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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

Lori A. Shibinette
Commissioner

Patricia M. Tilley
Director

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May 9, 2022

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, NH, in the amount of $306,200 for the provision of injury prevention services, with the option to renew for up to two (2) additional years, effective upon Governor and Council approval, through March 31, 2024. 100% Federal Funds.

Funds are available in the following accounts for State Fiscal Years 2022 and 2023, and are anticipated to be available in State Fiscal Year 2024, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

05-95-90-901010-8011 HEALTH AND SOCIAL SERVICES. DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF POLICY & PERFORMANCE, PREVENTIVE HEALTH BLOCK GRANT – 100% Federal Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	074-500585	Community Grants	90001023	$23,125
2023	074-500585	Community Grants	90001023	$92,500
2024	074-500585	Community Grants	90001023	$69,375
			Subtotal	***$185,000***

05-95-48-481010-8917 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: ELDERLY & ADULT SVCS DIV, GRANTS TO LOCALS, HEALTH PROMOTION CONTRACTS – 100% Federal Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	074-500585	Community Grants	48108462	$5,000
2023	074-500585	Community Grants	48108462	$20,000
2024	074-500585	Community Grants	48108462	$15,000
			Subtotal	***$40,000***

05-95-48-481010-2638 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, GENERAL FUND MATCH FOR ARPA – 100% Federal Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	074-500585	Community Grants	48108462	$10,150
2023	074-500585	Community Grants	48108462	$40,600
2024	074-500585	Community Grants	48108462	$30,450
			Subtotal	***$81,200***
			Total	**$306,200**

EXPLANATION

This request is **Sole Source** because the Contractor is the only entity of its kind in the State that provides comprehensive evidence-based injury prevention activities that addresses all age groups, including older adult falls risk reduction, teenage driver safety, and prevention of other childhood injuries. Additionally, the Contractor has maintained a network of injury prevention stakeholders and partners on the local, state, and national level for more than three (3) decades. Therefore the Contractor is uniquely qualified to provide these services.

Injury prevention programming has demonstrated significant progress to date towards reducing the burden of injuries in the State of New Hampshire. For example, the use of seatbelts among teenage drivers has increased from 70% during the 2014-2015 school year to 87.7% in 2019. The Contractor will implement, evaluate, and promote injury prevention strategies that address the most pressing injury issues, with the overall goal to decrease injury related to morbidity and mortality and increase sustainability of injury prevention programs and practices statewide. The Contractor will assist the Department with ongoing injury prevention programing, including adolescent driver safety, older adult falls prevention, child safety, child maltreatment prevention, as well as updating the State Injury Prevention Strategic Plan. By working with the Contractor's Injury Prevention Program, the Department is able to leverage the Contractor's partnerships with multiple stakeholders and broad knowledge base regarding injury prevention in New Hampshire.

The Contractor's injury prevention programming work will reduce injuries for and benefit a wide range of New Hampshire residents, including adolescent drivers, drivers and passengers of all ages who may otherwise have been impacted by a teenage driver, and individuals sixty-five (65) years and older, who will improve strength and physical stability to prevent deaths and injuries due to falls.

Approximately 500,000 individuals will be served through State Fiscal Year 2024.

The Department will monitor services by:

- Reviewing activities annually to ensure that the Contractor implements at least eight-five percent (85%) of the strategies and accompanying activities outlined in the Department's Injury Prevention Plan.
- Reviewing corrective action plans submitted by the Contractor on a quarterly basis for any performance measure(s) not achieved.

As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and Governor and Council approval.

Should the Governor and Council not authorize this request, essential injury prevention programing provided by the Contractor aimed at decreasing morbidity and mortality as a result of unintentional injuries will cease, which may lead to increased injuries and death in the state.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number #93.991, FAIN #NB01OT009381; #93.043, FAIN #2201NHOAPH; and #93.043, FAIN #2101NHPHC6.

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

Respectfully submitted,

Lori A. Shibinette
Commissioner

Subject: Injury Prevention Services (SS-2023-DPHS-03-INJUR-01)

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address One Medical Center Drive Lebanon, NH, 03756	
1.5 Contractor Phone Number (603) 650-5000	1.6 Account Number 05-95-90-901010-8011, 05-95-48-481010-8917, 05-95-48-481010-2638	1.7 Completion Date March 31, 2024	1.8 Price Limitation $306,200
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Edward Merrens Date: 5/17/2022		1.12 Name and Title of Contractor Signatory Edward Merrens Chief Clinical Officer	
1.13 State Agency Signature DocuSigned by: Patricia M. Tilley Date: 5/17/2022		1.14 Name and Title of State Agency Signatory Patricia M. Tilley Director	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino		On: 5/17/2022	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

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

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

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

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8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

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

9. TERMINATION.

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

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

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

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

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

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

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

14. INSURANCE.

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

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

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

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

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

15. WORKERS' COMPENSATION.

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

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

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

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

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

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

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

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

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

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

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

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Date 5/17/2022

New Hampshire Department of Health and Human Services
Injury Prevention Services

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

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

3.1. Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire as indicated in block 1.17, this Agreement, and all obligations of the parties hereunder, shall become effective on April 1, 2022 ("Effective Date").

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

3.3. The parties may extend the Agreement for up two (2) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

1.3. Paragraph 7, Personnel, is amended by modifying subparagraphs 7.1 and 7.2 to read:

7.1. The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor certifies 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's personnel who are engaged in the performance of Services under this Agreement, 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.

1.4. Paragraph 9, Termination, is amended by modifying subparagraph 9.2 to read:

9.2. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than thirty (30) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject

matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached Exhibit B. In addition, at the State's discretion, the Contractor shall, within thirty (30) days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

1.5. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

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

1.6. Paragraph 14, Insurance, is amended by modifying subsection 14.1.2. to delete the text in its entirety and replace it to read:

14.1.2. Professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 per annual aggregate.

1.7. Paragraph 14, Insurance, is amended by modifying subparagraph 14.2 to read:

14.2. The policies described in subparagraph 14.1 herein shall beon 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 or registered to conduct business in the State of New Hampshire.

New Hampshire Department of Health and Human Services
Injury Prevention Services

EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall support the Department's Injury Prevention Program to reduce death and disabilities that result from intentional and unintentional injuries by:

1.1.1. Providing trainings based on data that shows a need for more information about a given injury prevention subject.

1.1.2. Educating the public and health care professionals about injury prevention.

1.1.3. Developing, implementing, and promoting the use of proven injury prevention strategies.

1.2. The Contractor shall collaborate with communities and stakeholders to provide services Statewide. Collaboration partners include, but are not limited to the following entities:

1.2.1. School Districts

1.2.2. Police and Fire Departments

1.2.3. Medical Professionals

1.2.4. Public Health Region Leadership

1.2.5. Charitable Organizations

1.3. The Contractor shall provide educational interventions, environmental modifications, and develop polices which includes, but is not limited to:

1.3.1. An example of an educational intervention is the Teen Driver Safety Program, which facilitates peer-lead groups in high schools to promote a culture of safety.

1.3.2. Another example of an educational intervention is the train-the-trainer sessions for Tia Ji Quan: Moving for Better Balance® and Matter of Balance instructors.

1.3.3. An example of environmental modifications is advising older adults on changes they can make in their homes or reduce their risk of falling.

1.3.4. An example of policy development is working to improve road safety for bicyclists and pedestrians.

1.4. The Contractor shall:

1.4.1. Facilitate and oversee the following statewide coalitions in order to implement injury prevention programming:

1.4.1.1. Safe Kids New Hampshire, which meets quarterly.

1.4.1.1.1. During quarterly Safe Kids New Hampshire meetings, the Contractor shall conduct professional trainings on best practice injury prevention strategies and other topics as determined by coalition member interest, emergent issues, and injury surveillance data.

1.4.1.2. The Teen Driving/Buckle-Up NH Committee, which meets bi-monthly.

1.4.1.3. The New Hampshire Falls Risk Reduction Task Force, which meets monthly.

1.4.1.4. The New Hampshire Injury Prevention Advisory Council, which meets quarterly.

1.4.2. Facilitate and oversee development and implementation of the State Injury Prevention Strategic Plan (the Plan), including:

1.4.2.1. Facilitating evaluation meetings, as needed, and developing evaluation plans for Plan components, including, but not limited to:

1.4.2.1.1. Older adult falls prevention strategies, including Tia Ji Quan: Moving for Better Balance® and Matter of Balance programs;

1.4.2.1.2. Teenage driving; and

1.4.2.1.3. Childhood poison prevention.

1.4.2.2. A Data Specialist will be hired and may conduct semi-structured individual or group interviews with key program stakeholders as part of the evaluation.

1.4.2.3. Analyzing the most recent data related to the types of injuries that occur in New Hampshire that may be addressed by prevention services.

1.4.2.4. Facilitating work groups to ensure key partners are represented and that the Plan is properly updated based on:

1.4.2.4.1. New Hampshire specific injury data.

1.4.2.4.2. Evidence-based practices.

1.4.2.4.3. Current initiatives.

1.4.2.4.4. Resource availability.

1.4.2.4.5. Programming and evaluation feasibility.

1.4.2.5. Reviewing outcomes from the work group submissions from both a programmatic and evaluative perspective.

1.4.2.6. Conducting a formative process-level evaluation for purposes of performance monitoring and tracking program efforts.

1.4.2.7. Conducting a summative outcome-level evaluation to assess annual changes in desired short- and intermediate-term outcomes.

1.4.3. The Contractor shall implement a pilot program to provide Tia Ji Quan: Moving for Better Balance® to at least one (1) community in New Hampshire where English is their second language.

1.4.3.1. The Contractor shall plan, promote, and provide logistical support and evaluation of evidence-based falls risk reduction training for older adults age sixty-five (65) and older.

1.4.4. The Contractor shall attend the following meetings and conferences:

1.4.4.1. Monthly telephone meetings and quarterly in-person meetings of the Northeast and Caribbean Injury Prevention Network (NCIPN).

1.4.4.2. Safe States Alliance annual meeting.

1.4.4.3. Monthly check-in meetings with the Department's Injury Prevention Program Manager.

1.4.5. The Contractor shall conduct a mixed-method, longitudinal evaluation of the Plan's strategies and associated activities, including collecting and analyzing quantitative and qualitative data from different target groups over time to inform future injury prevention activities. This shall be accomplished by aligning evaluation protocols and procedures with Injury Prevention Program activities and strategic priorities. Evaluation activities may include, but are not limited to:

1.4.5.1. Conducting participant surveys on use, experiences, satisfaction and knowledge/awareness.

1.4.5.2. Tracking training attendance, number of training sessions, program outreach activities, and other metrics, as requested by the Department.

1.4.5.3. Employing targeted qualitative methods, including, but not limited to, focus groups and/or semi-structured interviews, to supplement quantitative data collection methods.

1.4.5.4. Collecting feedback from target audiences on the delivery and content of Injury Prevention trainings, meetings, and/or other programming to inform future programming.

1.4.5.5. Compiling secondary de-identified, aggregated data such as injury data, incidence and severity rates, and registry data, subject to Section 1.7 of this Exhibit B. Also, any relevant document review (e.g., advisory group meeting minutes; fiscal data).

1.4.6. The Contractor shall analyze quantitative data, including counts such as injury incidents, meeting attendance, educational event participation and/or survey data, using appropriate statistical methods, including t-tests or analysis of variances for continuous or interval data and chi-square for categorical variables, to make inferences about program effects on process or outcome variables.

1.4.7. The Contractor shall systematically code qualitative data, including focus group and semi-structured interview narratives, using a mix of grounded theory methods and content analysis to identify overarching themes that emerge from participant perspectives on activities, challenges, successes and other outcomes.

1.5. Within thirty (30) days of the effective date of the Agreement, the Contractor shall develop and submit a Work Plan for Department approval that includes, but is not limited to:

1.5.1. Strategies for completing the required activities outlined in this Agreement; and

1.5.2. Deadline dates by which activities will be completed.

1.6. The Contractor shall provide quarterly updates on the Work Plan to the Department, which shall include, but are not limited to, a brief justification for any deadlines that the Contractor did not meet and the new proposed deadline.

1.7. In connection with the performance of this Agreement, the Parties will not exchange any confidential information of any type, including but not limited to:

1.7.1. Protected health information as defined in Health Insurance Portability and Accountability Act (HIPAA);

1.7.2. Personally identifiable information; and

1.7.3. Any type of information that may be used to determine, distinguish or trace an individual's identity.

2. Exhibits Incorporated

2.1. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

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

3. Reporting Requirements

3.1. The Contractor shall provide quarterly progress reports, other than information noted in the restrictions in section 1.7 above, to the Department that includes, but is not limited to:

3.1.1. Progress toward performance measures and overall program goals and objectives;

3.1.2. Type and number of Injury Prevention-related meetings facilitated by the Contractor and count of attendees;

3.1.3. Number of fall prevention classes and count of attendees; and

3.1.4. Successes, and challenges.

3.2. Within thirty (30) days of the conclusion of each State Fiscal Year, the Contractor shall provide an annual report to the Department that includes, but is not limited to:

3.2.1. A summary of successes, challenges, and Injury Prevention activities conducted by the Contractor.

3.2.2. Number of training sessions and attendance count for train-the-trainer sessions for Tia Ji Quan: Moving for Better Balance® and Matter of Balance instructors.

3.2.3. Aggregate pre- and post- survey participant data for Tia Ji Quan: Moving for Better Balance® and Matter of Balance training sessions.

3.2.4. Other reporting requirements as needed, in accordance with American Rescue Plan Act reporting requirements.

3.2.5. The Contractor shall submit quarterly progress reports towards Process Indicators as per grant requirements and noted in the State Injury Prevention Plan[1].

3.3. Performance Measures

3.3.1. The Contractor shall implement and evaluate eight-five percent (85%) of the strategies and accompanying activities outlined in the Work Plan.

[1] Microsoft Word - 2020-25_StateVIPPlanFINAL rev4-06-20.docx (nh.gov)

3.3.2. Quarterly, the Contractor shall develop and submit to the Department a corrective action plan for any activities in the Work Plan that were not achieved.

4. Additional Terms

4.1. Impacts Resulting from Court Orders or Legislative Changes

4.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith. In the event that any future state or federal legislation or court order impacts the Services described herein, the Department shall provide the Contractor with reasonable advanced notice of any necessary modification to Service priorities and expenditure requirements. The parties agree to cooperate in the implementation and planning of any such modification and the Department shall consider Contractor's reasonable requests with respect to such modifications. Notwithstanding the foregoing, the Department shall retain the final right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance with any future state or federal legislation or court orders that have an impact on the Services described herein.

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

4.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

4.3. Credits and Copyright Ownership

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

4.3.2. All materials produced or purchased under the Agreement shall have

prior approval from the Department before printing, production, distribution or use.

4.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

4.3.3.1. Brochures.

4.3.3.2. Resource directories.

4.3.3.3. Protocols or guidelines.

4.3.3.4. Posters.

4.3.3.5. Reports.

4.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

5. Records

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

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

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

5.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

During the term of this Agreement 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 Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder,

the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) 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.

New Hampshire Department of Health and Human Services
Injury Prevention Services

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 60% Federal Funding from the Preventive Health Services Block Grant, as awarded on October 25,2021, by the U.S. Department of Health and Human Services, Center for Disease Control, CFDA #93.991 FAIN #NB01OT009366;
   1.2. 13% Federal Funding from the Elderly and Adult Services Grant, as awarded on November 8, 2021, by the U.S. Department of Health and Human Services, Special Programs for the Aging, Title III, Part D, Disease Prevention and Health Promotion Services, CFDA# 93.043 FAIN #2201NHOAPH; and
   1.3. 27% Federal Funding from the Elderly and Adult Servcies Grant, awarded on April 5, 2021, by the U.S. Department of Health and Human Services, Special Prgrams for the Aging, ARP Title III, Part Dm CFDA #93.043 FAIN 2101NHPHC6.
2. For the purposes of this Agreement:
   2.1. The Department has identified the Contractor as a subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Department has identified this Agreement as NON-R&D, in accordance with 2 CFR §200.332.
   2.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibits C-1, Budget through Exhibit C-6, Budget.
4. The Contractor shall submit an invoice and supporting documents to the Department no later than the twentieth (20th) working day of the following month. The Contractor shall:
   4.1. Ensure the invoice is presented in a form that is provided by the Department or is otherwise acceptable to the Department.
   4.2. Ensure the invoice identifies and requests payment for allowable costs incurred in the previous month.
   4.3. Provide supporting documentation of allowable costs that may include, but is not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.

4.4. Ensure the invoice is completed, dated and returned to the Department with the supporting documentation for authorized expenses, in order to initiate payment.

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

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

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

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

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

9. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B, Scope of Services.

