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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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July 21, 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 MaineHealth d/b/a Northern New England Poison Center (VC#177129-B003), Portland, ME, in the amount of $1,197,000 to operate and manage the poison information and control hotline services, with the option to renew for up to two (2) additional years, effective retroactive to July 1, 2022, upon Governor and Council approval, through June 30, 2024. 7% Federal Funds. 89% General Funds. 4% Other Funds (Poison Control Center).

Funds are available in the following accounts for State Fiscal Year 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.

005-95-90-902010-1228 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF COMM & HEALTH SERV, POISON CONTROL CENTER – 100% General Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	102-500731	Contracts for Prog Svc	90001228	$520,000
2024	102-500731	Contracts for Prog Svc	90001228	$520,000
			Subtotal	***$1,040,000***

05-95-90-902510-1114 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF DISEASE CONTROL, PH EMERGENCY PREPAREDNESS – 69% Federal Fund & 31% General Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	102-500731	Contracts for Prog Svs	90077410	$43,500
2024	102-500731	Contracts for Prog Svs	90077410	$43,500
			Subtotal	***$87,000***

05-95-90-903010-8280 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF LABORATORY SERVICES, BIOMONITORING GRANT – 100% Federal Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	102-500731	Contracts for Prog Svc	90082801	$10,000
2024	102-500731	Contracts for Prog Svc	90082801	$10,000
			Subtotal	***$20,000***

05-95-90-902010-1228 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF COMM & HEALTH SERV, POISON CONTROL CENTER – 100% Other Funds

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	102-500731	Contracts for Prog Svc	90079102	$25,000
2024	102-500731	Contracts for Prog Svc	90079102	$25,000
			Subtotal	***$50,000***
			Total	**$1,197,000**

EXPLANATION

The Department originally sent the contract to the Contractor to sign in May 2022. However, this request is **Retroactive** because the contract negotiation process took longer than anticipated. The Department is requesting this item be retroactive to July 1, 2022 to ensure there is no lapse in services being provided to the public.

This request is **Sole Source** because the Contractor is the only Contractor that provides poison information and control hotline services in the northern New England region that is accredited by the American Association of Poison Control Centers. The Contractor's service area includes Maine, Vermont, and New Hampshire.

The purpose of this request is to ensure the availability of poison information and control hotline services through the utilization of the national toll free call number established by the American Association of Poison Control Centers. The Contractor will provide medical consultation to New Hampshire residents and health care providers on a twenty-four (24) hour per day, seven (7) days a week basis and has the capacity to respond to approximately twelve thousand (12,000) calls per year.

Poison control services are critical because unintentional and intentional poisonings are a significant public health problem in New Hampshire. These poison information services reduce unnecessary and costly utilization of emergency response, emergency department, and primary health care services. Researchers have estimated that poison center services nationally save about thirteen dollars ($13.39) in health care costs for every one dollar ($1.00) spent.

In State Fiscal Years 2023 and 2024, the Department anticipates the poison control hotline will handle more than 10,000 cases in New Hampshire, including over 9,000 cases that may involve human exposures to poison that could generate more than 11,000 follow-up calls.

Historically, approximately 22% of the human exposure cases were generated by calls from health care facilities. These cases tend to be more serious and require follow-up calls. The Contractor will also:

- Field calls related to poisonings in children under 6 years of age from homes and schools that can be treated on-site with poison center advice, thus saving the expense of a doctor's office or emergency department visit.
- Address calls related to suspected suicide and substance abuse-related poisonings.
- Field calls related to poisonings in adults sixty (60) years and older.
- Distribute educational materials and provide virtual or in-person outreaches, media interviews and one-on-one meetings to educate the general public, health care providers, social service providers, legislators, the media, educators and others.
- Attend quarterly Injury Prevention Advisory Counsel (IPAC) meetings.
- Provide expert guidance to the Department during bioterrorism or public health emergencies that may have a poisoning component, and provide appropriate messaging to assist the public during these types of events.

As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up 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 Executive Council not authorize this request, poison control services would not be available to New Hampshire residents through the national toll free hotline, which may increase health care costs due to individuals going to emergency rooms for potentially non-emergent matters.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number #93.069, FAIN #NU90TP22018 and Assistance Listing Number #93.070, FAIN #NU88EH01327.

The Department will not request additional General Funds in the event that Federal Funds are no longer available and services are still needed.

