E., Butcher, R. L., Foster-Johnson, L., & Barnett, E. R. (2018). Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study. *Child Maltreatment*. https://doi.org/10.1177/1077559518796336

4. Barnett, E.R., Cleary, S.E., Butcher, R.L., Jankowski, M.K. (2018, May 3). Child behavior problems and satisfaction of foster and adoptive parents: Do trauma-informed services make a difference? *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance e-pub http://dx.doi.org/10.1037/tra0000357

5. Barnett, E. R., Jankowski, M. K., Butcher, R. L., Meister, C., Parton, R. L., & Drake, R. E. (2017). Foster and Adoptive Parent Perspectives of Needs and Services: A Mixed Methods Study. *Journal of Behavioral Health Services & Research*, 1-16. DOI 10.1007/s11414-017-9569-4.

6. Barnett, E., Butcher, R.L., Neubacher, K., Jankowski, M. K., Daviss, W. B., Carluzzo, K. L., Ungarelli, E., & Yackley. C. (2016). Psychotropic medications in child welfare: From federal mandate to direct care. *Children & Youth Services Review,* 66, 9-17.

7. Schifferdecker, K.E., Adachi-Mejia, A., Butcher, R.L., O'Connor, S., Bazos, D. and Li, Z. (2015). Translation of an Action Learning Collaborative Model into a community-based intervention to promote physical activity and healthy eating. *Health Promotion Practice*. Published online before print August 27, 2015, doi: 10.1177/1524839915601371.

8. Aytur SA, RL Butcher, CH Carlson, KE Schifferdecker. (2014). Creating Safe Neighborhoods for Obesity Prevention: Perceptions of Urban Youth. In V Brennan, S Kumanyika, and R Zambrana (Eds.) *Obesity Interventions in Underserved US Populations: Evidence and Directions*. Baltimore: Johns Hopkins University Press.

9. Butcher, R. L., Ellis, T., Holt, K.G. (2001). Teaching Spasticity and Weakness from a Dynamical Systems Perspective: Part II. *Neurology Report*, 25 (3), 106-113.

10. Holt, K.G., Saltzman, E., Ellis, T., Butcher, R. L. (2001). Teaching Spasticity and Weakness from a Dynamical Systems Perspective: Part I. *Neurology Report*, 25 (3), 102-105.

11. Butcher, R.L. & Ellis, T. (2001). "Teaching Materials and Strategies for Entry-Level Curricula in Neurologic Rehabilitation Across the Lifespan: A Compendium of Examples.", Neurology Section, APTA, Jan. 2001.

12. Holt, KG, Butcher, R. & Fonseca ST. (2000). Limb stiffness in active movements of children with spastic hemiplegic cerebral palsy. *Pediatric Physical Therapy.*

13. "A Measure of Limb Stiffness during Active Movement", Butcher, R.L. Boston University, Master's Thesis.

D. Funded Support

VA Health Professions Education Evaluation Research Fellowship **Sept. 2015-ongoing**
Veterans Administration Office of Academic Affiliations (OAA) & the VA's National Center for Patient Safety
The HPEER fellowship is a two-year program that offers didactic and experiential training and mentoring to post graduates interested in developing knowledge and skills in evaluation and education research. I lead the curriculum development, delivery, and ongoing mentoring of two-four fellows per year, including in manuscript development and a full range of mixed methods evaluation activities.
Role: Lead Faculty Mentor

VA Chief Resident in Quality & Safety Program (Vince Watts, Program Director) **May 2014-ongoing**
Veterans Administration Office of Academic Affiliations (OAA) & the VA's National Center for Patient Safety
The CRQS is a 1-year unaccredited residency program at the VA to develop physicians' knowledge and experience in quality improvement methods for applications in healthcare delivery, research and education. Following a mixed methods evaluation of program implementation and impacts in 2014, ongoing work involves resident, faculty and alumni Needs Assessments, and development of a comprehensive evaluation plan to study process and outcome effects longitudinally while building capacity of program leaders and evaluation fellows to conduct internal evaluation activities.
Role: Lead Evaluator (2014-2016); Co-Evaluator (2017-present)

NH Adoption Preparation and Preservation Project (E. Mullen & M.K. Jankowski, co-I) **Mar. 2014-ongoing**
Dartmouth Trauma Intervention Research Ctr (DTIRC) & NH Div of Children Youth, and Families (DCYF)
funded by 5 year grant from Federal DHHS (ACF)
The goal of NHAPP is to improve social and emotional well-being, family functioning and placement stability for children in pre adoptive and post adoptive families in NH. This joint project will utilize many of the collaborations and processes developed with the Partners of Changes project (see below) with additional screening and assessment measures specific to the pre- and post-adoption population of children, families, DCYF staff and community mental / behavioral health providers. Mixed method evaluation activities at the service delivery and treatment outcomes level.
Role: Lead Evaluator

Partners for Change (Mary Kay Jankowski, PI) **Mar. 2013-ongoing**
Dartmouth Trauma Intervention Research Ctr (DTIRC) & NH Div of Children Youth, and Families (DCYF)
funded by 5 year grant from Federal DHHS Administration of Children and Families (ACF).
A joint project to provide training and technology updates to state child welfare staff and community mental health providers in evidence based screening, assessment, and treatment practices for children and youth with history of trauma and PTSD. Project consists of interventions and program evaluation components at three main levels: a) the NH child welfare (including Juvenile Justice) System, b) staff and providers across all regions of the state, and c) children and families. In a mixed methods longitudinal transformation randomized cross-over design with pilot project, the primary domains of evaluation include: program implementation, system integration, cost-benefit analyses, and outcomes across all three levels.
Role: Lead Evaluator

NH Injury Prevention Program (D. Samaha, IP Program Contractor) **April 2018 – ongoing**
Provide evaluation technical assistance in revising/updating State's 5 year Injury and Violence Prevention State Plan. Develop intermediate and long term goals, indicators, measures to assess effectiveness of program activities and efforts to address shared risk and protective factors.
Role: Lead Evaluator.