10. Notwithstanding anything to the contrary herein, the Contractor agrees that funding 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 applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

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

12. Audits

    12.1. The Contractor must email an annual audit to melissa.s.morin@dhhs.nh.gov if **any** of the following conditions exist:

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

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

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

12.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 30 days after the completion of the single audit or upon submission of the Contractor's single audit to the Federal Audit Clearinghouse conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

12.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

Exhibit C-1, Budget

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

Contractor Name: Mary Hitchcock Memorial Hospital

Project Title: Injury Prevention Services (AU 2638 ARPA Funds)

Budget Period: Effective Date to 06/30/2022

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 4,672	$ 467	$ 5,140	$ -	$ -	$ -	$ 4,672	$ 467	$ 5,140
2. Employee Benefits	$ 1,486	$ 149	$ 1,635	$ -	$ -	$ -	$ 1,486	$ 149	$ 1,635
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ 269	$ 27	$ 296	$ -	$ -	$ -	$ 269	$ 27	$ 296
6. Travel	$ 800	$ 80	$ 880	$ -	$ -	$ -	$ 800	$ 80	$ 880
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ 2,000	$ 200	$ 2,200	$ -	$ -	$ -	$ 2,000	$ 200	$ 2,200
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 9,227	$ 923	$ 10,150	$ -	$ -	$ -	$ 9,227	$ 923	$ 10,150
Indirect As A Percent of Direct		10.0%							

Contractor Initials EM

Date 5/17/2022

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

Contractor Name: Mary Hitchcock Memorial Hospital

Project Title: Injury Prevention Services (AU 8011 & 8917 Funds)

Budget Period: Effective Date - 6/30/2022

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 19,186	$ 1,919	$ 21,105	$ -	$ -	$ -	$ 19,186	$ 1,919	$ 21,105
2. Employee Benefits	$ 6,101	$ 610	$ 6,711	$ -	$ -	$ -	$ 6,101	$ 610	$ 6,711
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 281	$ 28	$ 309	$ -	$ -	$ -	$ 281	$ 28	$ 309
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 25,568	$ 2,557	$ 28,125	$ -	$ -	$ -	$ 25,568	$ 2,557	$ 28,125
Indirect As A Percent of Direct		10.0%							

Contractor Initials EM

Date 5/17/2022

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

Contractor Name: Mary Hitchcock Memorial Hospital

Project Title: Injury Prevention Services (AU 2638 ARPA Funds)

Budget Period: 7/1/2022 - 6/30/2023

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 22,376	$ 2,238	$ 24,614	$ -	$ -	$ -	$ 22,376	$ 2,238	$ 24,614
2. Employee Benefits	$ 7,116	$ 712	$ 7,828	$ -	$ -	$ -	$ 7,116	$ 712	$ 7,828
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 417	$ 42	$ 458	$ -	$ -	$ -	$ 417	$ 42	$ 458
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 7,000	$ 700	$ 7,700	$ -	$ -	$ -	$ 7,000	$ 700	$ 7,700
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 36,909	$ 3,691	$ 40,600	$ -	$ -	$ -	$ 36,909	$ 3,691	$ 40,600
Indirect As A Percent of Direct		10.0%							

Contractor Initials EM

Date 5/17/2022

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

Contractor Name: Mary Hitchcock Memorial Hospital

Project Title: Injury Prevention Services (AU 8011 & 8917 Funds)

Budget Period: 7/1/2022 - 6/30/2023

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 75,361	$ 7,536	$ 82,897	$ -	$ -	$ -	$ 75,361	$ 7,536	$ 82,897
2. Employee Benefits	$ 23,965	$ 2,396	$ 26,361	$ -	$ -	$ -	$ 23,965	$ 2,396	$ 26,361
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ 487	$ 5	$ 492	$ -	$ -	$ -	$ 487	$ 5	$ 492
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 1,500	$ 150	$ 1,650	$ -	$ -	$ -	$ 1,500	$ 150	$ 1,650
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 102,313	$ 10,187	$ 112,500	$ -	$ -	$ -	$ 102,313	$ 10,187	$ 112,500
Indirect As A Percent of Direct		10.0%							

Contractor Initials EM

Date 5/17/2022

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

Contractor Name: Mary Hitchcock Memorial Hospital

Project Title: Injury Prevention Services (AU 2638 ARPA Funds)

Budget Period: 7/1/2023 - 3/31/2024

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 20,849	$ 2,085	$ 22,934	$ -	$ -	$ -	$ 20,849	$ 2,085	$ 22,934
2. Employee Benefits	$ 6,630	$ 663	$ 7,293	$ -	$ -	$ -	$ 6,630	$ 663	$ 7,293
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 203	$ 20	$ 223	$ -	$ -	$ -	$ 203	$ 20	$ 223
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 27,682	$ 2,768	$ 30,450	$ -	$ -	$ -	$ 27,682	$ 2,768	$ 30,450
Indirect As A Percent of Direct		10.0%							

Contractor Initials EM

Date 5/17/2022

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

Contractor Name: Mary Hitchcock Memorial Hospital

Project Title: Injury Prevention Services (AU 8011 & 8917 Funds)

Budget Period: 7/1/2023 - 3/31/2024

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 57,547	$ 5,755	$ 63,302	$ -	$ -	$ -	$ 57,547	$ 5,755	$ 63,302
2. Employee Benefits	$ 18,300	$ 1,830	$ 20,130	$ -	$ -	$ -	$ 18,300	$ 1,830	$ 20,130
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 857	$ 86	$ 943	$ -	$ -	$ -	$ 857	$ 86	$ 943
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training			$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 76,705	$ 7,670	$ 84,375	$ -	$ -	$ -	$ 76,705	$ 7,670	$ 84,375
Indirect As A Percent of Direct		10.0%							

Contractor Initials EM

Date 5/17/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

Vendor Initials EM (DS)

Date 5/17/2022

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

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

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

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

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

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

Vendor Name:

DocuSigned by:
Edward Merrens
BACA3CF0A0C040...

5/17/2022
Date

Name: Edward Merrens
Title: Chief Clinical Officer

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Vendor Name:

5/17/2022
Date

DocuSigned by:
Edward Merrens
8ACA3CFCA0CC418...
Name: Edward Merrens
Title: Chief Clinical Officer

Vendor Initials DS EM
Date 5/17/2022

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

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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:

DocuSigned by:
Edward Merrens
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5/17/2022
Date

Name: Edward Merrens
Title: Chief Clinical Officer

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

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

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

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

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

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

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

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

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

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

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

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

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

New Hampshire Department of Health and Human Services
Exhibit G

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

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

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

Contractor Name:

DocuSigned by:
Edward Merrens
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5/17/2022
Date

Name: Edward Merrens
Title: Chief Clinical Officer

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Contractor Name:

DocuSigned by:
Edward Merrens
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5/17/2022
Date

Name: Edward Merrens
Title: Chief Clinical Officer

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

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

(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) **Obligations and Activities of Business Associate.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Obligations of Covered Entity

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

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

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

(5) Termination for Cause

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

(6) Miscellaneous

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

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

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

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

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

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

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

Department of Health and Human Services	Dartmouth-Hitchcock
The State by:	Name of the Contractor
Patricia M. Tilley	Edward Merrens
046FB38F5BFD4G8...	8ACA3CFCA0CC438...
Signature of Authorized Representative	Signature of Authorized Representative
Patricia M. Tilley	Edward Merrens
Name of Authorized Representative	Name of Authorized Representative
Director	Chief Clinical Officer
Title of Authorized Representative	Title of Authorized Representative
5/17/2022	5/17/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

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:

DocuSigned by:
Edward Merrens
Name: Edward Merrens
Title: Chief Clinical Officer

5/17/2022
Date

FORM A

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

1. The DUNS number for your entity is: 069910297

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

Contractor Initials DS EM

Date 5/17/2022

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

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" or "Confidential Data" 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, 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 an explicit or implied security policy, which includes attempts (either failed or successful) 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

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

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 reasonably necessary as outlined under this Contract. 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. If DHHS notifies the Contractor that DHHS 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 Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. 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.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User 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. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User 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 End User 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. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User 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 End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User 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 End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User 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 End User 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 the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. 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.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department 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, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware 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

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. 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.
3. 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. The Contractor will 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.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

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

7. 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.

8. 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.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

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

11. Data Security Breach Liability. In the event of any security 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.

12. 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 requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. 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.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. 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.

15. 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.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. 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 and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. 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 Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

State of New Hampshire

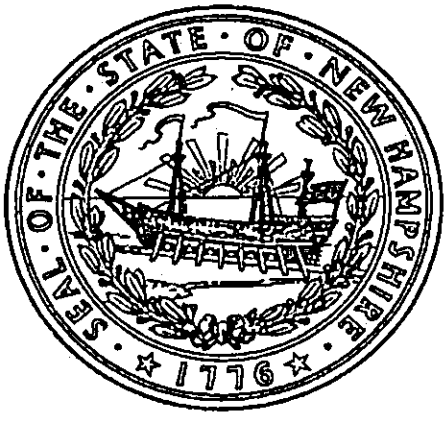
Department of State

CERTIFICATE

I, David M. Scanlan, 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: **0005760740**



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 18th day of April A.D. 2022.

David M. Scanlan

Secretary of State

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

Dartmouth-Hitchcock

CERTIFICATE OF VOTE/AUTHORITY

I, Roberta L. Hines, MD, 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 June 23rd, 2017 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 in furtherance of its charitable purposes."
3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer, the Chief Clinical Officer, and other officers, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Edward J. Merrens, MD, is the Chief Clinical Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
5. The foregoing authority remains in full force and effect as of the date of the agreement executed or action taken in reliance upon this Certificate. This authority shall remain valid for thirty (30) days from the date of this Certificate and the State of New Hampshire shall be entitled to rely upon same, until written notice of the modification, rescission or revocation of same, in whole or in part, has been received by the State of New Hampshire.

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 17th day of May, 2022.

Roberta L. Hines, MD, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 17 day of May, 2022 by Roberta L Hines, MD.

LAURA K. RONDEAU
NOTARY PUBLIC
STATE OF NEW HAMPSHIRE
MY COMMISSION EXPIRES MARCH 9, 2027

Notary Public
My Commission Expires: March 9, 2027

CERTIFICATE OF INSURANCE

DATE: April 21, 2022

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

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

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

COVERAGES

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

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002021-A	7/1/2021	7/1/2022	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$1,000,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	$3,000,000
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY					EACH CLAIM	
	CLAIMS MADE				ANNUAL AGGREGATE	
	OCCURENCE					
OTHER						

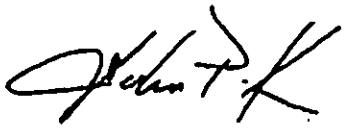
DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)
Certificate is issued as evidence of insurance.

CERTIFICATE HOLDER

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

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

AUTHORIZED REPRESENTATIVES



DARTHIT-01 ASTOBERT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/30/2021

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

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

PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: Angela Columbus PHONE (A/C, No, Ext): (774) 233-6204 FAX (A/C, No): E-MAIL ADDRESS: Angela.Columbus@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	WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY Y / N			AGC4065185	7/1/2021	7/1/2022	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐	N/A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

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

CERTIFICATE HOLDER	CANCELLATION
NH DHHS 129 Pleasant Street Concord, NH 03301	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

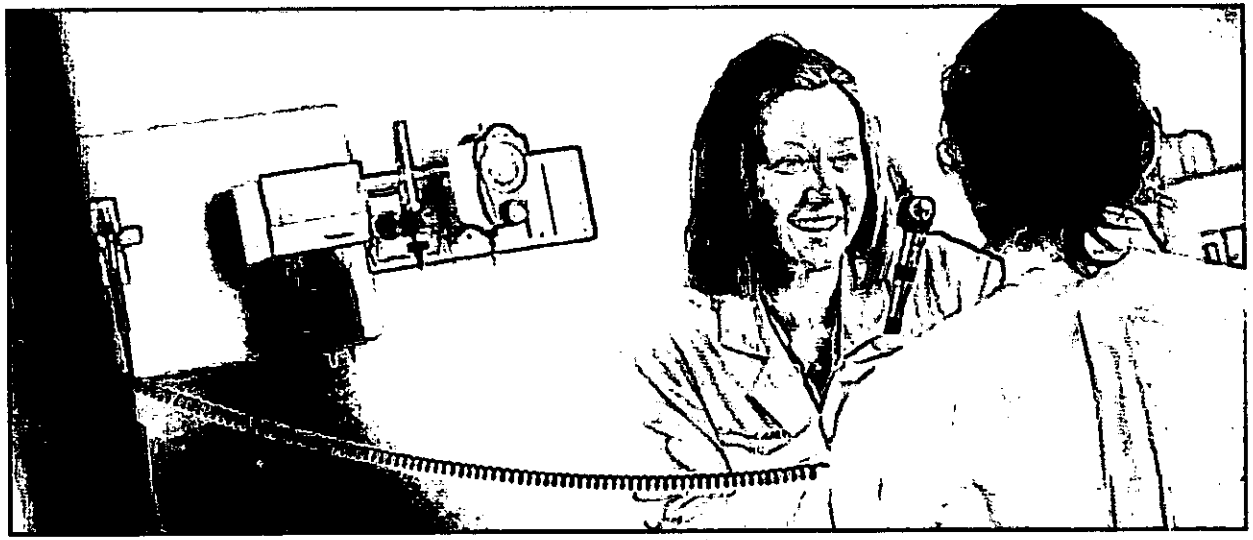
ACORD 25 (2016/03)

About Dartmouth-Hitchcock

Dartmouth-Hitchcock (D-H) is comprised of the Dartmouth-Hitchcock Medical Center (DHMC) and several clinics throughout New Hampshire and Vermont. Our physicians and researchers collaborate with Geisel School of Medicine scientists and faculty as well as other leading health care organizations to develop new treatments at the cutting edge of medical practice bringing the latest medical discoveries to the patient.

Dartmouth-Hitchcock includes:

Dartmouth-Hitchcock Medical Center (DHMC)



DHMC is the state's only academic medical center, and the only Level I Adult and Pediatric Trauma Center in New Hampshire. The Dartmouth-Hitchcock Advanced Response Team (DHART), based in Lebanon and Manchester, provides ground and air medical transportation to communities throughout northern New England. DHMC was named in 2021 as the #1

hospital in New Hampshire by U.S. News & World Report (https://health.usnews.com/best-hospitals/area/nh), and recognized for high performance in nine clinical specialties, procedures, and conditions.

The Dartmouth-Hitchcock Clinic

The Dartmouth-Hitchcock Clinic is a network of primary and specialty care physicians located throughout New Hampshire and Vermont, with major community group practices in Lebanon, Concord, Manchester, Nashua, and Keene, New Hampshire, and Bennington, Vermont.

Mary Hitchcock Memorial Hospital

Mary Hitchcock Memorial Hospital is New Hampshire's only teaching hospital, with an inpatient capacity of 396 beds.

Children's Hospital at Dartmouth-Hitchcock (CHaD)

CHaD is New Hampshire's only children's hospital and a member of the Children's Hospital Association, providing advanced pediatric inpatient, outpatient and surgical services at DHMC in Lebanon as well as in Bedford, Concord, Manchester, Nashua, and Dover, New Hampshire.

Norris Cotton Cancer Center (NCCC)

NCCC is a designated Comprehensive Cancer Center by the National Cancer Institute, and is one of the premier facilities for cancer treatment, research, prevention, and education. Interdisciplinary teams, devoted to the treatment of specific types of cancer, work together to care for patients of all ages in Lebanon, Manchester, Nashua, Keene, New Hampshire, and St. Johnsbury, Vermont.

Our mission, vision, and 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.

Our values

- Respect
- Integrity

- Commitment
- Transparency
- Trust
- Teamwork
- Stewardship
- Community

Learn more about us

- Facts and Figures
- Community Outreach
- Collaborations
- Population Health
- Awards and Honors
- History

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2020 and 2019

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2020 and 2019

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Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2020 and 2019, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2020 and 2019, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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

Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for leases and the presentation of net periodic pension costs in 2020. Our opinion is not modified with respect to these matters.

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 17, 2020

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Assets		
Current assets		
Cash and cash equivalents	$ 453,223	$ 143,587
Patient accounts receivable (Note 4)	183,819	221,125
Prepaid expenses and other current assets	161,906	95,495
Total current assets	798,948	460,207
Assets limited as to use (Notes 5 and 7)	1,134,526	876,249
Other investments for restricted activities (Notes 5 and 7)	140,580	134,119
Property, plant, and equipment, net (Note 6)	643,586	621,256
Right of use assets, net (Note 16)	57,585	-
Other assets	137,338	124,471
Total assets	$ 2,912,563	$ 2,216,302
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 9,467	$ 10,914
Current portion of right of use obligations (Note 16)	11,775	-
Current portion of liability for pension and other postretirement plan benefits (Note 11 and 14)	3,468	3,468
Accounts payable and accrued expenses	129,016	113,817
Accrued compensation and related benefits	142,991	128,408
Estimated third-party settlements (Note 4 and 17)	302,525	41,570
Total current liabilities	599,242	298,177
Long-term debt, excluding current portion (Note 10)	1,138,530	752,180
Long-term right of use obligations, excluding current portion (Note 16)	46,456	-
Insurance deposits and related liabilities (Note 12)	77,146	58,407
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11 and 14)	324,257	281,009
Other liabilities	143,678	124,136
Total liabilities	2,329,309	1,513,909
Commitments and contingencies (Notes 4, 6, 7, 10, 13, 16 and 17)		
Net assets		
Net assets without donor restrictions (Note 9)	431,026	559,933
Net assets with donor restrictions (Notes 8 and 9)	152,228	142,460
Total net assets	583,254	702,393
Total liabilities and net assets	$ 2,912,563	$ 2,216,302

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, 2020 and 2019

(in thousands of dollars)	2020	2019
Operating revenue and other support		
Patient service revenue (Note 4)	$ 1,880,025	$ 1,999,323
Contracted revenue	74,028	75,017
Other operating revenue (Note 5)	374,622	210,698
Net assets released from restrictions	16,260	14,105
Total operating revenue and other support	2,344,935	2,299,143
Operating expenses		
Salaries	1,144,823	1,062,551
Employee benefits	272,872	262,812
Medications and medical supplies	455,381	407,875
Purchased services and other	360,496	323,435
Medicaid enhancement tax (Note 4)	76,010	70,061
Depreciation and amortization	92,164	88,414
Interest (Note 10)	27,322	25,514
Total operating expenses	2,429,068	2,240,662
Operating (loss) income	(84,133)	58,481
Non-operating gains (losses)		
Investment income, net (Note 5)	27,047	40,052
Other components of net periodic pension and post retirement benefit income (Note 11)	10,810	11,221
Other losses, net (Note 10)	(2,707)	(3,562)
Loss on early extinguishment of debt	-	(87)
Total non-operating gains, net	35,150	47,624
(Deficiency) excess of revenue over expenses	$ (48,983)	$ 106,105