Respectfully submitted,

Ann dow. Landry
For Lori A. Shibinette
Commissioner

FORM NUMBER P-37 (version 12/11/2019)

Subject: Poison Control Services (SS-2023-DPHS-01-POISON-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 MaineHealth d/b/a Northern New England Poison Center		1.4 Contractor Address 22 Bramhall Street, Portland, ME 04102	
1.5 Contractor Phone Number (207) 662-3538	1.6 Account Number 05-95-090-902010-1228; 05-95-90-902510-1114; 05-95-90-903010-8280	1.7 Completion Date 6/30/2024	1.8 Price Limitation $1,197,000
1.9 Contracting Officer for State Agency Robert W. Moore, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Albert G. Swallow III 295EB02AB6144AB... Date: 7/25/2022		1.12 Name and Title of Contractor Signatory Albert G. Swallow III CFO	
1.13 State Agency Signature DocuSigned by: Patricia M. Tilley 840FB38F3BFD4C8... Date: 7/25/2022		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 748734844941460...		On: 7/29/2022	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

Contractor Initials DS AGS
Date 7/25/2022

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 7/25/2022

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 July 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 to 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 9, Subparagraph 9.1, Termination, is amended as follows:

      9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by ninety (90) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

   1.4. 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 if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

   1.5. Paragraph 18, Choice of Law and Forum, is amended as follows:

      18. 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.

New Hampshire Department of Health and Human Services
Poison Control Services

EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall provide poison control hotline services twenty-four (24) hours per day, seven (7) days per week, 365 days per year by utilizing the national toll-free call number, 1-800-222-1222, as established by the American Association of Poison Control Centers, which routes phone calls to the respective regional poison control centers, for both the public and health care professionals regarding poisoning emergencies and basic poison prevention non-emergencies.

1.2. The Contractor shall maintain the capacity to respond to more than 12,000 calls per year. including, but not limited to:

1.2.1. Responding to calls from the general public and determining whether the case is emergent, requiring emergency medical services, or non-emergent and can be addressed with home-based treatment.

1.2.2. Informing the receiving hospital emergency department that the patient is coming upon determining the case is emergent and requires emergency services. The Contractor shall:

1.2.2.1. Describe the poison, circumstance, expected effects, and recommended management to the emergency department.

1.2.2.2. Consult with the health care providers managing the patient to determine ongoing needs.

1.2.2.3. Monitor the patient's case according to their needs throughout the course of treatment and revise clinical approach, as needed, during the assessment and reassessment process.

1.2.3. Providing primary support to non-emergent cases in the home setting including, but not limited to:

1.2.3.1. Responding to inquiries for general information about household poisons.

1.2.3.2. Responding to inquires about medication errors in the home that do not require a doctor's care.

1.2.3.3. Responding to inquires about non-medication related poisonings that occur at home that do not require a doctor's care.

1.2.3.4. Ensure that the patient is aware that the call is being recorded and that privacy is being protected.

1.2.4. Supporting primary prevention efforts by distributing messages through partners, the news media and the internet regarding how to

avoid poisoning. The Contractor shall distribute messaging on topics during specific time periods and/or events, including, but not limited to:

1.2.4.1. Carbon monoxide and food safety risks during power outages.

1.2.4.2. Common medication errors.

1.2.4.3. Safe pesticide use.

1.2.4.4. Mushroom ingestion from the spring through the fall.

1.2.4.5. Holiday hazards.

1.2.4.6. Safe storage and disposal of medications and chemicals.

1.2.5. Supporting secondary prevention efforts by promoting awareness of the services provided by the Northern New England Poison Center among the public so that patients and their families know to call a poison center quickly after a possible poisoning occurs. The Contractor shall disseminate messaging through multiple distribution channels that includes but is not limited to presentations, brochures, and social media. Messaging shall include, but is not limited to:

1.2.5.1. Child exposure to plants, mushrooms, cleaners, personal care products, or medication at home with instructions on home management and follow-up when it is safe to do so.

1.2.5.2. Older adults exposure to double dosing of heart or diabetes medications that can often be safely managed at home by working with the patient and their family to monitor heart rate, blood pressure and blood glucose.

1.2.5.3. Tertiary prevention, which is the prevention of disease progression after an injury or event has occurred, that is more applicable to health care facility cases in which poison center staff can mitigate the severity of the poisoning and shorten the hospital course.

1.2.6. Increasing human exposure case calls from health care facilities by providing in-person and online education by poison center educators and toxicologists, as well as developing electronic materials to educate and encourage consultation.

1.3. The Contractor shall:

1.3.1. Record all Northern New England Poison Center call data in the Toxicall system. The Toxicall system shall not be configured to permit sharing of identifiable Department data outside of the contiguous United States.

1.3.2. Ensure that all individuals whose identifiable information is recorded, stored, or maintained in the Toxicall system have provided consent and notice of privacy practices consistent with Section 1.2.3.4.

1.3.3. Not permit the use of personal devices by its workforce in the fulfillment of this contract.

1.3.4. Transfer hotline call data multiple times per hour to the National Poisoning Data System, which is operated by the American Association of Poison Control Centers.

1.3.5. Agree to work with the Department to ensure the Toxicall and the National Poisoning Data systems meet NH DoIT IT and NH DHHS Security Requirements, including a Security Risk Assessment, prior to Department data being entered into the systems.