Wellness at Dartmouth (Melissa Miner, Program Director) **Aug. 2013-Mar 2018**
Dartmouth College
The Wellness program, created in 2012, provides a range of health promotion and supports including health coaching, screening, and primary care clinic to benefits-eligible staff and faculty, spouses/partners and adult dependents with the goal of empowering people to initiate and sustain positive lifestyle choices. This three

year evaluation includes environmental assessment, interviews and focus groups with stakeholders across the institution, consulting client in program evaluation and dashboard display of monthly benchmarks.
Role: Lead Evaluator

CREST for EMS Network (Dr. Thomas Trimarco, PI) **Jan. 2014-Nov. 2017**
Dartmouth Hitchcock Medical Center - HRSA grant
A federal grant to fund the establishment of an educational network and the creation of educational tools for EMS providers in Vermont and New Hampshire with the goal of improving the confidence, knowledge, skills, and competency of EMS providers in dealing with prehospital pediatric emergencies. Evaluation will include initial needs assessment, baseline measures of knowledge and attitudes, followed by mixed methods evaluation activities over a total of 3 years to assess program implementation and impacts at the provider, system, and child level.
Role: Lead Evaluator

VA Quality Scholars Fellowship (Tina Foster, Program Director) **Aug 2013-Dec 2013**
Veterans Administration Office of Academic Affiliations (OAA) & The Dartmouth Institute
The VAQS Fellowship is a 2-year fellowship for physicians and graduate-level nurses to develop knowledge and experience in quality improvement methods for applications in healthcare delivery, research and education. In partial fulfillment of the Dartmouth Hub site's contract with VA's Office of Academic Affiliations (OAA), this mixed methods evaluation examined contextual supports, program structures, delivery, and outcomes at the eight sites to describe overall accomplishments, systematic issues and future recommendations for the program.
Role: Lead Evaluator

NCHIP (Patricia Lanter, MD, PI, Lisa Johnson, MS, Project Manager) **2012-2014**
The Dartmouth Institute of Health Policy and Clinical Practice.
The National College Health Improvement Program convened a 32-institution learning collaborative on high risk drinking on college campuses. Using the Breakthrough Series Initiative model, institutional teams learned improvement science methods to better measure and track high risk drinking rates and associated harms, as well as determine the effectiveness of newly-applied evidenced-based interventions aimed at individuals, environments, and systems.
Role: Co-Evaluator, Phase I Impact Assessment
Lead Evaluator, Phase II Realist Evaluation
Co-Evaluator, Phase II Impact Assessment

In Shape Together (Karen Schifferdecker, PhD, MPH, PI) **2011-2014**
Prevention Research Center at Dartmouth (CDC; HRSA funded) in
collaboration with three partner communities: Keene and Manchester, NH
and St. Johnsbury, VT.
This project focused on an innovative intergenerational neighborhood physical activity and nutrition program aimed at building community capacity and wellness though community assessment, goal setting, and team- and individually-based activities. In the final year of project with current focus on dissemination and publication.
Role: Program Design; Project Manager for Implementation; Contribution to scholarly publications.

New Hampshire Injury Prevention Program (Rhonda Seigel, MS, PI) **2012-2013**
CDC Core VIPP.
Develop logic model, health impact measures and a comprehensive evaluation plan around four state priority areas across a five-year funding period. Each priority area has 2-4 policy or intervention components requiring measurement indicators to link with either existing data sources or from which new evaluation methods are developed to track impact and effectiveness.
Role: Evaluator

ARISE (Mark Splaine, MD, PI) **2011-2012**

John Snow Inc.
The ARISE project, based in Uganda, focused on improving routine immunizations in one district of Uganda through a health unit learning collaborative. Participants learned quality improvement methods to apply in their own health unit.
Role: Co- Evaluator

E. Peer Reviewed Presentations

"Lessons learned in evaluating two statewide child welfare system change initiatives," American Evaluation Association Annual Meeting, Cleveland, OH. November 3, 2018.

"Managing Qualitative Analysis in Complex Projects: Tips and Tools for using a mixed inductive and deductive approach with Dedoose," American Evaluation Association Annual Meeting, Washington, DC, November 9, 2017.

Evaluation of VA Training Programs without Re-Inventing the Wheel." American Evaluation Association Annual Meeting, Chicago, IL, November 11, 2015.

"Multi-level System Change Evaluation." American Evaluation Association Annual Meeting, Chicago, IL, November 2015.

"Evaluating Dartmouth's Multi-Level Employee Wellness Initiative Using Mixed Methods." 45 min. presentation at *Building Healthy Academic Communities* Annual Summit, UC Irvine, April 24-25, 2015.

"The Importance of Context & Program Structure in Training Evaluation." Panel presentation at American Evaluation Association Annual Meeting, Denver, CO, Oct. 14-18, 2014.
"Evaluation of the Chief Resident in Quality & Safety Program." Presentation to the VA Office of Academic Affiliations, Washington, DC., Sept. 10, 2014.

"Lessons from the National College Health Improvement Project Realist Evaluation." NCHIP Symposium, Boston, MA. June 26, 2013.

"Evaluation of Injury Prevention Programs," 1 hour presentation before regional audience of injury prevention specialists and state program directors at *Perspectives of Enhancing Injury Prevention: Research & Practice,* Waltham, MA. Oct. 24, 2012.