Consolidated Statements of Operations and Changes in Net Assets – Continues on Next Page

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets - Continued
Years Ended June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Net assets without donor restrictions		
(Deficiency) excess of revenue over expenses	$ (48,983)	$ 106,105
Net assets released from restrictions for capital	1,414	1,769
Change in funded status of pension and other postretirement benefits (Note 11)	(79,022)	(72,043)
Other changes in net assets	(2,316)	-
(Decrease) increase in net assets without donor restrictions	(128,907)	35,831
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	26,312	17,436
Investment income, net	1,130	2,682
Net assets released from restrictions	(17,674)	(15,874)
Contribution of assets with donor restrictions from acquisition	-	383
Increase in net assets with donor restrictions	9,768	4,627
Change in net assets	(119,139)	40,458
Net assets		
Beginning of year	702,393	661,935
End of year	$ 583,254	$ 702,393

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, 2020 and 2019

(in thousands of dollars)	2020	2019
Cash flows from operating activities		
Change in net assets	$ (119,139)	$ 40,458
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	93,857	88,770
Amortization of right of use asset	8,218	-
Payments on right of use lease obligations - operating	(7,941)	-
Change in funded status of pension and other postretirement benefits	79,022	72,043
Gain on disposal of fixed assets	(39)	(1,101)
Net realized gains and change in net unrealized gains on investments	(14,060)	(31,397)
Restricted contributions and investment earnings	(3,605)	(2,292)
Proceeds from sales of securities	-	1,167
Changes in assets and liabilities		
Patient accounts receivable	37,306	(1,803)
Prepaid expenses and other current assets	(78,907)	2,149
Other assets, net	(13,385)	(9,052)
Accounts payable and accrued expenses	9,772	17,898
Accrued compensation and related benefits	14,583	2,335
Estimated third-party settlements	260,955	429
Insurance deposits and related liabilities	18,739	2,378
Liability for pension and other postretirement benefits	(35,774)	(33,104)
Other liabilities	19,542	12,267
Net cash provided by operating and non-operating activities	269,144	161,145
Cash flows from investing activities		
Purchase of property, plant, and equipment	(128,019)	(82,279)
Proceeds from sale of property, plant, and equipment	2,987	2,188
Purchases of investments	(321,152)	(361,407)
Proceeds from maturities and sales of investments	82,986	219,996
Cash received through acquisition	-	4,863
Net cash used in investing activities	(363,198)	(216,639)
Cash flows from financing activities		
Proceeds from line of credit	35,000	30,000
Payments on line of credit	(35,000)	(30,000)
Repayment of long-term debt	(10,665)	(29,490)
Proceeds from issuance of debt	415,336	26,338
Repayment of finance lease	(2,429)	-
Payment of debt issuance costs	(2,157)	(228)
Restricted contributions and investment earnings	3,605	2,292
Net cash provided by (used in) financing activities	403,690	(1,088)
Increase (decrease) in cash and cash equivalents	309,636	(56,582)
Cash and cash equivalents		
Beginning of year	143,587	200,169
End of year	$ 453,223	$ 143,587
Supplemental cash flow information		
Interest paid	$ 22,562	$ 23,977
Net assets acquired as part of acquisition, net of cash aquired	-	(4,863)
Construction in progress included in accounts payable and accrued expenses	17,177	1,546
Donated securities	-	1,167

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Notes to Financial Statements
June 30, 2020 and 2019

1. Organization and Community Benefit Commitments

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

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

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

On September 30, 2019, D-HH and GraniteOne Health ("GOH") entered into an agreement ("The Combination Agreement") to combine their respective healthcare systems. The GOH system is comprised of Catholic Medical Center ("CMC"), an acute care community hospital in Manchester, New Hampshire, Huggins Hospital ("HH") located in Wolfeboro, NH and Monadnock Community Hospital, ("MCH") located in Petersborough, NH. Both HH and MCH are designated as Critical Access Hospitals. The three member hospitals of GOH have a combined licensed bed count of 380 beds. GOH is a non-profit, community based health care system. The overarching rationale for the proposed combination is to improve access to high quality primary and specialty care in the most convenient, cost-effective sites of service for patients and the communities served by D-HH and GOH. Other stated benefits of the combination include reinforcing the rural health network, investing in needed capacity to accommodate unmet and anticipated demand, and drawing on our combined strengths to attract the necessary health care workforce. The parties have submitted regulatory filings with the Federal Trade Commission and the New Hampshire Attorney General's office seeking approval of the proposed transaction.

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

Consistent with this mission, the Health System provides high quality, cost effective, comprehensive, and integrated healthcare to individuals, families, and the communities it serves regardless of a patient's ability to pay. The Health System actively supports community-based healthcare and promotes the coordination of services among healthcare providers and social services organizations. In addition, the Health System also seeks to work collaboratively with other

area healthcare providers to improve the health status of the region. As a component of an integrated academic medical center, the Health System provides significant support for academic and research programs.

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

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

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

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

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

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

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

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

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

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2019 was approximately $143,013,000. The 2020 Community Benefits Reports are expected to be filed in February 2021.

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, 2019:

(in thousands of dollars)

Government-sponsored healthcare services	$	291,013
Health professional education		40,621
Charity care		15,281
Subsidized health services		15,165
Community health services		6,895
Research		5,238
Community building activities		3,777
Financial contributions		1,597
Community benefit operations		1,219
Total community benefit value	$	380,806

In fiscal years 2020 and 2019, funds received to offset or subsidize charity care costs provided were $1,224,000 and $487,000, 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, net assets without donor restrictions are amounts not subject to donor-imposed stipulations and are available for operations. Net assets with donor restrictions are those whose use has been limited by donors to a specific time period or purpose, or whose use has been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

Use of Estimates

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

(Deficiency) Excess of Revenue over Expenses

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

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

Charity Care

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

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

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

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

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes the Department of Health and Human Services ("HHS") Coronavirus Aid, Relief, and Economic Securities Act ("CARES Act" Provider Relief Funds ("Provider Relief Funds") operating agreements, grant revenue, cafeteria sales and other support service revenue.

Cash Equivalents
Cash and cash equivalents include amounts on deposit with financial institutions; short-term investments with maturities of three months or less at the time of purchase and other highly liquid investments, primarily cash management funds. Short-term highly liquid investments held within the endowment and similar investment pools are classified as investments rather than cash equivalents and restricted cash is defined as that which is legally restricted to withdrawal and usage.

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

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the (deficiency) excess of revenues over expenses. All investments, whether

held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a non-distressed basis.

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

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

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

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

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

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

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

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

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

leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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

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

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

Intangible Assets and Goodwill
The Health System records within other assets on the consolidated balance sheets goodwill and intangible assets such as trade names and leases-in-place. The Health System considers trade names and goodwill to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $10,007,000 and $10,524,000 as intangible assets associated with its affiliations as of June 30, 2020 and 2019, respectively.

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

Recently Issued Accounting Pronouncements

In January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which addresses 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. The standard has been adopted during the current fiscal year and no material impact was noted.

In February 2016, the FASB issued *ASU 2016-02 – Leases (Topic 842).* Under the new guidance, lessees are required to recognize the following for all leases (with the exception of leases with a term of twelve months or less) at the commencement date: (a) a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis; and (b) a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. Leases are classified as either operating or finance. Operating leases result in straight-line expense in the statement of operations (similar to previous operating leases), while finance leases result in more expense being recognized in the earlier years of the lease term (similar to previous capital leases). The Health System adopted the new standard on July 1, 2019 using the modified retrospective approach. The Health System elected the transition method that allows for the application of the standard at the adoption date rather than at the beginning of the earliest comparative period presented in the consolidated financial statements. The Health System also elected available practical expedients (Note 16).

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits* (Topic 715): *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost.* Under the new standard, the service cost component of the net benefit cost will be included within income from operations as a component of benefits expenses and the other components of net benefit cost as defined by ASC 715 will be reported in non-operating activities within the consolidated statements of operations and changes in net assets. The standard also prohibits reporting of the other components of net benefit cost in the same line as other pension related changes on the statements of operations and changes in net assets. ASU 2017-07 is effective for the fiscal year ended June 30, 2020 and is applied on a retrospective basis.

Reclassifications

As a result of adopting the provisions of ASU 2017-07, the Health System reclassified $11,221,000 from benefits expense to non-operating activities within the consolidated statements of operations and changes in net assets for the fiscal year ended June 30, 2019. The amount included in non-operating activities for the fiscal year ending June 30, 2020 was $10,810,000.

3. Acquisition

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

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

4. Patient Service Revenue and Accounts Receivable

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

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

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

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

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

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

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

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

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

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

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

- Revenues under Managed Care Plans (Plans) consist primarily of payment terms involving mutually agreed upon rates per diagnosis, discounted fee-for service rates, or similar contractual arrangements. These revenues are also subject to review and possible audit.

The Plans are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustments in accordance with contractual terms in place with the Plans following their review and adjudication of each bill.

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

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

Vermont imposes a provider tax on home health agencies in the amount of 4.25% of annual net patient revenue. In fiscal years 2020 and 2019, home health provider taxes paid were $624,000 and $628,000, respectively.

Medicaid Enhancement Tax & Disproportionate Share Hospital

On May 22, 2018, the State of New Hampshire and all New Hampshire hospitals (Hospitals) agreed to resolve disputed issues and enter into a seven-year agreement to stabilize Disproportionate Share Hospital (DSH) payments, with provisions for alternative payments in the event of legislative changes to the DSH program. Under the agreement, the State committed to make DSH payments to the Hospitals in an amount no less than 86% of the Medicaid Enhancement Tax (MET) proceeds collected in each fiscal year, in addition to providing for directed payments or increased rates for Hospitals in an amount equal to 5% of MET proceeds collected from state fiscal year (SFY) 2020 through SFY 2024. The agreement prioritizes DSH payments to critical access hospitals in an amount equal to 75% of allowable uncompensated care (UCC), with the remainder distributed to Hospitals without critical access designation in proportion to their allowable UCC amounts.

During the years ended June 30, 2020 and 2019, the Health System received DSH payments of approximately, $71,133,000 and $69,179,000 respectively. DSH payments are subject to audit and therefore, for the years ended June 30, 2020 and 2019, the Health System recognized as revenue DSH receipts of approximately $67,500,000 and approximately $64,864,000, respectively.

During the years ended June 30, 2020 and 2019, the Health System recorded State of NH MET and State of VT Provider taxes of $76,010,000 and $70,061,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain patient service revenues. The Provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

Implicit Price Concessions

Generally, patients who are covered by third-party payer contracts are responsible for related co-pays, co-insurance and deductibles, which vary depending on the contractual obligations of patients. The Health System also provides services to uninsured patients and offers those patients a discount from standard charges. The Health System estimates the transaction price for patients with co-pays, co-insurance, and deductibles and for those who are uninsured based on historical collection experience and current market conditions. The discount offered to uninsured patients reduces the transaction price at the time of billing. The uninsured and patient responsible

accounts, net of discounts recorded, are further reduced through implicit price concessions based on historical collection trends for similar accounts and other known factors that impact the estimation process. Subsequent changes to the estimate of transaction price are generally recorded as adjustments to net patient services revenue in the period of change.

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

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely amount. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and historical settlement activity, including assessments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews or investigations. As of June 30, 2020 and 2019, the Health System had reserves of $302,525,000 and $41,570,000, respectively, recorded in Estimated third-party settlements. Included in the 2020 Estimated third party settlements is $239,500,000 of Medicare accelerated and advanced payments, received as working capital support during the novel coronavirus ("COVID-19") outbreak at June 30, 2020. In addition, $10,900,000 has been recorded in Other liabilities as of June 30, 2020 and 2019, respectively.

For the years ended June 30, 2020 and 2019, additional increases in revenue of $2,314,000 and $1,800,000, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Notes to Financial Statements
June 30, 2020 and 2019

The table below shows the Health System's sources of net operating revenues presented at the net transaction price for the years ended June 30, 2020 and 2019.

	2020		
(in thousands of dollars)	**PPS**	**CAH**	**Total**
Hospital			
Medicare	$ 461,990	$ 64,087	$ 526,077
Medicaid	130,901	10,636	141,537
Commercial	718,576	60,715	779,291
Self Pay	2,962	2,501	5,463
Subtotal	1,314,429	137,939	1,452,368
Professional			
Professional	383,503	22,848	406,351
VNA	-	-	21,306
Other Revenue	-	-	376,185
Provider Relief Fund	-	-	88,725
Total operating revenue and other support	$ 1,697,932	$ 160,787	$ 2,344,935

	2019		
(in thousands of dollars)	**PPS**	**CAH**	**Total**
Hospital			
Medicare	$ 456,197	$ 72,193	$ 528,390
Medicaid	134,727	12,794	147,521
Commercial	746,647	64,981	811,628
Self Pay	8,811	2,313	11,124
Subtotal	1,346,382	152,281	1,498,663
Professional			
Professional	454,425	23,707	478,132
VNA	-	-	22,528
Other Revenue	-	-	299,820
Total operating revenue and other support	$ 1,800,807	$ 175,988	$ 2,299,143

Accounts Receivable

The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2020 and 2019:

	2020	**2019**
Medicare	36%	34%
Medicaid	13%	12%
Commercial	39%	41%
Self Pay	12%	13%
Patient accounts receivable	100%	100%

5. Investments

The composition of investments at June 30, 2020 and 2019 is set forth in the following table:

(in thousands of dollars)	2020	2019
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 9,646	$ 21,890
U.S. government securities	103,977	91,492
Domestic corporate debt securities	199,462	196,132
Global debt securities	70,145	83,580
Domestic equities	203,010	167,384
International equities	123,205	128,909
Emerging markets equities	22,879	23,086
Real Estate Investment Trust	313	213
Private equity funds	74,131	64,563
Hedge funds	36,964	32,287
	843,732	809,536
Investments held by captive insurance companies (Note 12)		
U.S. government securities	15,402	23,241
Domestic corporate debt securities	8,651	11,378
Global debt securities	8,166	10,080
Domestic equities	15,150	14,617
International equities	7,227	6,766
	54,596	66,082
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	236,198	631
Total assets limited as to use	1,134,526	876,249
Other investments for restricted activities		
Cash and short-term investments	7,186	6,113
U.S. government securities	28,055	32,479
Domestic corporate debt securities	35,440	29,089
Global debt securities	11,476	11,263
Domestic equities	26,723	20,981
International equities	15,402	15,531
Emerging markets equities	2,766	2,578
Private equity funds	9,483	7,638
Hedge funds	4,013	8,414
Other	36	33
Total other investments for restricted activities	140,580	134,119
Total investments	$ 1,275,106	$ 1,010,368

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

The following tables summarize the investments by the accounting method utilized, as of June 30, 2020 and 2019. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

	2020		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 253,030	$ -	$ 253,030
U.S. government securities	147,434	-	147,434
Domestic corporate debt securities	198,411	45,142	243,553
Global debt securities	44,255	45,532	89,787
Domestic equities	195,014	49,869	244,883
International equities	77,481	68,353	145,834
Emerging markets equities	1,257	24,388	25,645
Real Estate Investment Trust	313	-	313
Private equity funds	-	83,614	83,614
Hedge funds	-	40,977	40,977
Other	36	-	36
	$ 917,231	$ 357,875	$ 1,275,106

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

For the years ended June 30, 2020 and 2019 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as other operating revenue of approximately $936,000 and $983,000 and as non-operating gains of approximately $27,047,000 and $40,052,000, 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, 2020 and 2019, the Health System has committed to contribute approximately $172,819,000 and $164,319,000 to such funds, of which the Health System has contributed approximately $119,142,000 and $109,584,000 and has outstanding commitments of $53,677,000 and $54,735,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Land	$ 40,749	$ 38,232
Land improvements	39,820	42,607
Buildings and improvements	893,081	898,050
Equipment	927,233	888,138
Equipment under capital leases	-	15,809
	1,900,883	1,882,836
Less: Accumulated depreciation and amortization	1,356,521	1,276,746
Total depreciable assets, net	544,362	606,090
Construction in progress	99,224	15,166
	$ 643,586	$ 621,256

As of June 30, 2020, construction in progress primarily consists of two projects. The first project, started in fiscal 2019, consists of the addition of the ambulatory surgical center (ASC) located in Manchester, NH. The estimated cost to complete the project is $42 million. The anticipated completion date is the second quarter of fiscal 2021. The second project, involves the addition of the in-patient tower located in Lebanon, NH. The estimated cost to complete the tower project is $140 million over the next three fiscal years.

The construction in progress as of June 30, 2019, included both the ASC, as well as renovations taking place at the various pharmacy locations to bring their facilities compliant with Regulation USP800. The pharmacy upgrade was completed during the first quarter of fiscal year 2021. Capitalized interest of $2,297,000 and $0 is included in Construction in progress as of June 30, 2020 and 2019, respectively.

Depreciation and amortization expense included in operating and non-operating activities was approximately $92,217,000 and $88,496,000 for 2020 and 2019, respectively.