"National College Health Improvement Project Evaluation Findings." NCHIP Learning Session, Washington, DC., July 9, 2012.

"Using Evidence in Teaching", a Roundtable Discussion at the Neurology Section, *APTA Combined Sections Meeting*, Boston, MA, Feb. 2002.

"The Sixth Annual Stroke Update for Health Professionals", co-presented with physicians at Lutheran Medical Center, Brooklyn, NY for the AHA, June, 2002.

"Using the Disablement Model to Teach Physical Therapy Students the Process of Diagnosis", *APTACombined Sections Meeting*, Seattle, Washington, February 1999.

F. Invited Presentations (selection)

"An Evaluation Framework for Wellness in an Academic Setting." 1-hour presentation at Ivy Plus Annual Meeting, Harvard University, Cambridge, MA. June 2016.

"Principles of Program Evaluation." 1-hr presentation to UNH MPH students, Manchester, NH. June 2012.

"An Internal Assessment of the NH Department of Health and Human Services." Presentation before NH DHHS leaders and agency officials as part of their Service Delivery Transformation project. Concord, NH. May 2012.

"Preventing Falls in Your Facility." 1-hr keynote speech to NH Association of Residential Care Homes. Concord, NH. Oct. 26, 2010.

"Recovery of Function Post-Stroke: Evidence-based Treatment Strategies." Two-day continuing education seminar co-sponsored by *The Dogwood Institute* May 2000 - 2008. Four to six courses taught per year in facilities around the country.

"Motor Control, Cognition, and Motor Learning for the Neurological and Geriatric Patient: Functional Assessment, Evaluation and Treatment". *The Dogwood Institute*. Oct. 1999 – May 2000. Southwestern Medical Center, San Antonio, TX & Southwestern VA Training Center, Hillsville, VA.

REBECCA R. PARTON, LICSW

[redacted]

Education:

UNIVERSITY OF NEW HAMPSHIRE, MSW, *May 2009*

UNIVERSITY OF NEW HAMPSHIRE, BASW with a minor in Education, *May 2004*

- IV-E Intern 2003-2004; Graduate Research Assistant 2008-2009; GSSW officer

Credentials:

LICENSED INDEPENDENT CLINICAL SOCIAL WORKER, *September 2011- present*

- Training and supervision for two years to obtain LICSW, ongoing training and consultation to maintain
- Supervised a Social Work colleague toward licensure, *September 2013-June 2014*

NH EARLY CHILDHOOD MASTER PROFESSIONAL CREDENTIAL WITH ALLIED PROFESSIONAL ENDORSEMENT, *October 2018- present*

Related Experience:

University of New Hampshire, Durham, NH

ADJUNCT PROFESSOR, *January 2017- present*

- Teach online MSW students and in-person classes for undergraduate and graduate Social Work students on Child Welfare related topics, Childhood Risk and Resiliency, and Field Placements
- Use a mix of synchronous and asynchronous activities to support adult learners

Plymouth State University, Plymouth, NH

TEACHING LECTURER, *January 2017- present*

- Prepare and teach in-person classes on Child Maltreatment and Child Welfare Policy to undergraduate students in Social Work, Psychology, Criminal Justice and related fields

Dartmouth Trauma Interventions Research Center, Lebanon, NH

PROJECT COORDINATOR, Upstream Upper Valley, *October 2018- present*

- Coordinate collaboration and training for the Upper Valley region of NH and VT focused on trauma and early childhood
- Co-develop referral system, tracking and coordination of grant activities
- Improve relationships between community agencies (e.g., police, fire, childcare) and mental health providers

PROJECT COORDINATOR, New Hampshire Adoption Preparation and Preservation Project, *August 2014- present*

- Project lead for a statewide implementation and research project in collaboration with NH Division for Children, Youth and Families (DCYF), focused on creating a trauma-informed child welfare and juvenile justice system
- Train DCYF staff across the state in Adoption Competency
- Train Mental Health providers across the state in Adoption Competency, Complex Trauma
- Train and support "Trauma Specialists" at DCYF
- Provide case consultation to DCYF and mental health providers
- Manage an online database of screening information for DCYF

- Oversee the implementation of child level mental health screening and family level screening tools with foster parents
- Partner and collaborate with an Evaluation Team to assess system level change
- Participated in 18 Month Learning Collaborative for Child-Parent Psychotherapy

PROJECT LEAD, Partners for Change Project, *July 2016- September 2018*

- Supervised Mental Health Clinicians who took over for previous project director
- Provided guidance on both the DTIRC and DCYF sides of project during and after transition
- Led project team meetings between DTIRC and DCYF
- Ensured continued implementation of project activities

TRAINING PARTNER, University Partnership Grant, *September 2014- May 2018*

- Contracted by University of New Hampshire to provide training and consultation to Social Work Interns in Trauma Informed Care and related practices

Riverbend Community Mental Health, Concord, NH

GRANT PROJECT COORDINATOR, Capital Region Pediatric Psychiatry Project, *June 2012-June 2014*

- Managed several day long trainings and follow up case based calls for 53 local pediatric medical providers
- Collected and analyzed relevant data pre- and post- training
- Presented to stakeholders and interested groups about the grant in various settings

FAMILY SUPPORT CLINICIAN, *February 2011-June 2014*

- Provided family therapy, family support and case management services
- Member of the Dialectical Behavioral Therapy (DBT) clinical team, provided DBT to families
- Member of the Child Parent Psychotherapy (CPP) clinical team, provided CPP to families
- Provided clinical services to a variety of families pre- and post-adoption, and with guardianship or kinship care cases

CHILD AND FAMILY THERAPIST, Family Intensive Team, *May 2009-February 2011*

- Provided individual and family therapy to high needs families
- Assisted in prevention of placement and frequent hospitalization for high risk clients
- Trained in and utilized MST, DBT, the Change Model, and Attachment Theory

Manchester Community Health Center, Manchester, NH

HEALTH CARE SOCIAL WORK INTERN, *May 2008-May 2009*, 24 hrs/wk, 1200 hrs supervised internship

- Conducted prenatal social work intakes
- Provided crisis, short and long term counseling and support services for clients of all ages
- Met with adolescents in city schools through a grant to prevent drop out and teen pregnancy

Division for Children, Youth and Families

CHILD PROTECTIVE SERVICE WORKER III, **Conway, NH**, *June 2004-May 2005*; **Concord, NH**, *May 2005-January 2008*

- Managed a case load of 12-20 families and kept case records
- Worked with families long term toward reunification and/or adoption
- Participated in court hearings, treatment team meetings, and administrative case reviews
- Completed home studies, court reports and written assessments of families

- Attended numerous trainings and conferences related to child protection, domestic violence, substance abuse, family violence, adoption and mental health
- Conducted a week long Case Practice Review of another District Office

CPSW, IV-E INTERN, **Portsmouth, NH**, *September 2003-May 2004*, 16 hrs/wk, 500 hrs supervised internship

- Managed a case load of 3 clients, assisted with 15-20 other clients
- Organized and recruited sponsors for an annual toy drive

Publications:

Parton, R. R., Barnett, E. R., Meister, C. L., & Jankowski, M. K. (2018). Challenges and strengths in one state's effort to screen and support resource parents' family functioning. *APSAC Advisor, 30*(3), 39-43.

Barnett, E. R., Jankowski, M. K., Butcher, R. L., Meister, C. L., Parton, R. R., & Drake, R. E. (2017). Foster and adoptive parent perspectives on needs and services: A mixed methods study. *Journal of Behavioral Health Services & Research, 45*(1), 74-89. doi: 10.1007/s11414-017-9569-4

Speaking Engagements:

- "Keys to Prevention: Understanding ACEs Research and Applying it to Your Work with Youth". Presented *October 19, 2018*, at the 6th Annual Community Prevention Summit, hosted by the Raymond Coalition for Youth, Candia, NH.
- Expert Panel Member, Public Showings of the Movie "Resilience: The Biology of Stress and the Science of Hope". Boys and Girls Club of Souhegan Valley, Milford, NH, *June 14, 2018*; NH House of Representatives and Senators, Concord, NH, *April 26, 2018;* Monadnock Thrives, Keene, NH, *February 15, 2018.*
- "ACEs Up Your Sleeve: Understanding the Impact of Adverse Childhood Experiences on Individual and Community Health". Presented *April 12, 2018*, hosted by the UNH Interdisciplinary Working Group on Children and Youth with Emotional and Behavioral Challenges, Durham, NH.
- "Trauma Informed Care: What It Means and How To Apply It To Your Work". Presented *October 5, 2017*, at the 2017 Greater Nashua Public Health Annual Meeting and Integrated Behavioral Health Conference, Nashua, NH.
- "Evidence Based Practices For Infant and Young Child Attachment: A Review and Focus on Child-Parent Psychotherapy". Presented *June 14, 2017*, hosted by the NH Association of Infant Mental Health, Manchester, NH.
- "Caring for Children Who Have Experienced Complex Trauma and Attachment Disruptions". Presented *September 23, 2016* at ATTACh Conference, St. Louis, MO.
- "Complex Trauma and Attachment: Working with Children Living Outside Their Families of Origin". Presented *April 4, 2016* at Strengthening Families Summit, hosted by NH Children's Trust, Concord, NH.
- Guest speaker at several college classes (New England College, Colby-Sawyer College, Plymouth State College), *2011-2016*

Related Volunteer Work:

- NH National Association of Social Workers: President-Elect, *2018- present*; Children's Issues Committee, *2008-present,* Current Co-Chair; Social and Legislative Action Committee liaison, *2008-2014;* Ethics Committee, *2016- present;* CEU Committee, *2017- present*
- Statewide Taskforce on Childhood Resiliency, *2018- present*
- NH Behavioral Health for Childhood Trauma Recovery Project Advisory Board Member, *2018-present*

- Mentor for teen girl in foster care, *2008- 2010*

Other Work Experience:

- Head Teacher, Growing Places Daycare, Durham, NH, *2000- 2004*
- BSW Intern, Our House Group Home for Girls, Dover, NH, *2001*
- Camp Counselor and Staff Member, Camp Wightman, Griswold, CT, *1996-2002*

CONTRACTOR NAME
Mary Hitchcock Memorial Hospital

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Jankowski, Mary Kay	Psychologist - Doctorate	$111,800	35%	$50,750
Barnett, Erin R	Psychologist - Doctorate	$104,000	25%	$33,750
Butcher, Rebecca L	Senior Research Analyst	$100,943	10%	$13,000
Parton, Rebecca R	Research Coordinator	$58,885	40%	$32,000

21 MTL

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HUMAN SERVICES

DIVISION FOR CHILDREN, YOUTH & FAMILIES

Nicholas A. Toumpas
Commissioner

Maggie Bishop
Director

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4451 1-800-852-3345 Ext. 4451
FAX: 603-271-4729 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

January 27, 2014

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

100% Federal Funds

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Children, Youth and Families to enter into a **retroactive sole source** agreement with the Trustees of Dartmouth College, Dartmouth College, Office of Sponsored Projects, 11 Rope Ferry Road #6210, Hanover, NH 03755-1404 (Vendor Code # 233097) to improve permanency and wellbeing outcomes for children adopted through the Department, in an amount not to exceed $2,156,447 retroactive to October 1, 2013 effective upon Governor and Executive Council approval, through January 1, 2019.