7. Fair Value Measurements

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

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

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

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

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2020 and 2019:

	2020					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 253,030	$ -	$ -	$ 253,030	Daily	1
U.S. government securities	147,434	-	-	147,434	Daily	1
Domestic corporate debt securities	17,577	180,834	-	198,411	Daily–Monthly	1–15
Global debt securities	22,797	21,458	-	44,255	Daily–Monthly	1–15
Domestic equities	187,354	7,660	-	195,014	Daily–Monthly	1–10
International equities	77,481	-	-	77,481	Daily–Monthly	1–11
Emerging market equities	1,257	-	-	1,257	Daily–Monthly	1–7
Real estate investment trust	313	-	-	313	Daily–Monthly	1–7
Other	2	34	-	36	Not applicable	Not applicable
Total investments	707,245	209,986	-	917,231		
Deferred compensation plan assets						
Cash and short-term investments	5,754	-	-	5,754		
U.S. government securities	51	-	-	51		
Domestic corporate debt securities	7,194	-	-	7,194		
Global debt securities	1,270	-	-	1,270		
Domestic equities	24,043	-	-	24,043		
International equities	3,571	-	-	3,571		
Emerging market equities	27	-	-	27		
Real estate	11	-	-	11		
Multi strategy fund	51,904	-	-	51,904		
Guaranteed contract	-	-	92	92		
Total deferred compensation plan assets	93,825	-	92	93,917	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,202	9,202	Not applicable	Not applicable
Total assets	$ 801,070	$ 209,986	$ 9,294	$ 1,020,350		

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

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

	2020		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,301	$ 89	$ 9,390
Net unrealized (losses) gains	(99)	3	(96)
Balances at end of year	$ 9,202	$ 92	$ 9,294

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

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, 2020 and 2019.

8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Investments held in perpetuity	$ 59,352	$ 56,383
Healthcare services	33,976	20,140
Research	22,116	26,496
Health education	16,849	19,833
Charity care	12,366	12,494
Other	4,488	3,841
Purchase of equipment	3,081	3,273
	$ 152,228	$ 142,460

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

9. Board Designated and Endowment Funds

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

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

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

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2020 and 2019.

Endowment net asset composition by type of fund consists of the following at June 30, 2020 and 2019:

	2020		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ -	$ 80,039	$ 80,039
Board-designated endowment funds	33,714	-	33,714
Total endowed net assets	$ 33,714	$ 80,039	$ 113,753

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

Changes in endowment net assets for the years ended June 30, 2020 and 2019 are as follows:

	2020		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Balances at beginning of year	$ 31,421	$ 78,268	$ 109,689
Net investment return	713	1,460	2,173
Contributions	890	2,990	3,880
Transfers	14	267	281
Release of appropriated funds	676	(2,946)	(2,270)
Balances at end of year	$ 33,714	$ 80,039	$ 113,753

Balances at end of year	80,039
Beneficial interest in perpetual trusts	6,782
Net assets with donor restrictions	$ 86,821

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

Balances at end of year	78,268
Beneficial interest in perpetual trusts	8,422
Net assets with donor restrictions	$ 86,690

10. Long-Term Debt

A summary of long-term debt at June 30, 2020 and 2019 is as follows:

(in thousands of dollars)	2020	2019
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	$ 83,355	$ 83,355
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2020A, principal maturing in varying annual amounts, through August 2059 (2)	125,000	-
Series 2017A, principal maturing in varying annual amounts, through August 2040 (3)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (3)	109,800	109,800
Series 2019A, principal maturing in varying annual amounts, through August 2043 (4)	99,165	-
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	25,160	25,865
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	24,315	25,145
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	19,765	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (7)	14,530	14,530
Series 2016B, principal maturing in varying annual amounts, through August 2045 (8)	10,970	10,970
Note payable		
Note payable to a financial institution due in monthly interest only payments through May 2023 (9)	125,000	-
Total obligated group debt	$ 1,062,597	$ 722,162

A summary of long-term debt at June 30, 2020 and 2019 is as follows (continued):

(in thousands of dollars)	2020	2019
Other		
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	$ 287	$ 445
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	273	323
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046	2,560	2,629
Obligations under capital leases	-	17,526
Total nonobligated group debt	3,120	20,923
Total obligated group debt	1,062,597	722,162
Total long-term debt	1,065,717	743,085
Add: Original issue premium and discounts, net	89,542	25,542
Less: Current portion	9,467	10,914
Debt issuance costs, net	7,262	5,533
	$ 1,138,530	$ 752,180

Aggregate annual principal payments for the next five years ending June 30 and thereafter are as follows:

(in thousands of dollars)	2020
2021	$ 9,467
2022	9,419
2023	131,626
2024	1,871
2025	1,954
Thereafter	911,380
	$ 1,065,717

Dartmouth-Hitchcock Obligated Group (DHOG) Debt

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

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

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

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

(2) Series 2020A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds Series 2020A in February, 2020. The proceeds from the Series 2020A Revenue Bonds are being used primarily to fund the construction of a 212,000 square foot inpatient pavilion in Lebanon, NH as well as various equipment. The interest on the Series 2020A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2059.

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

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

(4) Series 2019A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds Series 2019A in October, 2019. The proceeds from the Series 2019A Revenue Bonds are being used primarily to fund the construction of a 91,000 square foot expansion of facilities in Manchester, NH to include an Ambulatory Surgical Center as well as various equipment. The interest on the Series 2019A Revenue Bonds is fixed with an interest rate of 4.00% and matures in variable amounts through 2043.

(5) Series 2018C Revenue Bonds

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

(6) Series 2012 Revenue Bonds

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

(7) 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.

(8) Series 2016B Revenue Bonds

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

(9) Note payable to financial institution

The DHOG issued a note payable to TD Bank in May 2020. Issued in response to the COVID-19 pandemic, the proceeds from the note will be used to fund working capital as needs require. The interest on the note payable is fixed with an interest rate of 2.02% and matures in 2023.

Outstanding joint and several indebtedness of the DHOG at June 30, 2020 and 2019 approximates $1,062,597,000 and $722,162,000, respectively.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $236,198,000 and $631,000 at June 30, 2020 and 2019, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 5). In addition, debt service reserves of approximately $9,286,000 and $1,331,000 at June 30, 2020 and 2019, respectively, are classified as other current assets in the accompanying consolidated balance sheets. The debt service reserves are mainly comprised of escrowed construction funds at June 30, 2020 and escrowed funds held for future principal and interest payments at June 30, 2019.

For the years ended June 30, 2020 and 2019 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 $27,322,000 and $25,514,000 and other non-operating losses of $3,784,000 and $3,784,000, respectively.

11. Employee Benefits

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

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

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

Defined Benefit Plans
Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Service cost for benefits earned during the year	$ 170	$ 150
Interest cost on projected benefit obligation	43,433	47,814
Expected return on plan assets	(62,436)	(65,270)
Net loss amortization	12,032	10,357
Total net periodic pension expense	$ (6,801)	$ (6,949)

The following assumptions were used to determine net periodic pension expense as of June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	3.90 % – 4.60%
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50%

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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,135,523	$ 1,087,940
Service cost	170	150
Interest cost	43,433	47,814
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Actuarial loss	139,469	93,358
Settlements	(38,549)	(42,306)
Benefit obligation at end of year	1,209,100	1,135,523
Change in plan assets		
Fair value of plan assets at beginning of year	897,717	884,983
Actual return on plan assets	121,245	85,842
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Employer contributions	19,986	20,631
Settlements	(38,549)	(42,306)
Fair value of plan assets at end of year	929,453	897,717
Funded status of the plans	(279,647)	(237,806)
Less: Current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(279,601)	(237,760)
Liability for pension	$ (279,647)	$ (237,806)

As of June 30, 2020 and 2019, the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in net assets without donor restrictions include approximately $546,818,000 and $478,394,000 of net actuarial loss as of June 30, 2020 and 2019, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2021 for net actuarial losses is $12,752,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,209,282 and $1,135,770,000 at June 30, 2020 and 2019, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	4.20 % – 4.50 %
Rate of increase in compensation	N/A	N/A

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of both June 30, 2020 and 2019, it is expected that the LDI strategy will hedge approximately 60% of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5%	3%
U.S. government securities	0–10	5
Domestic debt securities	20–58	40
Global debt securities	6–26	7
Domestic equities	5–35	18
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	1
Private equity funds	0–5	0
Hedge funds	5–18	10

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

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

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

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Notes to Financial Statements
June 30, 2020 and 2019

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, 2020 and 2019:

	2020					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ -	$ 7,154	$ -	$ 7,154	Daily	1
U.S. government securities	49,843		-	49,843	Daily–Monthly	1–15
Domestic debt securities	133,794	318,259	-	452,053	Daily–Monthly	1–15
Global debt securities	-	69,076	-	69,076	Daily–Monthly	1–15
Domestic equities	152,688	24,947	-	177,635	Daily–Monthly	1–10
International equities	13,555	70,337	-	83,892	Daily–Monthly	1–11
Emerging market equities	-	39,984	-	39,984	Daily–Monthly	1–17
REIT funds	-	2,448	-	2,448	Daily–Monthly	1–17
Private equity funds	-	-	17	17	See Note 7	See Note 7
Hedge funds	-	-	47,351	47,351	Quarterly–Annual	60–96
Total investments	$ 349,880	$ 532,205	$ 47,368	$ 929,453		

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

The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2020 and 2019:

	2020		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 44,126	$ 21	$ 44,147
Net unrealized gains (losses)	3,225	(4)	3,221
Balances at end of year	$ 47,351	$ 17	$ 47,368

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

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2020 and 2019 were approximately $18,261,000 and $14,617,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2020 and 2019.

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, 2020 and 2019.

The weighted average asset allocation for the Health System's Plans at June 30, 2020 and 2019 by asset category is as follows:

	2020	2019
Cash and short-term investments	1 %	2 %
U.S. government securities	5	5
Domestic debt securities	49	44
Global debt securities	8	9
Domestic equities	19	20
International equities	9	11
Emerging market equities	4	4
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 $25,755,000 to the Plans in 2021 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)

2021	$ 51,007
2022	53,365
2023	55,466
2024	57,470
2025	59,436
2026 – 2028	321,419

Effective May 1, 2020, the Health System terminated a defined benefit plan and settled the accumulated benefit obligation of $18,795,000 by purchasing nonparticipating annuity contracts. The plan assets at fair value were $11,836,000.

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $51,222,000 and $40,537,000 in 2020 and 2019, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by member and plan. No employer contributions were made to any of these plans in 2020 and 2019 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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Service cost	$ 609	$ 384
Interest cost	1,666	1,842
Net prior service income	(5,974)	(5,974)
Net loss amortization	469	10
	$ (3,230)	$ (3,738)

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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ 46,671	$ 42,581
Service cost	609	384
Interest cost	1,666	1,842
Benefits paid	(3,422)	(3,149)
Actuarial loss	2,554	5,013
Benefit obligation at end of year	48,078	46,671
Funded status of the plans	$ (48,078)	$ (46,671)
Current portion of liability for postretirement medical and life benefits	$ (3,422)	$ (3,422)
Long term portion of liability for postretirement medical and life benefits	(44,656)	(43,249)
Liability for postretirement medical and life benefits	$ (48,078)	$ (46,671)

As of June 30, 2020 and 2019, the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

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

(in thousands of dollars)	2020	2019
Net prior service income	$ (3,582)	$ (9,556)
Net actuarial loss	10,335	8,386
	$ 6,753	$ (1,170)

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2021 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, 2021 and thereafter:

(in thousands of dollars)

2021	$	3,422
2022		3,436
2023		3,622
2024		3,642
2025		3,522
2026-2028		16,268

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 2.90% in 2020 and an assumed healthcare cost trend rate of 6.50%, trending down to 5.00% in 2024 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2020 and 2019 by $1,772,000 and $1,601,000 and the net periodic postretirement medical benefit cost for the years then ended by $122,000 and $77,000, 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, 2020 and 2019 by $1,603,000 and $1,452,000 and the net periodic postretirement medical benefit cost for the years then ended by $108,000 and $71,000, respectively.

12. Professional and General Liability Insurance Coverage

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

Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2020 and 2019, are summarized as follows:

	2020		
(in thousands of dollars)	HAC	RRG	Total
Assets	$ 93,686	$ 1,785	$ 95,471
Shareholders' equity	13,620	50	13,670

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

13. Commitments and Contingencies

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

Lines of Credit
The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $10,000,000 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 31, 2021. There was no outstanding balance under the lines of credit as of June 30, 2020 and 2019. Interest expense was approximately $20,000 and $95,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

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

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2020:

	2020			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 981,320	$ 161,704	$ 1,799	$ 1,144,823
Employee benefits	231,361	41,116	395	272,872
Medical supplies and medications	454,143	1,238	-	455,381
Purchased services and other	236,103	120,563	3,830	360,496
Medicaid enhancement tax	76,010	-	-	76,010
Depreciation and amortization	26,110	65,949	105	92,164
Interest	5,918	21,392	12	27,322
Total operating expenses	$ 2,010,965	$ 411,962	$ 6,141	$ 2,429,068

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,239	$ 1,549	$ 22	$ 10,810
Total non-operating income	$ 9,239	$ 1,549	$ 22	$ 10,810

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

	2019			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 922,902	$ 138,123	$ 1,526	$ 1,062,551
Employee benefits	188,634	73,845	333	262,812
Medical supplies and medications	406,782	1,093	-	407,875
Purchased services and other	212,209	108,783	2,443	323,435
Medicaid enhancement tax	70,061	-	-	70,061
Depreciation and amortization	37,528	50,785	101	88,414
Interest	3,360	22,135	19	25,514
Total operating expenses	$ 1,841,476	$ 394,764	$ 4,422	$ 2,240,662

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,651	$ 1,556	$ 14	$ 11,221
Total non-operating income	$ 9,651	$ 1,556	$ 14	$ 11,221

15. Liquidity

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

The Health System's financial assets available at June 30, 2020 and 2019 to meet cash needs for general expenditures within one year of June 30, 2020 and 2019, are as follows:

(in thousands of dollars)	2020	2019
Cash and cash equivalents	$ 453,223	$ 143,587
Patient accounts receivable	183,819	221,125
Assets limited as to use	1,134,526	876,249
Other investments for restricted activities	140,580	134,119
Total financial assets	$ 1,912,148	$ 1,375,080
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	54,596	66,082
Investments for restricted activities	140,580	134,119
Bond proceeds held for capital projects	245,484	-
Other investments with liquidity horizons greater than one year	111,408	97,063
Total financial assets available within one year	$ 1,360,080	$ 1,077,816

For the years ended June 30, 2020 and June 30, 2019, the Health System generated positive cash flow from operations of approximately $269,144,000 and $161,145,000, respectively. In addition, the Health System's liquidity management plan includes investing excess daily cash in intermediate or long term investments based on anticipated liquidity needs. The Health System has an available line of credit of up to $30,000,000 which it can draw upon as needed to meet its liquidity needs. See Note 13 for further details on the line of credit.

16. Lease Commitments

In February 2016, the FASB issued ASU 2016-02 (Topic 842) "Leases." Topic 842 supersedes the lease requirements in Accounting Standards Codification Topic 840, "Leases." Under Topic 842, lessees are required to recognize assets and liabilities on the balance sheet for most leases and provide enhanced disclosures. Leases will be classified as either finance or operating. D-HH adopted Topic 842 effective July 1, 2019.

D-HH applied Topic 842 to all leases as of July 1, 2019 with comparative periods continuing to be reported under Topic 840. We have elected the practical expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial direct costs for existing leases. We have also elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

D-HH determines if an arrangement is or contains a lease at inception of the contract. Right-of-use assets represent our right to use the underlying assets for the lease term and our lease liabilities represent our obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. We use the implicit rate noted within the contract. If not readily available, we use our estimated incremental borrowing rate, which is derived using a collateralized borrowing rate for the same currency and term as the associated lease. A right-of-use asset and lease liability is not recognized for leases with an initial term of 12 months or less and we recognize lease expense for these leases on a straight-line basis over the lease term within lease and rental expense.

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of 5 to 10 years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from 2 to 5 years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

On adoption, the Health System recognized lease liabilities and right-of-use assets of $60,269,884, respectively.

The components of lease expense for the year ended June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Operating lease cost	8,992
Variable and short term lease cost (a)	1,497
Total lease and rental expense	10,489
Finance lease cost:	
Depreciation of property under finance lease	2,454
Interest on debt of property under finance lease	524
Total finance lease cost	2,978

(a) Includes equipment, month-to-month and leases with a maturity of less than 12 months.

Supplemental cash flow information related to leases for the year ended June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	8,755
Operating cash flows from finance leases	542
Financing cash flows from finance leases	2,429
	$ 11,726

Supplemental balance sheet information related to leases as of June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Operating Leases	
Right of use assets - operating leases	42,621
Accumulated amortization	(8,425)
Right of use assets - operating leases, net	**34,196**
Current portion of right of use obligations	9,194
Long-term right of use obligations, excluding current portion	25,308
Total operating lease liabilities	**34,502**
Finance Leases	
Right of use assets - finance leases	26,076
Accumulated depreciation	(2,687)
Right of use assets - finance leases, net	**23,389**
Current portion of right of use obligations	2,581
Long-term right of use obligations, excluding current portion	21,148
Total finance lease liabilities	**23,729**
Weighted Average remaining lease term, years	
Operating leases	4.64
Finance leases	19.39
Weighted Average discount rate	
Operating leases	2.24%
Finance leases	2.22%

Included in the $42.6 million of right-of-use assets obtained in exchange for operating lease obligations is $5.6 million of new and modified operating leases entered into during the year ended June 30, 2020. Included in the $26.1 million of right-of-use assets obtained in exchange for finance lease obligations is $2.3 million of new and modified operating leases entered into during the year ended June 30, 2020.

Future maturities of lease liabilities as of June 30, 2020 are as follows:

(in thousands of dollars)	Operating Leases	Finance Leases
Year ending June 30:		
2021	9,852	3,314
2022	8,274	3,003
2023	6,836	2,718
2024	5,650	1,892
2025	3,023	1,109
Thereafter	2,794	17,339
Total lease payments	36,429	29,374
Less: Imputed interest	1,927	5,645
Total lease payments	$ 34,502	$ 23,729

Future minimum rental payments under lease commitments with a term of more than one year as of June 30, 2019, prior to our adoption of ASC 842 are as follows:

(in thousands of dollars)	Capital Leases	Operating Leases
Year ending June 30:		
2020	1,706	11,342
2021	1,467	10,469
2022	1,471	7,488
2023	1,494	6,303
2024	1,230	4,127
Thereafter	10,158	5,752
Total lease payments	$ 17,526	$ 45,481

The Health System's rental expense totaled approximately $12,707,000 for the year ended June 30, 2019.

17. COVID - 19

In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic and the United States federal government declared COVID-19 a national emergency. The Health System quickly developed and implemented an emergency response to the situation to ensure the safety of its patients and staff across the System. A key decision was made to postpone elective and non-urgent care in mid-March. Several factors drove that decision, including efforts to reduce the spread of COVID-19; conservation of personal protective equipment ("PPE"), which was and remains in critically short supply worldwide; and at the urging of the CDC and U.S. Surgeon General who in March urged all hospitals to reduce the number of elective procedures and visits.

On March 27, 2020, the President of the United States signed into law the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") to provide economic assistance to a wide array of industries to ease the financial impact of COVID-19. As part of the CARES Act, the Centers for Medicare and Medicaid Services ("CMS") expanded its Accelerated and Advance Payment Program which allows participants to receive expedited payments during periods of national emergencies.

As of June 30, 2020, the Health System has received approximately $88,877,000 in governmental assistance including funding under the CARES Act. This includes recognition of approximately $88,725,000 of stimulus revenue recorded as a component of other operating revenue in the consolidated statements of operations and changes in net assets as a result of satisfying the conditions of general and targeted grant funding under the Provider Relief Fund established by the CARES Act. The Health System recognized revenue related to the CARES Act provider relief funding based on information contained in laws and regulations, as well as interpretations issued by the HHS, governing the funding that was publicly available as of June 30, 2020. The Health System recorded approximately $239,500,000 attributable to the Medicare Accelerated and Advance Payment Program representing working capital financing to be repaid through the provision of future services. These funds are recorded as a contract liability as a payment received before performing services. This amount is reported as a component of estimated third party settlements in the consolidated balance sheet as of June 30, 2020. Subsequent to June 30, 2020, the Health System received additional stimulus funding attributable to a targeted distribution of approximately $19,700,000 for Safety Net Hospitals and $2,500,000 for a general distribution.

Additionally, the CARES Act provides for payroll tax relief, including employee retention tax credits and the deferral of all employer Social Security tax payments to help employers in the face of economic hardship related to the COVID-19 pandemic. As of June 30, 2020, the Health System deferred approximately $13,727,000 attributable to the employer portion of Social Security taxes and $2,600,000 of employee retention tax credits. D-HH Leadership has also taken advantage of additional Federal and State programs including the Payroll Tax Deferral, Employee Retention Credit, First Responder Support, Front-Line Employees Hazard Pay Grant Program and FEMA funding to help offset some of the incremental costs being incurred to provide comprehensive and safe care during the pandemic.

18. Subsequent Events

The Health System has assessed the impact of subsequent events through November 17, 2020, 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.

HHS Reporting Requirements for the CARES Act

In September 2020 and October 2020, HHS issued new reporting requirements for the CARES Act provider relief funding. The new requirements first require Hospitals to identify healthcare-related expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source. If those expenses do not exceed the provider relief funding received, Hospitals will need to demonstrate that the remaining provider relief funds were used to compensate for a negative variance in year over year patient service revenue. HHS is entitled to recoup Provider Relief Funding in excess of the sum of expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source and the decline in calendar year over year patient care revenue. Due to these new reporting requirements there is at least a reasonable possibility that amounts recorded under the CARES Act provider relief fund by the Health System may change in future periods.

Medicare and Medicaid Services ("CMS") expanded Accelerated and Advance Payment Program

In October 2020, new regulations were issued to revise the recoupment start date from August 2020 to April 2021.

Note Payable Amendment

In October 2020, the note payable issued to TD Bank in May 2020 was amended. Under the amended terms, the interest on the note payable is fixed at a rate of 2.56%, and matures in 2035. Repayment terms are semi-annual, interest only through July 2024, with annual principal payments to begin August 2024. The obligation can be satisfied at any time beforehand, without penalty.

Consolidating Supplemental Information – Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2020

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 108,856	$ 217,352	$ 43,940	$ 26,079	$ 22,874	$ 14,377	$ -	$ 433,478	$ 19,745	$ -	$ 453,223
Patient accounts receivable, net	-	146,886	11,413	8,634	10,200	4,367	-	181,500	2,319	-	183,819
Prepaid expenses and other current assets	25,243	179,432	37,538	3,808	6,105	1,715	(82,822)	171,019	(8,870)	(243)	161,906
Total current assets	134,099	543,670	92,891	38,521	39,179	20,459	(82,822)	785,997	13,194	(243)	798,948
Assets limited as to use	344,737	927,207	19,376	13,044	12,768	12,090	(235,568)	1,093,654	40,872	-	1,134,526
Notes receivable, related party	848,250	593	-	1,211	-	-	(848,843)	1,211	(1,211)	-	-
Other investments for restricted activities	-	98,490	6,970	97	3,077	6,266	-	114,900	25,680	-	140,580
Property, plant, and equipment, net	8	466,938	64,803	20,805	43,612	16,823	-	612,989	30,597	-	643,586
Right of use assets	1,542	32,714	1,822	17,574	621	3,221	-	57,494	91	-	57,585
Other assets	2,242	122,481	1,299	14,748	5,482	4,603	(10,971)	139,884	(2,546)	-	137,338
Total assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 747	$ 147	$ 232	$ -	$ 9,371	$ 96	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	1,316	259	631	-	11,716	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	272,764	126,283	39,845	3,087	4,250	3,408	(318,391)	131,244	(1,985)	(243)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,570	3,875	3,582	-	141,151	1,840	-	142,991
Estimated third-party settlements	-	210,144	34,664	25,421	24,667	6,430	-	301,326	1,199	-	302,525
Total current liabilities	273,102	478,419	83,526	34,141	33,198	14,281	(318,391)	598,276	1,209	(243)	599,242
Notes payable, related party	-	814,525	-	-	27,718	6,600	(848,843)	-	-	-	-
Long-term debt, excluding current portion	1,050,694	37,373	23,617	24,312	147	10,595	(10,970)	1,135,768	2,762	-	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,432	16,429	368	2,698	-	46,420	36	-	46,456
Insurance deposits and related liabilities	-	75,697	475	325	388	220	-	77,105	41	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	-	511	-	324,258	(1)	-	324,257
Other liabilities	-	117,631	1,506	384	2,026	-	-	121,547	22,131	-	143,678
Total liabilities	1,324,999	1,849,842	132,396	75,591	63,845	34,905	(1,178,204)	2,303,374	26,178	(243)	2,329,309
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	5,524	242,824	47,729	29,464	36,158	21,247	-	382,946	48,040	40	431,026
Net assets with donor restrictions	355	99,427	7,036	945	4,736	7,310	-	119,809	32,459	(40)	152,228
Total net assets	5,879	342,251	54,765	30,409	40,894	28,557	-	502,755	80,499	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2020

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 108,856	$ 218,295	$ 47,642	$ 22,874	$ 14,568	$ 34,072	$ 6,916	$ -	$ 453,223
Patient accounts receivable, net	-	146,887	11,413	10,200	4,439	8,634	2,246	-	183,819
Prepaid expenses and other current assets	25,243	180,137	27,607	6,105	1,737	2,986	1,156	(83,065)	161,906
Total current assets	134,099	545,319	86,662	39,179	20,744	45,692	10,318	(83,065)	798,948
Assets limited as to use	344,737	946,938	18,001	12,768	13,240	13,044	21,366	(235,568)	1,134,526
Notes receivable, related party	848,250	593	-	-	-	-	-	(848,843)	-
Other investments for restricted activities	-	105,869	25,272	3,077	6,265	97	-	-	140,580
Property, plant, and equipment, net	8	469,613	68,374	43,612	18,432	40,126	3,421	-	643,586
Right of use assets	1,542	32,714	1,822	621	3,220	17,574	92	-	57,585
Other assets	2,242	122,647	7,429	5,482	2,152	8,199	158	(10,971)	137,338
Total assets	$ 1,330,878	$ 2,223,693	$ 207,560	$ 104,739	$ 64,053	$ 124,732	$ 35,355	$ (1,178,447)	$ 2,912,563
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 147	$ 257	$ 747	$ 71	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	259	631	1,316	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	272,762	126,684	35,117	4,251	3,517	3,528	1,791	(318,634)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,875	3,626	3,883	1,483	-	142,991
Estimated third-party settlements	-	210,143	34,664	24,667	6,430	25,421	1,200	-	302,525
Total current liabilities	273,100	478,819	78,798	33,199	14,461	34,895	4,604	(318,634)	599,242
Notes payable, related party	-	814,525	-	27,718	6,600	-	-	(848,843)	-
Long-term debt, excluding current portion	1,050,694	37,373	23,618	147	10,867	24,312	2,489	(10,970)	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,433	368	2,700	16,429	33	-	46,456
Insurance deposits and related liabilities	-	75,697	475	388	222	325	39	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	510	-	-	-	324,257
Other liabilities	-	117,631	1,506	2,026	-	22,515	-	-	143,678
Total liabilities	1,324,997	1,850,242	127,670	63,846	35,360	98,476	7,165	(1,178,447)	2,329,309
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	5,526	266,327	48,549	36,158	21,385	24,881	28,160	40	431,026
Net assets with donor restrictions	355	107,124	31,341	4,735	7,308	1,375	30	(40)	152,228
Total net assets	5,881	373,451	79,890	40,893	28,693	26,256	28,190	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,223,693	$ 207,560	$ 104,739	$ 64,053	$ 124,732	$ 35,355	$ (1,178,447)	$ 2,912,563

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

(In thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 42,456	$ 47,465	$ 9,411	$ 7,066	$ 10,462	$ 8,372	$ -	$ 125,232	$ 18,355	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	7,279	8,960	5,010	-	218,067	3,058	-	221,125
Prepaid expenses and other current assets	14,178	139,034	8,583	2,401	5,567	1,423	(74,083)	97,083	1,421	(3,009)	95,495
Total current assets	56,634	367,437	33,854	16,746	24,989	14,805	(74,083)	440,382	22,834	(3,009)	460,207
Assets limited as to use	92,602	688,485	18,759	12,684	12,427	11,619	-	836,576	39,673	-	876,249
Notes receivable, related party	553,484	752	-	1,406	-	-	(554,236)	1,406	(1,406)	-	-
Other investments for restricted activities	-	91,882	6,970	31	2,973	6,323	-	108,179	25,940	-	134,119
Property, plant, and equipment, net	22	432,277	67,147	30,945	41,948	17,797	-	590,134	31,122	-	621,256
Right of use assets	-	-	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,208	1,279	15,019	6,042	4,388	(10,970)	127,484	(3,013)	-	124,471
Total assets	$ 706,260	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,104,161	$ 115,150	$ (3,009)	$ 2,216,302
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 954	$ 547	$ 282	$ -	$ 10,819	$ 95	$ -	$ 10,914
Current portion of right of use obligations	-	-	-	-	-	-	-	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	55,499	99,884	15,620	6,299	3,878	2,776	(74,083)	109,873	6,953	(3,009)	113,817
Accrued compensation and related benefits	-	110,639	5,851	3,694	2,313	4,270	-	126,767	1,641	-	128,408
Estimated third-party settlements	-	26,405	103	1,290	10,851	2,921	-	41,570	-	-	41,570
Total current liabilities	55,499	248,622	22,404	12,237	17,589	10,229	(74,083)	292,497	8,689	(3,009)	298,177
Notes payable, related party	-	526,202	-	-	28,034	-	(554,236)	-	-	-	-
Long-term debt, excluding current portion	643,257	44,820	24,503	35,604	643	11,465	(10,970)	749,322	2,858	-	752,180
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-	-	-
Insurance deposits and related liabilities	-	56,786	440	513	388	240	-	58,367	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	-	4,320	-	281,009	-	-	281,009
Other liabilities	-	96,201	1,104	28	1,585	-	-	100,918	23,218	-	124,136
Total liabilities	698,756	1,241,058	58,713	48,382	48,239	26,254	(639,289)	1,482,113	34,805	(3,009)	1,513,909
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	7,486	356,880	63,051	27,653	35,518	21,242	-	511,830	48,063	40	559,933
Net assets with donor restrictions	18	91,103	6,245	796	4,620	7,436	-	110,218	32,282	(40)	142,460
Total net assets	7,504	447,983	69,296	28,449	40,138	28,678	-	622,048	80,345	-	702,393
Total liabilities and net assets	$ 706,260	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,104,161	$ 115,150	$ (3,009)	$ 2,216,302

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 42,456	$ 48,052	$ 11,952	$ 11,120	$ 8,549	$ 15,772	$ 5,686	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	8,960	5,060	7,280	3,007	-	221,125
Prepaid expenses and other current assets	14,178	139,832	9,460	5,567	1,401	1,678	471	(77,092)	95,495
Total current assets	56,634	368,822	37,292	25,647	15,010	24,730	9,164	(77,092)	460,207
Assets limited as to use	92,602	707,597	17,383	12,427	12,738	12,685	20,817	-	876,249
Notes receivable, related party	553,484	752	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	99,807	24,985	2,973	6,323	31	-	-	134,119
Property, plant, and equipment, net	22	434,953	70,846	42,423	19,435	50,338	3,239	-	621,256
Right of use assets	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,366	7,388	5,476	1,931	8,688	74	(10,970)	124,471
Total assets	$ 706,260	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (642,298)	$ 2,216,302
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 547	$ 288	$ 954	$ 69	$ -	$ 10,914
Current portion of right of use obligations	-	-	-	-	-	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,499	100,441	19,356	3,879	2,856	6,704	2,174	(77,092)	113,817
Accrued compensation and related benefits	-	110,639	5,851	2,313	4,314	4,192	1,099	-	128,408
Estimated third-party settlements	-	26,405	103	10,851	2,921	1,290	-	-	41,570
Total current liabilities	55,499	249,179	26,140	17,590	10,379	13,140	3,342	(77,092)	298,177
Notes payable, related party	-	526,202	-	28,034	-	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	24,503	643	11,763	35,604	2,560	(10,970)	752,180
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-
Insurance deposits and related liabilities	-	56,786	440	388	240	513	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	4,320	-	-	-	281,009
Other liabilities	-	98,201	1,115	1,585	-	23,235	-	-	124,136
Total liabilities	698,756	1,241,615	62,460	48,240	26,702	72,492	5,942	(642,298)	1,513,909
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	7,486	379,498	65,873	36,087	21,300	22,327	27,322	40	559,933
Net assets with donor restrictions	18	99,184	29,561	4,619	7,435	1,653	30	(40)	142,460
Total net assets	7,504	478,682	95,434	40,706	28,735	23,980	27,352	-	702,393
Total liabilities and net assets	$ 706,260	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (642,298)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2020

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,490,516	$ 207,416	$ 65,496	$ 53,943	$ 41,349	$ -	$ 1,858,720	$ 21,305	$ -	$ 1,880,025
Contracted revenue	5,369	114,906	400	-	10	7,427	(54,543)	73,569	498	(39)	74,028
Other operating revenue	26,349	321,028	16,406	7,179	10,185	7,847	(28,972)	360,022	15,128	(528)	374,622
Net assets released from restrictions	409	13,013	1,315	162	160	84	-	15,143	1,117	-	16,260
Total operating revenue and other support	32,127	1,939,463	225,537	72,837	64,298	56,707	(83,515)	2,307,454	38,048	(567)	2,344,935
Operating expenses											
Salaries	-	947,275	115,777	37,596	33,073	27,600	(34,706)	1,126,615	17,007	1,201	1,144,823
Employee benefits	-	227,138	26,979	8,214	6,741	8,344	(4,864)	268,552	4,009	311	272,872
Medications and medical supplies	-	401,165	36,313	8,390	5,140	2,944	-	453,952	1,429	-	455,381
Purchased services and other	13,615	284,714	31,864	11,639	14,311	13,351	(20,942)	348,552	13,943	(1,999)	360,496
Medicaid enhancement tax	-	59,708	8,476	3,226	2,853	1,747	-	76,010	-	-	76,010
Depreciation and amortization	14	71,108	9,351	3,361	3,601	2,475	-	89,910	2,254	-	92,164
Interest	25,780	23,431	953	906	1,097	252	(25,412)	27,007	315	-	27,322
Total operating expenses	39,409	2,014,539	229,713	71,332	66,816	54,713	(85,924)	2,390,598	38,957	(487)	2,429,068
Operating (loss) margin	(7,282)	(75,076)	(4,176)	1,505	(2,518)	1,994	2,409	(83,144)	(909)	(80)	(84,133)
Non-operating gains (losses)											
Investment income (losses), net	4,877	18,522	714	292	359	433	(198)	24,999	2,048	-	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	-	134	-	10,810	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(205)	544	4,317	(2,211)	(3,133)	346	80	(2,707)
Total non-operating gains (losses), net	945	26,238	2,028	87	903	4,884	(2,409)	32,676	2,394	80	35,150
(Deficiency) excess of revenue over expenses	(6,337)	(48,838)	(2,148)	1,592	(1,615)	6,878	-	(50,468)	1,485	-	(48,983)
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	564	179	-	344	300	-	1,387	27	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	-	(7,188)	-	(79,022)	-	-	(79,022)
Net assets transferred to (from) affiliates	4,375	(7,269)	(32)	219	1,911	15	-	(781)	781	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	(2,316)	-	(2,316)
Increase in net assets without donor restrictions	$ (1,962)	$ (114,056)	$ (15,322)	$ 1,811	$ 640	$ 5	$ -	$ (128,884)	$ (23)	$ -	$ (128,907)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2020