Funds are available in SFY 2014 and are anticipated to be available in SFYs 2015 through 2019 based upon the available of future federal grant funding and continuing appropriation of funds in future operating budgets with authority to adjust the amounts between State Fiscal Years if needed and justified.

05-95-42-421010-89030000 HEALTH AND HUMAN SERVICES DEPT OF, HHS: HUMAN SERVICES, CHILD PROTECTION, ADOPTION TRAUMA GRANT

State Fiscal Year	Class/Object	Class Title	Activity Number	Budget
2014	102-50731	Contracts for Program Services	42100300	$293,335
2015	102-50731	Contracts for Program Services	42100300	$461,958
2016	102-50731	Contracts for Program Services	42100300	$438,245
2017	102-50731	Contracts for Program Services	42100300	$424,763
2018	102-50731	Contracts for Program Services	42100300	$429,920
2019	102-50731	Contracts for Program Services	42100300	$108,226
			Total:	$2,156,447

EXPLANATION

This request is **sole source** and **retroactive** because prior identification and justification of the vendor as a grant partner was required as part of the Federal grant application process. The grant application

for the Children's Bureau Promoting Well Being and Adoption after Trauma grant required the Department identify and justify any agencies or organizations that would be critical to successfully implementing the Department's proposal to improve permanency and wellbeing outcomes for children adopted through the Department. Further, the Department was required to assert that any partners identified are implementation ready. Prior identification of grant partners is becoming a part of many federal grant application requirements. Due to the partnership and work of the Dartmouth Trauma Intervention and Research Center, the Trustees of Dartmouth College was identified as the Contractor who was implementation ready. Prior identification and justification of partners ensures cost effectiveness for the State and the Federal government.

The Department originally submitted the grant application on August 5, 2013 for review by the United States Department of Health and Human Services Children's Bureau. The Department was notified of grant approval on October 1, 2013 and immediately began work to put the necessary documentation together for the contracting process. The Notice of Award was signed on November 6, 2013 with a grant budget period beginning October 1, 2013 through January 1, 2019. This request is **retroactive** because the Division's grant partner immediately began work on this project upon being notified that the grant was approved by the US Department of Health and Human Services.

Through this contract, the Contractor will replace the current resource family assessment process with an evidence-informed structured decision-making model, which incorporates a matching component such as Structured Analysis Family Evaluation (SAFE) or a similar model of family assessment, which provides a structured decision making model to guide the family assessment process. This structured decision making model is modeled after the type of structured decision-making that is often used in assessing for safety and risk in child protection cases. The new family assessment process will assist the Department with creating better matches between foster families and the children placed with them, which will lead to timely permanency and stable placements. The Contractor will train permanency workers and supervisors in each district office on how to use evidence-based screening and assessment tools which will inform case planning, which usually includes referrals to evidence-based treatments for those children who have experienced significant and complex trauma, resulting from abuse and neglect. These evidence-based treatments assist these children so they can eventually overcome past experiences and learn to function in a family unit.

Using the train-the-trainer model, the Contractor will train mental health providers on family-centered evidence-based treatments that will benefit adoptive parents who need special interventions to address family system changes, which must be in place in order to successfully parent children with trauma issues. The Contractor will ensure there are enough trained mental health providers, statewide, to meet the needs of the State's pre- and post-adoptive families. Lastly, the Contractor will assemble an advisory board that will serve the Contractor by identifying needs of pre- and post-adoptive children and families, as well as training needs in the mental health field. The advisory board will be comprised of key stakeholders, including families and youth.

The Contractor is the only trauma research and intervention center in the State with experience in research and evaluation of evidence-based trauma treatments. Not only does the Contractor have the existing infrastructure that was developed to work in collaboration with the Department that would support this project, but the Contractor has a long term, ongoing relationship with the Department through several other federally funded research initiative projects. These projects have been implemented in partnership with the Department and mental health providers, statewide, and include the previous Bridge Project and the current Partners for Change project.

The Contractor has been instrumental in assisting with the spread of evidence-based treatments for traumatized children in the State through the Bridge Project and the Partners for Change project. These projects initiated trauma screenings for youth and provided training in evidence-based trauma treatments to over 300 mental health providers across the state. Additionally, the projects included the development of a database, which the Department can build upon, that stores and tracks screening outcomes used in case planning.

The grant application required the Department to prove that the partnering agency had the infrastructure to support this initiative, which was accomplished through these aforementioned partnerships. The Contractor has been involved in the State's Systems of Care project and has a good working relationship with the new Care Management Organizations and the staff that are working on the implementation of these new programs. The Contractor has the national leadership, credibility, qualifications, ability and infrastructure to provide the necessary services to assist the Department in implementing this current project that will improve permanency and wellbeing outcomes for adopted youth and is highly respected by our federal partners due to the important work they have been doing in this field.

Should the Governor and Executive Council not approve this request; it will result in the loss of much needed resources to meet the needs of our pre- and post-adoptive population. Without this contract New Hampshire will continue to have a lack of pre-adoptive families that can meet the needs of the waiting children. Further, the children in State care will continue to have placement disruptions in foster homes and there will be a decline in the wellbeing outcomes of adopted children. If this request is not approved, New Hampshire will experience: a decrease in the wellbeing outcomes of children adopted from the child welfare system; a decrease in the number of adoptive homes in our state; and a decrease in the number of children adopted from foster care. Without this contract, the State will miss an opportunity to impact the lives of some of the most vulnerable children in the State system.

Area served: Statewide

Source of funds: 100% federal funds.

In the event that the federal funds become no longer available, general funds will not be requested to support this program.

Respectfully submitted,

Mary Ann Cooney
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

FORM NUMBER P-37 (version 1/09)

Subject: Dartmouth Trauma Intervention and Research Center Contract to Improve Permanancy and Well-Being Outcomes for Children Adopted through DCYF

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 Division for Children, Youth and Families		**1.2 State Agency Address** 129 Pleasant Street Concord, NH 03301	
1.3 Contractor Name Trustees of Dartmouth College		**1.4 Contractor Address** Dartmouth College Office of Sponsored Projects 11 Rope Ferry Road #6210 Hanover, NH 03755-1404	
1.5 Contractor Phone Number 603-646-6575	**1.6 Account Number** 010-402-89030000-102-500731	**1.7 Completion Date** January 1, 2019	**1.8 Price Limitation** $2,156,447
1.9 Contracting Officer for State Agency Eric D. Borrin		**1.10 State Agency Telephone Number** (603) 271-9558	
1.11 Contractor Signature 1/22/14		**1.12 Name and Title of Contractor Signatory** Jill Mordali, Director	

1.13 Acknowledgement: State of NH, County of Grafton

On 1/22 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

[Seal] Heather A. Arnold

1.13.2 Name and Title of Notary or Justice of the Peace

HEATHER A. ARNOLD
Notary Public - New Hampshire
My Commission Expires August 10, 2016

1.14 State Agency Signature	**1.15 Name and Title of State Agency Signatory** Mary Ann Cooney Associate Commissioner
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) By:	On: 2-4-14
1.18 Approval by the Governor and Executive Council 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, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement ("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. 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 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 consent of the N.H. Department of Administrative Services. None of the Services shall be subcontracted by the Contractor without the prior written 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 $250,000 per claim and $2,000,000 per occurrence; and
14.1.2 fire and extended coverage insurance 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.
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 fifteen (15) 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 endeavor to provide the Contracting Officer

Contractor Initials: JMM
Date: 11/22/14

identified in block 1.9, or his or her successor, no less than ten (10) 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.

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: _____
Date: 12/2/14

Exhibit A

Scope of Services

1. PROVISIONS APPLICABLE TO ALL SERVICES

1.1 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.

1.2 The Contractor shall pursue any and all appropriate public sources of funds that are applicable to the funding of the Services, operations prevention, acquisition, or rehabilitation. Appropriate records shall be maintained by the Contractor to document actual funds received or denials of funding from such public sources of funds.

2. Services To Be Provided

The Contractor hereby covenants and agrees that during the term of this Agreement, it will provide services to improve social emotional well-being, family functioning, and placement stability for children in pre adoptive and post adoptive families in the New Hampshire child Welfare system. These services include but are not limited to:

2.1. The Contractor will replace the current resource family assessment process with an evidence-informed structured decision-making model, which incorporates a matching component such as Structured Analysis Family Evaluation (SAFE) or a similar model of family assessment model which provides a structured decision making model to guide the family assessment process modeled after the type of structured decision-making that is often used in assessing for safety and risk in child protection cases.

- 2.1.1. The contractor will work in collaboration with the Divisions training partner to coordinate training in the SAFE, or similar family assessment model for all resource workers, their supervisors and staff from all private child placing agencies.
- 2.1.2. The contractor will measure and evaluate the efficacy of this home assessment model.
- 2.1.3. The contractor will provide assistance to the division in develop new training for families based upon the needs identified using the SAFE or similar family assessment model.

2.2. The contractor will assist the division with identifying and implementing screening and assessment measures specifically for the population of pre and post adopted children and their families. This will include:

- 2.2.1. Training permanency workers and supervisors in each district office in the utilization and application of screening measures
- 2.2.2. The development of a platform where results of screening can be stored and utilized by Division staff

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2.2.3. Developing training to assist staff in utilizing results of screening in their case planning and in the referral of children for evidenced based treatments.

2.3. The Contractor will provide training in family centered evidence-based treatments using a train the trainer model to providers in the Community Mental Health Centers, (CMHC's) and the private practitioners who provide services to the families and children involved in child welfare and will ensure that there are enough trained providers to meet the needs identified through the screening and assessments.

2.4. The contractor will assemble an advisory board, which shall be comprised of key stakeholders including families and youth.

2.5. The Contractor will meet all requirements set forward by the Children's Bureau including:

2.5.1. Planning and Implementation plans

2.5.2. Scheduling all travel and planning required for attendance for any key staff required at mandatory meetings

2.5.3. All reporting requirements

Method and Conditions Precedent to Payment

1. This contract is funded by funds made available under the Catalog of Federal Domestic Assistance (CFDA), as follows:
   CFDA #: 93.652
   Federal Agency: U.S. Department of Health and Human Services
   Program Title: Adoption Opportunities

2. The Contractor shall comply with all of the requirements of the grant under which the award was made and all of requirements of CFDA # 93.652.

3. The State shall pay the Contractor an amount not to exceed the price limitation, Section 1.8 Price Limitation.

4. Expenditures for each State Fiscal Year shall be in accordance with the line items as shown in Exhibits B-1, the Budget Narrative for the project.

5. Payment for said services shall be to the contractor, subject to the following conditions:

   3.1. Payment will be on a cost reimbursement basis based on actual expenditures incurred up to the total contract price incurred in the fulfillment of this agreement. An invoice template, provided by the Department shall be used for billing, and must be completed, signed (or emailed) to:

   Fiscal Administrator
   Division for Children, Youth and Families
   129 Pleasant Street
   Concord, NH 03301-3857

   dbclark@dhhs.state.nh.us

   3.2. Requests for payment shall be signed or submitted electronically by an authorized representative of the Contractor.

   3.3. Payment requests may be submitted monthly or at the end of each semester, but at a minimum must be submitted quarterly.