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,490,516	$ 207,416	$ 53,943	$ 41,348	$ 65,496	$ 21,306	$ -	$ 1,880,025
Contracted revenue	5,369	115,403	400	10	7,427	-	-	(54,581)	74,028
Other operating revenue	26,349	323,151	16,472	10,185	9,482	16,726	1,757	(29,500)	374,622
Net assets released from restrictions	409	13,660	1,335	160	83	613	-	-	16,260
Total operating revenue and other support	32,127	1,942,730	225,623	64,298	58,340	82,835	23,063	(84,081)	2,344,935
Operating expenses									
Salaries	-	947,275	115,809	33,073	28,477	41,085	12,608	(33,504)	1,144,823
Employee benefits	-	227,138	26,988	6,741	6,517	7,123	2,918	(4,553)	272,872
Medications and medical supplies	-	401,165	36,313	5,140	2,941	8,401	1,421	-	455,381
Purchased services and other	13,615	287,948	32,099	14,311	13,767	14,589	7,108	(22,941)	360,496
Medicaid enhancement tax	-	59,708	8,476	2,853	1,747	3,226	-	-	76,010
Depreciation and amortization	14	71,109	9,480	3,601	2,596	5,004	360	-	92,164
Interest	25,780	23,431	953	1,097	252	1,159	62	(25,412)	27,322
Total operating expenses	39,409	2,017,774	230,118	66,816	56,297	80,587	24,477	(86,410)	2,429,068
Operating (loss) margin	(7,282)	(75,044)	(4,495)	(2,518)	2,043	2,248	(1,414)	2,329	(84,133)
Non-operating gains (losses)									
Investment income (losses), net	4,877	19,361	1,305	359	463	292	588	(198)	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	134	-	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(25)	4,318	(205)	914	(2,131)	(2,707)
Total non-operating gains (losses), net	945	27,077	2,619	334	4,915	87	1,502	(2,329)	35,150
(Deficiency) excess of revenue over expenses	(6,337)	(47,967)	(1,876)	(2,184)	6,958	2,335	88	-	(48,983)
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	591	179	344	300	-	-	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	(7,188)	-	-	-	(79,022)
Net assets transferred to (from) affiliates	4,377	(7,282)	10	1,911	15	219	750	-	-
Other changes in net assets	-	-	(2,316)	-	-	-	-	-	(2,316)
Increase in net assets without donor restrictions	$ (1,960)	$ (113,171)	$ (17,324)	$ 71	$ 85	$ 2,554	$ 838	$ -	$ (128,907)

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,580,552	$ 220,255	$ 69,794	$ 60,166	$ 46,029	$ -	$ 1,976,796	$ 22,527	$ -	$ 1,999,323
Contracted revenue	5,011	109,051	355	-	-	5,902	(46,100)	74,219	790	8	75,017
Other operating revenue	21,128	186,852	3,407	1,748	4,261	2,289	(22,076)	197,609	13,386	(297)	210,698
Net assets released from restrictions	369	11,556	732	137	177	24	-	12,995	1,110	-	14,105
Total operating revenue and other support	26,508	1,888,011	224,749	71,679	64,604	54,244	(68,176)	2,261,619	37,813	(289)	2,299,143
Operating expenses											
Salaries	-	868,311	107,671	37,297	30,549	26,514	(24,682)	1,045,660	15,785	1,106	1,062,551
Employee benefits	-	217,623	25,983	6,454	5,434	7,152	(3,763)	258,883	3,642	287	262,812
Medications and medical supplies	-	354,201	34,331	8,634	6,298	3,032	-	406,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,622)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,061	-	-	70,061
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,360	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,981	533	-	25,514
Total operating expenses	32,057	1,828,123	220,108	74,229	63,107	55,012	(70,471)	2,202,165	38,726	(229)	2,240,662
Operating margin (loss)	(5,549)	59,888	4,641	(2,550)	1,497	(768)	2,295	59,454	(913)	(60)	58,481
Non-operating gains (losses)											
Investment income (losses), net	3,929	32,193	227	469	834	623	(198)	38,077	1,975	-	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	-	186	-	11,221	-	-	11,221
Other (losses) income, net	(3,784)	1,586	(187)	30	(240)	279	(2,097)	(4,413)	791	60	(3,562)
Loss on early extinguishment of debt	-	-	-	(87)	-	-	-	(87)	-	-	(87)
Total non-operating gains (losses), net	145	43,056	1,798	412	594	1,088	(2,295)	44,798	2,766	60	47,624
(Deficiency) excess of revenue over expenses	(5,404)	102,944	6,439	(2,138)	2,091	320	-	104,252	1,853	-	106,105
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	419	565	-	402	318	-	1,704	65	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	-	682	-	(72,043)	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,939	8,760	128	110	-	5,054	(5,054)	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 21,998	$ 1,223	$ 6,622	$ 2,621	$ 1,430	$ -	$ 38,967	$ (3,136)	$ -	$ 35,831

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,580,552	$ 220,254	$ 60,166	$ 46,029	$ 69,794	$ 22,528	$ -	$ 1,999,323
Contracted revenue	5,010	109,842	355	-	5,902	-	-	(46,092)	75,017
Other operating revenue	21,128	188,775	3,549	4,260	3,868	10,951	540	(22,373)	210,698
Net assets released from restrictions	371	12,637	732	177	26	162	-	-	14,105
Total operating revenue and other support	26,509	1,891,806	224,890	64,603	55,825	80,907	23,068	(68,465)	2,299,143
Operating expenses									
Salaries	-	868,311	107,706	30,549	27,319	40,731	11,511	(23,576)	1,062,551
Employee benefits	-	217,623	25,993	5,434	7,319	7,218	2,701	(3,476)	262,812
Medications and medical supplies	-	354,201	34,331	6,298	3,035	8,639	1,371	-	407,875
Purchased services and other	11,366	246,101	35,396	13,390	14,371	18,172	7,437	(22,798)	323,435
Medicaid enhancement tax	-	54,954	8,005	2,264	1,776	3,062	-	-	70,061
Depreciation and amortization	14	69,343	8,125	3,920	2,478	4,194	340	-	88,414
Interest	20,678	21,585	1,054	1,119	228	1,637	63	(20,850)	25,514
Total operating expenses	32,058	1,832,118	220,610	62,974	56,526	83,653	23,423	(70,700)	2,240,662
Operating (loss) margin	(5,549)	59,688	4,280	1,629	(701)	(2,746)	(355)	2,235	58,481
Non-operating gains (losses)									
Investment income (losses), net	3,929	33,310	129	785	645	469	983	(198)	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	186	-	-	-	11,221
Other (losses) income, net	(3,784)	1,586	(171)	(240)	288	31	765	(2,037)	(3,562)
Loss on early extinguishment of debt	-	-	-	-	-	(87)	-	-	(87)
Total non-operating gains (losses), net	145	44,173	1,716	545	1,119	413	1,748	(2,235)	47,624
(Deficiency) excess of revenue over expenses	(5,404)	103,861	5,996	2,174	418	(2,333)	1,393	-	106,105
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	484	565	402	318	-	-	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	682	-	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,963	128	118	3,629	45	-	-
Increase (decrease) in net assets without donor restrictions	$ 5,073	$ 22,980	$ 804	$ 2,704	$ 1,536	$ 1,296	$ 1,438	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Note to Supplemental Consolidating Information
June 30, 2020 and 2019

1. Basis of Presentation

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

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

BOARDS OF TRUSTEES AND OFFICERS
(22 D-H Trustees; 13 D-HH Trustees)

Effective: January 1, 2022

Geraldine "Polly" Bednash, PhD, RN, FAAN
(Thomas)
MHMH/DHC/D-HH Trustee
Adjunct Professor, Australian Catholic University

Mark W. Begor, MBA (Kristen)
MHMH/DHC/D-HH Trustee
Chief Executive Officer, Equifax

Duane A. Compton, PhD
MHMH/DHC/D-HH Trustee
Ex-Officio: Dean, Geisel School of Medicine at Dartmouth

Joanne M. Conroy, MD
MHMH/DHC/D-HH Trustee
Ex-Officio: CEO & President, D-H/D-HH
One Medical Center Drive, Lebanon, NH 03756

Paul P. Danos, PhD (Mary Ellen)
MHMH/DHC/D-HH Trustee
Dean Emeritus; Laurence F. Whittemore Professor of Business Administration, Tuck School of Business at Dartmouth

Nancy M. Dunbar, MD (Geoff)
MHMH/DHC Trustee
Medical Director, Blood Bank
Department of Pathology and Laboratory Medicine

Carl "Trey" Dobson, MD (Amy)
MHMH/DHC Trustee
Chief Medical Officer, Southwestern Vermont Medical Center & Medical Director for the D-H Practice, Bennington, Vermont

Elof Eriksson, MD, PhD (Gudrun)
MHMH/DHC Trustee
Professor Emeritus, Harvard Medical School and
Chief Medical Officer, Applied Tissues Technologies, LLC

Elof Eriksson, MD, PhD (Gudrun)
MHMH/DHC Trustee
Professor Emeritus, Harvard Medical School and

Chief Medical Officer, Applied Tissues Technologies, LLC

Gary L. Freed, MD, PharmD (Meghan Freed, MD)
MHMH/DHC Trustee
Medical Director of the Comprehensive Wound Clinic at D-H & Assistant Professor of Surgery, Geisel School of Medicine at Dartmouth

Thomas P. Glynn, PhD (Marylou Batt)
MHMH/DHC Trustee
Adjust Lecturer, Harvard Kennedy School of Government

Jarvis A. Green (Julien Blanchet)
MHMH/DHC Trustee
Founder & Producing Artistic Director, JAG Productions

Roberta L. Hines, MD (Jerome Liebrand)
MHMH/DHC Boards' Chair | D-HH Trustee
Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine

David S. Jevsevar, MD, MBA (Kori)
MHMH/DHC Trustee
Chair of the Department of Orthopaedics at the Geisel School of Medicine at Dartmouth and Vice President of the Orthopaedic Service Line for Dartmouth-Hitchcock Health

Aaron J. Mancuso, MD (Allison)
MHMH/DHC (Lebanon Physician) Trustee
Division Director of Thoracic Anesthesia and Assistant Professor of Anesthesiology and Medicine at Geisel

Jennifer L. Moyer, MBA (David Bartlett)
MHMH/DHC/D-HH Trustee
Managing Director & CAO, White Mountains Insurance Group, Ltd

Sherri C. Oberg, MBA (Curt)
MHMH/DHC Trustee
CEO and Co-Founder of Particles for Humanity, PBC

David P. Paul, MBA (Jill)
MHMH/DHC Board Secretary | D-HH Trustee
President & COO, JBG SMITH

Charles G. Plimpton, MBA (Barbara Nyholm)
MHMH/DHC/D-HH Trustee
MHMH/DHC Boards' Treasurer
D-HH Board Treasurer & Secretary
Retired Investment Banker

Thomas Raffio, MBA, FLMI (Ellen)
MHMH/DHC Trustee
President & CEO, Northeast Delta Dental

Edward Howe Stansfield, III, MA (Amy)
MHMH/DHC Trustee
D-HH Trustee & Board Chair
Senior VP, Resident Director for the Hanover, NH Bank of America/Merrill Lynch Office

Pamela Austin Thompson, MS, RN, CENP, FAAN
(Robert)
MHMH/DHC/D-HH Trustee
Chief executive officer emeritus of the American Organization of Nurse Executives (AONE)

Marc B. Wolpow, JD, MBA (Robin)
MHMH/DHC/D-HH Trustee
Co-Chief Executive Officer of Audax Group

Sandra L. Wong, MD, MS
MHMH/DHC Trustee
William N. and Bessie Allyn Professor of Surgery, Chair of the Department of Surgery at Dartmouth-Hitchcock Medical Center (DHMC) and the Geisel School of Medicine at Dartmouth, and senior vice president of the Surgical Service Line at D-HH

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

Richard J. Powell, MD (Roshini Pinto-Powell, MD)
D-HH Trustee
Section Chief, Vascular Surgery; Professor of Surgery and Radiology

Angie M. Raymond Leduc, MBA, CPS, Program Manager

[redacted]

Summary of Qualifications: Esteemed public health professional with over 5 years' experience in large scale multi-stakeholder collaborations, coalition building, program planning, program management and evaluation for nonprofit/healthcare organizations. Excels in managing multiple projects and responsibilities, consistently delivering high quality work. Highly self-motivated problem solver who is enthusiastic about community organizing and building meaningful partnerships. An innovative leader seeking positive social impact, with a passion for continuous learning and connecting others. Strong computer skills and embraces new systems & technologies.

Areas of Expertise: Program Planning, Execution and Evaluation | Community Organizing, Outreach, Engagement, & Education | Project Management | Communication | Data Management | Supervision | Facilitation | Training | Prevention | Coalition Building | Grants Management | Grant Writing

Skills and Proficiencies: MBA concentration in Social Innovation | Certified Prevention Specialist | Connect Suicide Prevention, Intervention and Postvention Trainer | Results Based Accountability Trainer | Lean Six Sigma Yellow Belt | Venngage | Survey Monkey | Mailchimp | Microsoft Office | Clear Impact | 10+ years Management

Work Experience:

Dartmouth Hitchcock Medical Center, Lebanon, NH, 603-653-6863

Program Manager - Injury Prevention Center, February 2021 – Present

- Sets program direction based on current data, research and professional contacts. Supervises Center staff and works with researchers, students, program partners and others.
- Evaluates the Center's activities to measure and improve program effectiveness.
- Participates with relevant state, regional and national organizations to increase visibility and awareness of related efforts. Provides direct service as needed/required by the service team.
- Promotes regional injury prevention efforts through leadership and active involvement in a variety of coalitions and task forces such as Safe Kids NH, Falls Risk Reduction Task Force, NH Public Health Association and NH Injury Prevention Advisory Council. Establish and/or maintain relationships with state legislatures and other organizations engaged in public health public policy to facilitate the implementation of legislative strategies to achieve injury prevention goals Increase the public's awareness of the importance of general and specific injury prevention messages through public speaking and media efforts.
- Secures resources to support and sustain Center and coalition activities including but not limited to personnel, program needs and effective safety equipment.
- Performs other duties as required or assigned.

Dartmouth Hitchcock Medical Center, Lebanon, NH, 603-653-6863

Senior Community Partnership Coordinator- Community Health Improvement Department, 2015 – January 2021

- Manage 6 years of the Drug Free Communities Grant and projects for the Substance Misuse Team and department.

- Wrote the application for years 6-10 of the newly awarded Drug Free Communities Grant.
- Initiate, build capacity of, support, maintain, evaluate and sustain three local community coalitions and one regional coalition, covering a bi-state geography with a population of over 60,000 residents.
- Co-coordinate the operations and activities of the regional coalition and its subcommittees.
- Facilitate and train the Strategic Prevention Framework in all team and coalition processes.
- Implement best practices and evidence based initiatives in substance misuse and suicide prevention.
- Collaborate with multiple, diverse community stakeholders on all projects; including law enforcement, employers, schools, faith leaders, parents, youth, civic organizations, organizations who work with youth, media, healthcare organizations and others.
- Responsible for strategic planning, evaluating performance and reporting outcomes of coalition and grant projects.
- Trainer of the Connect Suicide Prevention and Postvention Program
- Assist in the design, creation and implementation of multi-media prevention campaigns.
- Trainer of Results Based Accountability inter-department and within community coalitions.

Listen Community Services, Lebanon, NH and White River Jct., VT, 603-448-4553
Executive Assistant, 2011 - 2014

- Supervised the recruiting, hiring, training, evaluation, recognition, promotion, and termination of thrift store employees and volunteers.
- Developed the organizations employee performance evaluation process.
- Provided on-site support and assistance to store managers to achieve program goals.
- Assisted in the development and implementation of Listen's advertising program and public relations.
- Helped devise methods to obtain ongoing feedback from thrift store participants and clients.
- Assisted with sales oversight and pricing procedures.
- Supervised and managed the teen life skills program and staff.
- Assisted with the development of the Annual Newsletter, creating budgets for TLC and retail programs, Organized, planned, coordinated and delivered quarterly staff meetings.

Coordinator of Junction Teen Life Skills Center, 2008-2011,

- Managed the daily operations of a vibrant and effective program for youth and young adults ages 15-20 in a drop-in setting. Engaged and supported youth through life skills activities.
- Built sustainable community collaborations by developing and implementing responsive programs for transition aged youth in conjunction with community organizations and members.
- Co-authored teen life skills curriculum and frameworks. Created workshops and evening activities based on said curriculum.
- Advocated for youth and young adults among the community and within the school system.
- Developed and had oversight of the program, its policies and procedures
- Recruited, trained and supervised program staff, volunteers and interns.

- Maintained accurate and timely program records, data entry and other required reporting.

EDUCATION & CERTIFICATIONS

Marlboro College Graduate & Professional Studies, Marlboro, VT

- Master's in Business Administration, concentration Social Innovation, Graduated December 2019

New England College, Henniker, NH

- Bachelors in both Psychology and Education, GPA 3.56, Graduated Cum Laude in 1999

Other Skills and Experience:

- Certified Prevention Specialist
- Results Based Accountability Trainer
- National Coalition Academy Graduate 2015
- Certificate in Nonprofit Management 2011
- Connect Suicide Pre & Postvention Trainer
- Proficient skills in Microsoft Office Suite
- Program evaluation using SPF and RBA
- Grant writing and strategic planning.

Community/Volunteer Interests:

Headrest - Board Member (2017-Present)
Lebanon Partners United for Safety & Health - Co Founder and Board Member (2015 Present)
Hartford Community Coalition - Co Founder and Board Member (2013-2019)

April Simonds

Qualification Summary

- Motivated business professional with over 28 years of experience in general office functions
- with an unwavering commitment to customer service
- Ability to handle changes in priorities and increased responsibilities on a daily basis
- Excellent communication and interpersonal skills and a strong work ethic
- Proven experience working with the public delivering exceptional customer service

Career Summary

Dartmouth Hitchcock Medical Center 2016-current
Program Assistant, Injury Prevention Center

- Performs a variety of administrative assistance in support of the Program
- Provides operational assistance to the Program Manager and Program Staff
- Manages program documentation
- Coordinates conference calls and travel arrangements
- Assists with Grant proposal submission
- Supports and participates with a variety of community outreach events
- Tracks grant budget and expenditures

Dartmouth Hitchcock Memorial Hospital 2012-2016
Financial Counselor

- Conducts research to resolve a variety of inquiries, customer issues and complaints
- Proven ability to contribute positively in a team oriented environment
- Worked collaboratively with all necessary internal departments to resolve billing, patient
- issues, including Care Management and Risk Management
- Managed a high-volume work load within a deadline driven environment
- Prepared and processed daily deposits, transferred funds/credit as appropriate
- Pre-registered patients for upcoming appointments
- Counseled patients daily to review their financial situation and determine the best recommendation
- Processed a high volume of financial assistance applications with great attention to detail
- and exceeded expected turn-around time
- Collections of funds for high dollar elective procedures
- Ability to effectively communicate with patients and faculty in difficult situations to ensure a positive outcome
- Excellent time management and continually changed priorities as needed

New London Hospital New London, NH
Financial Representative
2011-2012

- Responsible for extensive follow through on all delinquent accounts
- Investigated and followed through on a broad range of inquiries, discrepancies and complaints
- Prepared and processed daily deposits with accuracy
- Assisted patients needing help completing financial application and shared information and
- advice where to go to for additional help with fuel assistance, Medicaid, etc
- Processed financial applications with accuracy and with great attention to detail and improved
- turn-around time
- Sent patients itemized bills and reviewed billing to help them have a better understanding of our
- billing processes

Dartmouth College, Department of Psychiatry, Lebanon, NH 2001-2011
Credit & Collections Specialist

- Responded to and resolved a broad range of client questions, inquiries and discrepancies
- Resolved patient issues and complaints with integrity and to ensure a positive customer experience
- Ability to effectively communicate with patients and faculty in difficult customer service situations
- Ability to effectively and respectfully communicate and facilitate communications between DHPA and DHMC and other departments as appropriate, including office of Care Management and Risk Management
- Directly involved in developing and implementing a pre-collections policy to increase revenue
- Created Financial reports to provide analysis to PFS Manager on a monthly basis

- Met with all new staff members to discuss and tram on billing and collection policies
- Prepared monthly excel reports tracking collections and uncollected debt for Manager review

West Central Behavior Services Lebanon, NH
Client Financial Representative
1997-2001

- Monitored and oversaw all office functions regarding billing and collections for two facilities
- Responsible for accounts receivable, insurance billing, denial management, charge entry
- cash posting and claims processing
- Investigated reimbursement issues as they related to private pay and contracted accounts
- Researched and resolved payment discrepancies
- Responsible for accounts receivable, payment posting, charge entry with great attention to
- detail
- Instrumental in the implementation of a pre-collections policy for patients

Dr. Ronald Carpe, DMD Boston, Ma
Office Manager 1992-1997

- Effectively controlled all office functions allowing for the highest efficiency of office flow
- Intensive follow through and resolution on all delinquent accounts as well as account
- discrepancies
- Monitored and reconciled all office productivity and comparative reports

JAMES E. ESDON

[redacted]

BACKGROUND SUMMARY

Skilled in implementing injury prevention programs, personnel management, budget management, volunteer recruitment and training, membership development and outdoor education. People skills include teaching, coaching, directing, listening, encouraging, and supporting. Additional skills include writing, problem solving, planning, and implementation. Knowledgeable in fundraising to include annual campaigns, special events, project sales, and product sales. Certified New Hampshire Part-Time Police Officer.

QUALIFICATIONS

Management

- Managed injury prevention programs for Injury Prevention Center at the Children's Hospital Dartmouth-Hitchcock.
- Managed staff of fourteen people including all aspects of hiring, training, evaluation, and counseling.
- Oversaw daily operations of a busy office.
- Administered field operations for a statewide non-profit agency.
- Demonstrated customer service skills.
- Member of the Management Team for a busy retail store with sales in excess of 3.5 million annually.

Fundraising/Development

- Increased annual sustaining membership campaign.
- Organized new special events and increased revenue from existing ones.
- Significantly grew annual product sale.
- Ability to recruit, train, and retain strong volunteer base.
- Able to accurately balance and maintain daily financial records.

Outdoor Education

- Managed large summer camp operation with balanced budget every year.
- Increased attendance through innovative programming and quality customer service.

Computer Literacy

- Knowledgeable in Windows XP, Microsoft Word; E-mail; Internet searches.
- Hotel reservations software.
- Cash register operation.

EMPLOYMENT HISTORY

- Program Coordinator, Injury Prevention Center, Dartmouth-Hitchcock Medical Center 2001-Present
- Instructor for New Hampshire Traffic Safety Institute 2010-2014
- Police Officer, Charlestown, NH Police Department 2008-Present
- Keyholder/Associate with Eastern Mountain Sports, Lebanon, NH 2002-Present
- Assistant Scout Executive/ Staff Leader with Green Mountain Council,BSA 1995-2001
- Senior Field Executive/ Camp Director with Daniel Webster Council,BSA 1989-1995
- District Executive/ Camp Director with Daniel Webster Council,BSA 1985-1989

EDUCATION & CERTIFICATIONS

- Bachelor of Science, Physical Education
  Plymouth State College, Plymouth, New Hampshire
- Professional Development Instructional Courses
  Professional Development Level I, II, and III
  Advanced District Administration
  Personnel Management Level I
  Fundraising/Endowment Roundtable
- Certified Child Passenger Safety Technician, Certification # TO26803
- SOLO Wilderness First Aid
- American Red Cross Basic First Aid, CPR & AED
- American Red Cross Certified Lifeguard
- New Hampshire Certified Part-Time Law Enforcement Officer
- Stop the Bleed Instructor
- Certified Law Enforcement Firearms Instructor
- Terrorism Response Tactics: Basic Active Shooter Level I
- Civilian Response to Active Shooter Events Train The Trainer
- Certification as Instructor- National Safety and Health Council ADD-DD
- Operations Management Course
  Plymouth State University

PERSONAL

- Hobbies include running, hiking, backpacking, and fishing.

Dartmouth-Hitchcock

Job Description:

Title:	**Data Specialist**	**Code:**	**402294**
Level:	**Individual Contributor**	**Grade:**	**028**
Function:	**ADM**	**FLSA Status:**	**Exempt**
Reports To:	**Director**	**Date:**	**06/28/18**

Purpose

Constructs and maintains systems for the continual monitoring of specialized data and maintains key site information. Provides technical guidance, training and data management support to appropriate staff and interested parties for assigned systems.

Key Responsibilities

1. Working closely with leaders, is responsible for the development, maintenance and reliability of tracking, trending and reporting specialized system information.
2. Serves as a technical expert and resource for departmental software systems.
3. Collaborates with IT in managing the delivery of systems, reporting, analysis and support of key information systems central to the department's mission.
4. Develops, maintains and improves the structure and process for extracting data in formats that enable the user to make informed decisions.
5. Responsible for systems documentation, including data standards, procedures, and definitions.
6. Identifies the need for data and makes changes and improvements to processes as required.
7. Educates and trains staff in the use of the departmental systems and provides problem resolution support.
8. Serves as the key point of contact for all issues related to data collection. Maintains intranet site to provide information which supports efficient, effective processes for the entire D-H system.
9. Assists and/or provides data analysis, structuring and reporting data in standardized and ad-hoc formats and reports for users, leadership, clinical departments and divisions across the D-H System.
10. Assists in deploying new modules and systems as needed to improve efficiencies in all functions.
11. Performs other duties as required or assigned.

Compensation Representative: Sue Monaghan
Reviewed: 11/12/18
Revised: 05/5/20

Minimum Qualifications:

- ✓ Bachelors' degree in business or a related field or the equivalent in education and experience required.
- ✓ One (1) year of experience managing databases required, 2 years preferred.
- ✓ Broad knowledge of the healthcare and related computer systems & requirements, including medical legal issues and laws, regulatory agencies, compliance surrounding electronic clinical data management systems and other national standards.
- ✓ Experience with writing audit reports.
- ✓ User experience with healthcare demographic databases and data retrieval tools preferred.
- ✓ Ability to train others in the use of software management systems.
- ✓ Strong written and verbal interpersonal skills required.
- ✓ High attention to detail and accuracy and strong quantitative analytic skills.
- ✓ Ability to independently solve problems.
- ✓ Ability to develop and oversee complex projects.
- ✓ Strong proficiency with word processing, spreadsheet software, systems management and data entry preferred.

Required Licensure/Certification Skills:

- ✓ None

Compensation Representative: Sue Monaghan
Reviewed: 11/12/18
Revised: 05/5/20

Dawna Pidgeon, PT

[redacted]

Education

1986, Bachelor of Science in Physical Therapy, University of Vermont, Burlington, VT

Positions Held

2015-Present, Oregon Research Institute Authorized Trainer: Tai Ji Quan: Moving for Better Balance•
Oregon Research Institute, Eugene Oregon
Position includes conducting two day Tai Ji Quan: Moving for Better Balance• (TJQMBB) Instructor Training workshops and 1 day TJQMBB Enhanced Training workshops, follow up with Instructors regarding program implementation and fidelity, communication with Dr. Li and ORI's TJQMBB National Core Group regarding program updates and developing implementation and sustainability strategies

July 2015 to present, Falls Team Lead
Dartmouth Centers for Health and Aging, Lebanon, New Hampshire
Position includes leading the Dartmouth Centers for Health and Aging Falls Grant implementation by recruiting community partners to participate in evidence based programs, developing educational materials and presentations, providing TJQMBB Instructor Training in NH and partner states, providing ongoing support to community sites including WebEx presentations, 1:1 communication with instructors and partner leads and training sites in community based falls screening. Position also includes coordinating falls prevention efforts across Dartmouth-Hitchcock including within Injury Prevention, the Geriatric Emergency Department and within Population Health.

1992-Present, Staff Physical Therapist
Coordinator, Balance and Vestibular Program
Dartmouth Hitchcock Medical Center, Lebanon New Hampshire
Position includes evaluating and treating individuals with a variety of neurological, musculoskeletal, and vestibular disorders causing dizziness and/or balance and gait dysfunction, coordinating clinical programs with DHMC Otolaryngology, Physiatry and Internal Medicine departments, being a clinical resource to other PT staff, supervising maintenance and update of balance center technology, and working with other medical departments at DHMC to improve coordination of care for individuals with balance and vestibular dysfunction.

1986-1992, Staff Physical Therapist
Mt. Ascutney Hospital and Health Center, Windsor Vermont
Position included evaluation and treatment of patients with neurological and orthopedic dysfunction in the acute rehabilitation unit, out-patient department, skilled nursing facility, home health agency, and acute medical wing.

Professional Organizations

American Physical Therapy Association Member

Neurology Section Member, APTA, Vestibular Special Interest Group, Brain Injury Special Interest Group

Geriatric Section Member, APTA, Balance and Falls Special Interest Group

Task Force and Committees

Evidence-based Falls Prevention Program Remote Research Advisory Committee, "Piloting the Remote Delivery of Falls Prevention Programs", ACL supplemental award, November 10, 2020 –present

Tai Ji Quan: Moving for Better Balance® National Core Group, Oregon Research Institute, Eugene Oregon, December 2016-present

Plymouth State University Doctorate of Physical Therapy (DPT) program Advisory Board. Plymouth New Hampshire, June 2016 to present

Co-Chair New Hampshire Falls Risk Reduction Task Force, Department of Health and Human Services, Concord, New Hampshire November 1, 2014 to present; Task Force Member 2000 to present

Brain Injury Work Group, Dartmouth Hitchcock Medical Center, led by Physiatrist developed comprehensive program at DHMC, January 2011 to 2016

New Hampshire Injury Prevention Community Planning Group, Department of Health and Human Services, 2010-2011

Northern New England Geriatric Education Center Falls Work Group, Dartmouth Centers for Health and Aging, August 2010-present

Healthy People 2010 Task Force, Fall Reduction subcommittee, Department of Health and Human Services, Concord, New Hampshire, February 2003

Dartmouth Hitchcock Falls Risk Reduction Task Force, Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire, 2000-present, Chair 2001-present

New Hampshire Falls Risk Reduction Task Force and Northern New England Geriatric Education Center Annual Conference Planning Committee 2000-present,

Trauma Prevention Committee, Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire, 2000-2002

New Hampshire APTA continuing Education Committee 1998-2000

Special Projects and Certifications

Program Lead and Instructor for DHMC Tai Ji Quan: Moving for Better Balance ®, 2013 to present

Local Support Staff (LSS) for eDH-new electronic medical record (EMR) at Dartmouth Hitchcock Medical Center, developed documentation templates and assisted with training staff during implementation of new EMR system

Co-developed Geriatric Interdisciplinary Falls Clinic with General Internal Medicine and Office of Care Management, 2010

Co-developed Falls Clinic Learning Laboratory with Northern New England Geriatrics Education Center, Dartmouth Centers for Health and Aging, 2010-2011

Certified Exercise Expert for the Aging Adult (CEEAA), American Physical Therapy Association certification, completed June 2010

Dartmouth Hitchcock Medical Center Rehab lead for "R.A.C.E.: Randomized ActiveStep Clinical Evaluation" study, Jon Lurie, MD principal investigator, January 2010-2016

Balance Assessment and Fractal Gait Analysis research project co-investigator; Harold Greeley, Principal Engineer, David Coffey, MD, co-investigator, Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire, December 11, 2009 – June 28, 2010

Dartmouth Hitchcock Medical Center Rehab lead for "R.A.C.E: Randomized ActiveStep Clinical Evaluation: a multicenter randomized pilot study", Jon Lurie, MD, principal investigator, January 2009-December 2009

Established Parkinson's Wellness Group at Dartmouth Hitchcock Medical Center based on Boston University Program, November 2008. Continue as leader and co-organizer 2008 to present

Co-developer of multidisciplinary falls clinic in collaboration with Internal Medicine and Office of Care Management for comprehensive evaluation of medically complex seniors, 2005-2007

Community Based Multifactorial Intervention for Falls Risk Reduction in the Elderly, A Pilot Study, Lebanon, New Hampshire with New Hampshire Department of Health and Human Services Falls Risk Reduction Task Force, March 2001-July 2002

Publications

Batsis JA, Petersen CL, Clark MM, Cook SB, Kotz D, Gooding TL, Roderka MN, Al-Nimr RI, Pidgeon D, Haedrich A, Wright KC, Aquila C, Mackenzie TA. Feasibility and acceptability of a technology-based, rural weight management intervention in older adults with obesity. BMC Geriatrics. 21(1):44, 2021 Jan 12.

Batsis JA, Petersen CL, Cook SB, Al-Nimr RI, Pidgeon D, Mackenzie TA, Bartels SJ. A Community-Based Feasibility Study of Weight-Loss in Rural, Older Adults with Obesity. Journal of Nutrition in Gerontology & Geriatrics. 39(3-4):192-204, 2020 Jul-Dec.

Petersen CL, Halter R, Kotz D, Loeb L, Cook S, Pidgeon D, Christensen BC, Batsis JA. Using Natural Language Processing and Sentiment Analysis to Augment Traditional User-Centered Design: Development and Usability Study. JMIR MHealth and UHealth. 8(8):e16862, 2020 08 07.