   3.4. A final payment will be submitted no later than sixty (60) days after the agreement ends. Failure to submit the invoice by this date could result in non-payment.

   3.5. Notwithstanding anything to the contrary herein, the Contractor agrees that payment under this Agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State Law, rule or regulation

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Date: 1/22/14

applicable to the services provided, or if the said services have not been satisfactory completed in accordance with the terms and conditions of this Agreement.

3.6. Payments may be withheld pending receipt of required reports as outlined in Exhibit A.

6. When the Contract Price limitation is reached, the program shall continue to operate at full capacity at no charge to the Division Children, Youth and Families for the duration of the Contract Period.

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

Contractor Initials: JM

Date: 1/28/14

New Hampshire Adoption Preparation and Preservation Project (NHAPP)
Budget Narratives for NHAPP Project - Year 1

Exhibit B-1

6.a - Personnel	Salary	SFY14 9/30/2013 6/30/2014
Kay Jankowski	$ 86,549.00	$ 25,997
Erin Barnett	$ 72,540.00	$ 21,789
Cathleen Yackley	$ 72,540.00	$ 14,526
TBD	$ 60,000.00	$ 60,075
CPDE-TBD (Center for Program, Design and Evaluation at Dartmouth)	$ 71,936.00	$ 36,013
Karen Schifferdecker	$ 96,428.00	$ 14,482
Budget total for Personnel		**$ 172,882**
Description:		
All staff listed are committed to project 12 months/year x 5 years		

6.c - Travel	
Budget total for Travel	**$ 25,045**
Description:	
1. Annual Meeting: (Each Year) Trip to Washington, DC for 3 people @	
3 days, 2 nights stay in hotel, airfare, per diem	
3. Travel for Staff to run Focus Groups: (4 Groups meeting 2 times/year) average evaluators)	
7. Staff travel to State offices, avg 160 miles/roundtrip * .565/mile for approximately	
8. Consumer Participation, avg 160 miles/roundtrip * .565/mile for approximately 30	
3. Mileage reimbursement for attendees, $2,260.00, Avg 160 miles/person roundtrip	

6.d - Equipment	
Budget total for Equipment	**$ 2,890**
Description:	
1. Computer for Coordinator - Year 1 only: $2,890.00	
2. Data Collection: Tablets, 10 Tablets at $620.00/tablet, Year 1 only: $6,200.00	
3 Data Collection: Programming of Tablets & General Data Instructions at	

6.e - Supplies	
Budget total for Supplies	**$ 675**
Description:	
Project materials, supplies and duplication, $75.00/month	

6.f - Contractual	
Budget for Contractual	**$ 4,200**
Description:	
(TBN) Adoption Consultants, 3 consultants, $100/hour - 15 hours year 1 & 7 hours years 2-5	

	Year 1
6.h - Other	
Budget for Other	**$ 12,401**
Description:	
1. Training Meetings: (6 meetings/year) Meeting room rental, $300.00/meeting	
2. Training Meetings: (6 meetings/year) Food and beverages, $500.00/meeting ($20.00/person, 25 pec	
Meeting with Adoption Consultants (food/beverage & room rental), $485/year	
Evaluation:	
4. Focus Groups Stipends: (4 Groups meeting 2 times/year) 8 participants at	
5. Food for Focus Groups: (4 Groups meeting 2 times/year) at $100.00/meeting	
6. Phone Charges: Conference Calls, 24-60 minute calls/year with 5 callers/call at	
7. Stipends: Consumer Participation Payments, $100.00 stipends for 30 consumers	

6.i - Total Direct Charges	**$ 218,093**
6.j - Indirect Charges	**$ 75,242**
6.k - Total (Budget includes inflation at 103.0%)	**$ 293,335**

Contractor Initials
Date 1/22/14

Exhibit B-2

			SFY15	SFY16	SFY17	SFY18	SFY19
Kay Jankowski	$	86,549.00	$ 35,904	$ 36,779	$ 37,883	$ 39,020	$ 9,827
Erin Barnett	$	72,540.00	$ 30,092	$ 30,826	$ 31,751	$ 32,704	$ 8,236
Cathleen Yackley	$	72,540.00	$ 20,061	$ 20,551	$ 21,168	$ 21,802	$ 5,491
TBD	$	60,000.00	$ 82,966	$ 84,992	$ 87,541	$ 90,168	$ 22,707
CPDE-TBD (Center for Program, Design and Evaluation at Dartmouth)	$	71,936.00	$ 42,231	$ 41,139	$ 42,214	$ 50,605	$ 13,333
Karen Schifferdecker	$	96,428.00	$ 20,001	$ 20,489	$ 21,103	$ 21,737	$ 5,474
Budget total for Personnel			$ 231,254	$ 234,776	$ 241,660	$ 256,035	$ 65,067
Description:							
All staff listed are committed to project 12 months/year x 5 years							
6.c - Travel							
Budget total for Travel			$ 19,348	$ 26,378	$ 27,167	$ 27,983	$ 7,047
Description:							
1. Annual Meeting (Each Year) Trip to Washington, DC for 3 people @							
3 days, 2 nights stay in hotel, airfare, per diem							
2. Entrance Conference. REMOVED							
3. Travel for Staff to run Focus Groups: (4 Groups meeting 2 times/year) average 160							
4. State Meetings: (4 meetings/year with State to review evaluators)							
7. Staff travel to State offices, avg 160 miles/roundtrip * .565/mile for approximately 35							
8 Consumer Participation, avg 160 miles/roundtrip * .565/mile for approximately 30							
3. Mileage reimbursement for attendees, $2,260.00, Avg 160 miles/person roundtrip							
6.d - Equipment							
Budget total for Equipment			$ 39,494	$ 7,899	$ 8,136	$ 8,380	$ 2,110
Description:							
1. Computer for Coordinator - Year 1 only: $2,890.00							
2. Data Collection: Tablets, 10 Tablets at $620.00/tablet, Year 1 only: $6,200.00							
3. Data Collection. Programming of Tablets & General Data Instructions at $50.00/hour							
6.e - Supplies							
Budget total for Supplies			$ 920	$ 948	$ 976	$ 1,006	$ 253
Description:							
Project materials, supplies and duplicatnon, $75.00/month							
6.f - Contractual							
Budget for Contractual			$ 4,850	$ 3,800	$ 3,563	$ 3,800	$ 950
Description:							
(TBN) Adoption Consultants, 3 consultants, $100/hour - 15 hours year 1 & 7 hours years 2-5							
requires intervennon studies to be evaluated by outside consultants, $650.00/year							
REMOVED							
6.h - Other							
Budget for Other			$ 47,598	$ 52,033	$ 34,071	$ 22,440	$ 5,037
Description:							
1. Training Meetings. (6 meetings/year) Meeting room rental, $300.00/meeting							
2. Training Meetings (6 meetings/year) Food and beverages, $500.00/meeting ($20.00/person, 25 people)							
Meeting with Adoption Consultants (food/beverage & room rental), $485/year							
Evaluation.							
4. Focus Groups Stipends: (4 Groups meeting 2 times/year) 8 participants at							
5 Food for Focus Groups. (4 Groups meeting 2 times/year) at $100.00/meeting							
6 Phone Charges: Conference Calls, 24-60 minute calls/year with 5 callers/call at							
7. Stipends Consumer Participation Payments, $100.00 stipends for 30 consumers							
8. SAFE Training: (Structured Analysis Family Evaluation), 2 day training at							
$700.00/person, 36 people in year 2, 13 people year 3, & 13 people year 4							
9 "Train the Trainers" Workshops, Years 2 & 3 only							
10. "Train the Trainers" Continuation Workshops, Years 4 & 5 only							
State Audit Set Aside							
6.i - Total Direct Charges			$ 343,463	$ 325,833	$ 315,809	$ 319,643	$ 80,465
6.j - Indirect Charges			$ 118,495	$ 112,412	$ 108,954	$ 110,277	$ 27,761
6.k - Total (Budget includes inflation at 103.0%)			$ 461,958	$ 438,245	$ 424,763	$ 429,920	$ 108,226

Contractor Initials _____
Date 4/22/14

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 fundors 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 fundors, 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. **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:

16.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function

16.2. 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

16.3. Monitor the subcontractor's performance on an ongoing basis

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

16.5. 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.

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:

1/22/14
Date

Name: Jill M. Mortali, Director
Title: Office of Sponsored Projects

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:

11/22/14
Date

Name: Jill M. Mortali, Director
Office of Sponsored Projects

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:

Date 1/22/14

Name: Jill M. Mortali, Director
Title: Office of Sponsored Projects

CERTIFICATION REGARDING
THE AMERICANS WITH DISABILITIES ACT COMPLIANCE

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 make reasonable efforts to comply with all applicable provisions of the Americans with Disabilities Act of 1990.

Contractor Name:

1/22/14
Date

Name:
Title:
Jill M. Mortali, Director
Office of Sponsored Projects

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:

1/22/14
Date

Name: Jill M. Mortali, Director
Title: Office of Sponsored Projects

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILTY 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 and those parts of the HITECH Act 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.

Definitions

1. "Breach" shall have the same meaning as the term "Breach" in Title XXX, Subtitle D. Sec. 13400.
2. "Business Associate" has the meaning given such term in section 160.103 of Tile 45, Code of Federal Regulations.
3. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
4. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.
5. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.
6. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.
7. "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.
8. "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.
9. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).
10. "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.
11. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
12. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.501.
13. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.
14. "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.
15. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreasonable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.
16. 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.

Use and Disclosure of Protected Health Information

1. 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, the Business Associate shall not, and shall ensure that its directors, officers, employees and agents, do not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. Business Associate may use or disclose PHI:
   2.1. For the proper management and administration of the Business Associate;
   2.2. As required by law, pursuant to the terms set forth in paragraph d. below; or
   2.3. For data aggregation purposes for the health care operations of Covered Entity.
3. 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 HITECH Act, Subtitle D, Part 1, Sec. 13402 of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
4. 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.
5. 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.

Obligations and Activities of Business Associate

1. Business Associate shall report to the designated Privacy Officer of Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement, including any security incident involving Covered Entity data, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402.
2. The Business Associate shall comply with all sections of the Privacy and Security Rule as set forth in, the HITECH Act, Subtitle D, Part 1, Sec. 13401 and Sec.13404.
3. 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.
4. 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)b and (3)k herein. 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 provision #13 of this Agreement for the purpose of use and disclosure of protected health information.
5. 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.

6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.

Obligations of Covered Entity

1. 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.
2. 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.
3. 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.

Termination for Cause

In addition to standard provision #10 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.

Miscellaneous

1. 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, and the HITECH Act as 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.
2. 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.
3. 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.
4. 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 and the HITECH Act.
5. 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.
6. 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 k, the defense and indemnification provisions of section 3 d and standard contract provision #13, shall survive the termination of the Agreement.

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

Contractor Name:

1/29/14
Date

Name:
Title: MaryAnn Carney
Associate Commissioner

State Agency Name: DHHS

1/22/14
Date

Name:
Jill M. Mortali, Director
Office of Sponsored Projects

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:

1/22/14
Date

Name:
Title: **Jill M. Mortali, Director**
Office of Sponsored Projects

Contractor Initials
Date 1/22/14

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: 041027822

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: _____