Kennedy MA, Pepin R, Stevens CJ, Bartels SJ, Batsis JA, Beyea A, Bruce ML, Eckhaus JM, Korsen N, Pidgeon DM, Powell KE, Reynolds CF, LaMantia, MA. Mind, Mood, Mobility: Supporting Independence Among Rural Older Adults at Risk for Functional Decline. American Journal of Health Promotion, June 2020; 1-4

Lurie JD, Zagaria AB, Ellis L, Pidgeon D, Gill-Body KM, Burke C, Armbrust K, Cass S, Spratt KF, McDonough CM. Surface Perturbation Training To Prevent Falls In Older Adults: A Highly Pragmatic, Randomized Controlled Trial. Physical Therapy 2020;100: 1153-1162

John A Batsis, Curtis L Petersen, Matthew M Clark, Summer B Cook, Francisco Lopez-Jimenez, Rima I Al-Nimr, Dawna Pidgeon, David Kotz, Todd A Mackenzie, Stephen J Bartels. A Weight Loss Intervention Augmented by a Wearable Device in Rural Older Adults With Obesity: A Feasibility Study.J Gerontol A Biol Sci Med Sci. 2021 Jan; 76(1): 95–100. Published online 2020 May 8

Li F, Harmer P, Eckstrom E, Fitzgerald K, Akers L, Chou LS, Pidgeon D, Voit J, Winters-Stone K. Cost-Effectiveness of a Therapeutic Tai Ji Quan Fall Prevention Intervention for Older Adults at High Risk of Falling. *J Gerontol A Biol Sci Med Sci*. 2019; Vol. 74, No. 9: 1504–1510

Batsis JA, Boateng GG, Seo LM, Petersen CL, Fortuna KL, Wechsler EV, Peterson RJ, Cook SB, Pidgeon D, Dokko RS, Halter RJ, Kotz DF. Development and Usability Assessment of a Connected Resistance Exercise Band Application for Strength-Monitoring. World Academy of Science, Engineering and Technology. 13(5):340-348, 2019

Li F, Harmer T, Fitzgerald K, Eckstrom E, Akers L, Pidgeon D, Voit J, Winters-Stone K. Effectiveness of a Therapeutic Tai Ji Quan Intervention vs a Multimodal Exercise Intervention to Prevent Falls among Older Adults at High Risk of Falling. JAMA Intern Med. 2018; 178(10): 1301-1310

Crow RS, Lohman MC, Pidgeon D, Bruce ML, Bartels SJ, Batsis BA. Frailty Versus Stopping Elderly Accidents, Deaths and Injuries Initiative Fall Risk Score: Ability to Predict Future Falls. Journal of the American Geriatrics Society. March 2018. 66(3):577-583

Batsis JA, Zbehlik A, Barre LK, Bynum JP, Pidgeon D, Bartels SJ. Impact of Obesity on Disability, Function and Physical Activity: Data from the Osteoarthritis Initiative. Scand J Rheumatol. 2015 November; 44(6): 495-502

Batsis JA, Zbehlik AJ, Pidgeon DM, Bartels JB. Dynapenic obesity and the effect on long-term physical function and quality of life: data from the osteoarthritis initiative. BMC Geriatrics 2015, 15:118: 1-13

Lurie, JD, Zagaria AB, Pidgeon DM, Forman JL, Spratt KF. Pilot comparative effectiveness study of surface perturbation treadmill training to prevent falls in older adults. BMC Geriatrics 2013, 13:49: 1-8

On-going Research Support

90FPSG0038-01-02 (Flaherty)
Empowering Communities to Reduce Falls and Falls Risk
Administration for Community Living
Objectives: (1) Create sustainable partnerships between community-based organizations and primary care sites in three states (2) Build program capacity through the Dartmouth Falls Prevention Training Center
Role: Implementation and Training lead
August 2020-July 2023

Completed Research Support

90FPSG0002-01-01 (Flaherty)
Administration for Community Living
Evidence Based Falls Prevention Program
Objectives: (1) Develop NH Falls Prevention Network Hub
(2) Develop Northeast Regional TJQMBB Training Center
Role: Lead Trainer
August 2017-July 2020

K23AG051681-02 (Batsis)
NIA, NIH
Mobile Obesity Wellness Interventions in Rural Older Adults
Role: Research staff
May 2017 – April 2020

90FP0020-01-00 (Flaherty)
Administration for Community Living
Evidence Based Falls Prevention Program
Objective: Implementing evidence-based fall prevention programming in the state of New Hampshire
Role: Lead Trainer
August 2015-July 2017

AHRQ R01HS018459 Lure (PI)
ActiveStep Comparative Effectiveness Trial (R.A.C.E.)
Role: Co-Investigator
9/30/09-7/31/14

NIH 1 R43 AGO32150-01A1 Greely (PI)
An Instrument for the Longitudinal Monitoring of Change in Balance and Gait Function
Role: Project Team
5/15/09-1/31/11

The Dartmouth Center for Clinical and Translational Science, Lurie (PI)
ActiveStep Comparative Effectiveness Pilot Trial (R.A.C.E.)
Role: Co-investigator
2008-2009

Awards and Honors

James W. Varnum Quality Health Care Award, Dartmouth Hitchcock Medical Center, 2009

Vermont American Physical Therapy Association Distinguished Service Award 2007

National and Regional Professional Presentations

"Dartmouth Falls Prevention Initiatives", Dartmouth Hitchcock Geriatric Education Series (webinar), January 7, 2021

"Tai Ji Quan: moving for Better Balance® Updates and Remote Delivery Adaptations", Massachusetts Healthy Living Center of Excellence annual Sharpening Your Skills conference, December 1, 2020

"Reducing Falls in Older Adults", lecture for Medical Assistant Training Program, Sponsored by the Institute for American Apprenticeships (IAA), Lebanon, New Hampshire, October 20, 2020

"The Dartmouth Falls Prevention Program", Brigham Health Stepping Strong Center for Trauma Innovation", Boston, Massachusetts (Webinar), October 15, 2020

"Tai Ji Quan: Moving for Better Balance®", Massachusetts Fall Prevention Awareness Week webinar, September 22, 2020

"Balance Days: Engage, Recruit and Prevent Fall", The Healthy Living Center of Excellence 8th Massachusetts Sharpening Your Skills Conference, Natick, Massachusetts, November 19, 2019

"Developing a Community-Based, Comprehensive Falls Prevention Program in Collaboration with Primary Care" within Dartmouth Centers for Health and Aging symposium, "Implementing the 4Ms in Primary Care: Building an Age-Friendly Health System", Gerontological Society of America Annual Scientific Meeting, Austin, Texas, November 16, 2019

"Ready, Steady, Balance: Effective Strategies to Reduce Falls in Older Adults, 2019 New England Rural Health Conference, Bethel, Maine, November 6, 2019

"Balance Days: Strategies to Enhance Participant Referrals: Screen, Engage, Recruit, and Prevent Falls!" , co-presented Age + Action Conference, Washington, D.C., June 20, 2019

"Tai Ji Quan: Moving for Better Balance®: New Tips and Strategies for Success", Age + Action Conference, Washington, D.C., June 19, 2019

"Ready, Set....Site Readiness in the Implementation of Programs that are Difficult to Implement", co-presented Age + Action Conference, Washington, D.C., June 18, 2019

"Emergency department Older Adult Falls Initiative and New Opportunities for Referral", NH Falls Task Force Quarterly meeting, Concord, New Hampshire, June 4, 2019

"Screening Measurements" Collaboratory Research Methods Seminar, Dartmouth Centers for Health and Aging, Lebanon, New Hampshire March 21, 2019

"Falls Prevention Program Update – 2018", co- presented, NH Falls Task Force Data Meeting, Concord New Hampshire, March 5, 2019

"Older Adult Falls Prevention Initiatives", Population Health team meeting, Lebanon, New Hampshire, March 1, 2019

"Older Adult Falls Prevention: DHMC, Local Community, Statewide and National Initiatives", Geriatric Resource Safety Champions Presentation, January 28, 2019

"Older Adult Falls Prevention: DHMC, Local Community, Statewide and National Initiatives", Special Nursing Grand Rounds, Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire, January 17, 2019

"Reducing Falls in Older Adults", lecture for Medical Assistant Training Program, Sponsored by the Institute for American Apprenticeships (IAA), Lebanon, New Hampshire, November 20, 2018

"A Pilot Study of a Multicomponent Obesity Intervention in Older Rural Adults with Obesity", co-presented poster presentation, Gerontologic Society of America Conference, Boston, MA, November 15, 2018

"Vestibular Rehabilitation: Treating Dizziness, Headache and Balance Deficits Following Concussion" Saint Anselm College Nursing Pediatric Symposium, Manchester, New Hampshire, November 6, 2018

"Understanding Falls Risk & Falls Prevention Opportunities in the Upper Valley", presented by Dawna Pidgeon to the Aging in Community Forum Quarterly Meeting, sponsored by the Upper Valley Public Health Council, Lebanon, New Hampshire, 9/19/18

"Collaborative Initiatives to Prevent Older Adult Falls in the Upper Valley", presented to the Upper Valley Elder Forum, Lebanon, New Hampshire, June 15, 2018

"Tai Ji Quan: Moving for Better Balance Updates", presentation at the National Council on Aging Center for Healthy Aging Annual Meeting, Arlington, Virginia, May 22, 2018

"Ready, Set....Site Readiness in the Implementation of Evidence-Based Falls Risk Reduction Programs", co-presented at the National Council On Aging Center for Healthy Aging Annual Meeting, Arlington, Virginia, May 22, 2018

"Reducing Falls in Older Adults", lecture for Medical Assistant Training Program, Sponsored by the Institute for American Apprenticeships (IAA), Lebanon, New Hampshire, May 9, 2018

"Dartmouth Centers for Health and Aging Fall Prevention Grant Update", co-presented at the Annual NH Falls Task Force Data Meeting, Concord, New Hampshire, March 6, 2018

"New Hampshire Falls Risk Reduction Task Force Initiatives", Panel presentation and discussion, New England Learning Collaborative Webinar, February 20, 2018

"Best Practice in Community Based Screening Events", Massachusetts Prevention Wellness Trust Fund-ASTHO workshop, Framingham, Massachusetts, January 30, 2018

"Reducing Falls in Older Adults", lecture for Medical Assistant Training Program, Sponsored by the Institute for American Apprenticeships (IAA), Lebanon, New Hampshire, December 18, 2017

"Physical Therapy for Geriatric Patients", DHMC Geriatric Clinical Competencies, Lebanon, New Hampshire, December 4, 2017

"Vestibular Rehabilitation: Treating Dizziness, Headache, and Balance Deficits" session from Current Concepts in Sports Concussion seminar, Lebanon, New Hampshire, September 7, 2017

"Dartmouth-Hitchcock Health and New Hampshire Community Based Fall Prevention", presented to D-H Community Health and community aging teams, Lebanon, New Hampshire, July 12, 2017

"New Hampshire Community Based Fall Prevention", Tri- State Learning Collaborative Webinar, March 30, 2017

"Administration for Community Living (ACL) Implementation Grant: Tai Ji Quan: Moving for Better Balance® and A Matter of Balance", NH Falls Task Force Annual Data Meeting, Concord, New Hampshire, March 7, 2017.

"Balance Days: Falls Screening and Program Recruitment", Massachusetts Prevention Wellness Trust Fund Webinar: Recruitment and Reimbursement after the PWTF, January 24, 2017

"Fall Risk Reduction in Older Adults", The Case Management Society of New England's 27th Annual Conference & Exhibitor Expo: New Frontiers of Technological Advancement-Reshaping Case Management Practice, Boxboro, Massachusetts, October 6, 2016

"Community Based Fall Prevention Best Practice" NH Association of Senior Centers Fall Conference, Concord, New Hampshire, September 30, 2016

"New Hampshire Fall Risk Reduction Collaborations: NH Falls Grants, Tai Ji Quan: Moving for Better Balance ®, and Balance Days Falls Screens", Annual NH Falls Task Force- NNEGEC Conference, Bedford, New Hampshire, September 15, 2016

"Balance Days: Falls Screening and Program Recruitment", NCOA Falls Prevention Awareness Day Webinar; Innovations to Promote and Sustain Evidence Based Programs, August 10, 2016

"Tai Ji Quan: Moving for Better Balance®", Annual NH Falls Task Force-NNEGEC conference, Bedford, New Hampshire, June 11, 2016

"Tai Ji Quan: Moving for Better Balance®", NCOA Center for Health Aging CDSME and Falls Prevention National Resource Meeting, Alexandria, Virginia, May 24, 2016

"Balance Days: A Novel Approach to Improve Rates of Community-Based Falls Risk Screening and Referral", co-Author, Poster Presentation, American Geriatrics Society Annual Scientific Meeting, Long Beach California, May 20, 2016

"Practical Pearls in Managing Older Adults with Obesity: Physical Activity in Older Adults", American Geriatrics Society Annual Scientific Meeting, National Harbor, Maryland, May 15, 2015

"A Program Evaluation of Parkinson Community Wellness Programs", co-author poster presentation, APTA Combined Sections Meeting, Indianapolis, Indiana, February 7, 2015

"Optimizing Aging: Health and Wellness Strategies that Work" New Hampshire Falls Risk Reduction Task Force breakout presentation and panel, Northern New England Tri-State Round Table, NH Endowment for Health sponsor, Portsmouth, New Hampshire, November 18, 2014

"Living with Essential Tremor: Strategies to Improve Function", International Essential Tremor Foundation Workshop, Concord, New Hampshire, November 14, 2014

"Tai Ji Quan: Moving for Better Balance", New Hampshire Falls Risk Reduction Task Force and Northern New England Geriatric Education Center Annual Conference, Bedford, New Hampshire, June 19, 2014

"Balance and Fall Risk Assessment and Intervention", APRN Geriatric Boot Camp, Northern New England Geriatric Education Center series, Lebanon, New Hampshire, April 16, 2014

"The Evolution of an Emergency Room Falls Screening Process", Poster Presentation, NH Falls Risk Reduction Task Force and Northern New England Geriatric Education Center annual falls conference: Falls and Emergency Medicine, Concord, New Hampshire, June 24, 2013

"Slips, Trips, and Falls...Avoid Them All!" New Hampshire Statewide Chronic Disease Conference 2013: Integrated Approaches to Chronic Disease Prevention and Management, Concord, New Hampshire, May 23, 2013

"Balance and Fall Risk Assessment and Intervention", RN Geriatric Boot Camp, Northern New England Geriatric Education Center series, Lebanon, New Hampshire February 12, 2013

"Case Presentation from DHMC Falls Clinic", Geriatrics Planning Committee meeting, Dartmouth Centers for Health and Aging, Lebanon, New Hampshire, December 12, 2012

"New Tools for Balance and Falls Risk Assessments", The Current Science of Brain Injury and Rehabilitation workshop, Dartmouth Hitchcock Medical Center/Northern New England Geriatric Education Center workshop, Lebanon, New Hampshire, September 18, 2012

"Treatment of Persistent Vestibular Problems after Concussion", Vermont American Physical Therapy Association's concussion series, Rutland, Vermont, June 12, 2012

"Exercise and its Importance in the Obese Elder, from Management of the Geriatric Patient with Obesity" co-presentation with John Batsis, MD and Laura Barre, MD, New England Society of General Internal Medicine Regional Meeting, Portland, Maine, March 9, 2012

"Geriatric Interdisciplinary Falls Clinic", Geriatrics Planning Committee meeting, co-presented with Ellen Flaherty, APRN, Lebanon, New Hampshire, June 20, 2011

"Promoting Mobility and Enhancing Function", Geriatrics Update Conference, Northern New England Geriatric Education Center, Lebanon, New Hampshire, November 30, 2010

"Evaluation and Treatment of BPPV: An Evidence Based Approach", Vermont APTA, Stowe, Vermont, October 22, 2010

"Pilot Study of a New Technology to Reduce Falls from Slips and Trips in Older Adults", poster presentation, APTA National Conference, Boston, Massachusetts, June 16, 2010

"Fall Risk Reduction in the Older Adult", New Hampshire LPN Annual Conference, Lebanon, New Hampshire, May 4, 2010

"NH Falls Task Force Update", Massachusetts Falls Coalition Regional Conference, Worcester, Massachusetts, May 19, 2009

"Falls Assessment and Prevention: Best Practice in Community Based Setting", sponsored by Northern New England Geriatric Education Center, Lebanon, New Hampshire, December 16, 2008

"Geriatric Risk Assessment for Falls: an Adult Interdisciplinary Clinic", Poster Presentation, APTA Annual Conference & Exposition, Denver, Colorado, June 27-30th, 2007

"Reducing Falls In the Elderly", New Hampshire APTA Thursday Evening Lecture Series, Concord, New Hampshire, January 18, 2007

"Vitamin D Deficiency, Effects and Recommendations", DHMC and Dartmouth Hitchcock Alliance Rehabilitation departments' workshop, Lebanon, New Hampshire, June 26, 2006

"Geriatric Risk Assessment for Falls: an Adult Interdisciplinary Clinic", Poster Presentation at NH Falls Risk Reduction Task Force Conference: Evidence Based Falls Risk Reduction in the Elderly, Lincoln, New Hampshire, June 2, 2006

"Intervention Strategies for Fall Risk Reduction", Central Vermont Hospital Visiting Nurses workshop, Barre, Vermont, September 27, 2005

"An Evidence-Based Approach to the Examination and Management of Falling in the Elderly", Case Study presentation and panel member, APTA Annual Conference & Exposition, Boston, Massachusetts, June 10, 2005

"Falls Risk Assessment and Intervention", Gerontology Update: 2005 workshop, Lebanon, New Hampshire, April 11, 2005

" NH DHHS and DHMC Falls Risk Reduction Task Force", DHMC and Dartmouth Hitchcock Alliance Rehabilitation staff workshop, Lebanon, New Hampshire, April 4, 2005

"Falls Risk Assessment and Intervention", Visiting Nurse Alliance of VT and NH workshop, Springfield, Vermont, November 4, 2004, Lebanon, NH, October 28, 2004

"Falls Assessment and Risk Reduction", NH Association of Residential Care Homes Annual Fall Convention, Concord, New Hampshire, November 5, 2003

"Prevention by the Numbers, NH Falls Risk Reduction Task Force Pilot Project", NH Falls Risk Reduction Task Force multidisciplinary workshop, September 30, 2003

"The New Hampshire Falls Risk Reduction Task Force", New Hampshire Osteoporosis Council meeting, Concord New Hampshire, June 16, 2003

"Slips, Trips and Falls-Avoid them all: Designing and Implementing a Community Based Multifactorial Falls Reduction Intervention Program", Poster Presentation, APTA Combined Sections Meeting, Tampa, Florida, February 15, 2003

"Treatment of Migraine Related Dizziness", Vestibular and Balance Rehabilitation conference, Lebanon, New Hampshire, April 27, 2002

"Slips, Trips and Falls, A Falls Risk Reduction Program", New Hampshire Falls Risk Reduction Task Force multidisciplinary workshop, Manchester, New Hampshire, March 23, 2002

"Balance Issues in the Elderly", New Hampshire Rehab Administrators workshop, presentation to rehabilitation professionals, Rochester, New Hampshire, March 31, 2001

"Vestibular Dysfunction: Evaluation and Treatment", New Hampshire APTA Evening Lecture Series, Concord New Hampshire, May 24, 2001

"Improving Physical Therapy Access: A must in Today's Healthcare Environment", APTA National Conference, Platform Presentation, Indianapolis, Indiana, June 15, 2000

"Treatment of Migraine-Related Dizziness with Vestibular Exercises and Manual Therapy: A Case Study", Poster Presentation, APTA Combined Sections, Dallas, Texas, February 14, 1997

Mary Hitchcock Memorial Hospital / Dartmouth Hitchcock

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Raymond Leduc, A	Program Manager	$78,797.00	.40	$31,519
Simonds, A.	Program Assistant	$48,630.40.	.25	$12,158
Esdon, J.	Program Coordinator	$68,452.80	.15	$10268
Vacant	Data Specialist	$57,886.40	.50	$28,943
Dawna Pidgeon	NH Falls Task Force Lead	$107,099.20	.15	$16,065