1.3.6. Ensure data dissemination is done with sufficient aggregation to protect patient privacy and prevent constructive identification of individuals, in accordance with Exhibit K – DHHS Information Security Requirements, unless deemed an emergency by the Department where individual level data may be required to protect public health. If a public emergency is determined by the Department then the Contractor shall agree to work with the Department to develop a Data Sharing Plan (DSP) and Data Migration Plan (DMgP), using the Departments templates, to capture, at a minimum, the scope, start and end date, and the identifiable data elements being collected, stored, and processed by the Contractor. It is understood that the Contractor shall not collect, store, administer, process or share identifiable data if it is unable to meet the terms and conditions of the DHHS Information Security Requirements Exhibit.

1.4. The Contractor shall provide a Disaster Recovery Plan (DRP) for bioterrorism and public health emergencies, including, but not limited to:

1.4.1. Providing call-surge backup to the Department, upon request by the Department, which shall include, but is not limited to:

1.4.1.1. Developing appropriate messaging in collaboration with the Department for both the general public and health care professionals.

1.4.1.2. Distributing the created messaging to and educating the Contractor's personnel as necessary.

1.4.1.3. Answering calls on the designated toll free line and triaging calls in order of severity.

1.4.1.4. Requesting that all available personnel assist, whether through over time or by answering calls in lieu of other duties.

1.4.1.5. Providing a clinical toxicologist to assist with calls requiring a higher level of technical expertise.

1.4.1.6. Providing a medical director to provide supervision and assist all personnel who are responding to increased inquiries related to poisonings during a bioterrorism or public health emergency.

1.4.1.7. Entering all cases into the Northern New England Poison Center data collection system in real time and reporting aggregated data to the Department hourly, daily, or as otherwise required. The Contractor shall collect the following data:

1.4.1.7.1. Date of call.

1.4.1.7.2. Site of caller, including, but not limited to, a health care facility, school, workplace, first responder, or residence.

1.4.1.7.3. Patient's age group.

1.4.1.7.4. Patient's gender.

1.4.1.7.5. Type of poison.

1.4.1.7.6. Method of exposure to the poison, including, but not limited to, ingestion, dermal, or inhalation.

1.4.1.7.7. Place of exposure to the poison, including, but not limited to, home, work, school, or public place.

1.4.1.7.8. Reason for call, including, but not limited to, self-harm and/or suicide attempt, medication error, unintentional poisoning, environmental poisoning, or general information request.

1.4.1.7.9. Site of exposure management, including, but not limited to, health care facility, ambulance, on-site, or school nurse's office.

1.4.1.7.10. Result of the exposure, including, but not limited to, minimal effect, severe effect, or death.

1.4.2. Collaborating with the Department to identify and share surveillance data from poison control center activities that may serve as early warning data for public health threats and emergencies with specific target audiences as determined by the Department.

1.4.3. Providing ongoing education, including emergency preparedness and response training, as requested by the Department for specific target audiences as determined by the Department.

1.5. The Contractor shall collaborate with the Department to develop New Hampshire Health Alert Network notifications related to poisoning for both drills and actual events.

1.6. The Contractor shall provide information on emergent issues to the New Hampshire Health Alert Network, the Department, and other New Hampshire stakeholders, that includes, but is not limited to, protocol and management of treatment for poisonings with an elevated occurrence.

1.7. The Contractor shall maintain a list of statewide locations, such as health care centers and hospitals where antidotes may be dispensed, and ability for mobilization of poison antidotes as requested by the Department.

1.8. The Contractor shall support the Department's response team on emergent chemical contamination issues, including, but not limited to, assisting the public with understanding laboratory reports by answering hotline calls and/or sending an educator to speak to community member groups.

1.9. The Contractor shall review poisoning cases with medical or clinical board-certified toxicologists, as needed.

1.10. The Contractor shall maintain, at a minimum, staffing consistent with accreditation requirements through the American Association of Poison Control Centers.

1.11. The Contractor shall coordinate education activities and strategies with the Department's Injury Prevention Program, including participating as a member of the Injury Prevention Advisory Council.

1.12. The Contractor shall provide a Poison Educator, whose responsibilities shall include, but are not limited to:

1.12.1. Collaborating with the Injury Prevention Program on poison prevention strategies in accordance with the NH State Violence and Injury Prevention Plan 2020-2025[1].

1.12.2. Meeting with the Injury Prevention Program Manager, either in person or by telephone, at least once per month to discuss activities conducted during the previous month and planned activities.

1.12.3. Presenting at or acting as a panel member for numerous community sessions related to decreasing substance abuse including, but not limited to Alcoholics Anonymous meetings and/or Department meetings with the public.

[1] https://www.dhhs.nh.gov/dphs/bchs/mch/documents/nh-vip-plan-2020-2025.pdf

1.12.4. Providing educational sessions and other outreach for the general public, health care providers, educators, legislators, members of the media, and others.

1.12.5. Attending injury prevention meetings in New Hampshire that include a poisoning prevention component, which may include community meetings and/or Department meetings.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

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 ensure the method used to de-identify and/or aggregate all data shall prevent constructive identification of any individual.

3.2. The Contractor shall report aggregate, de-identified data in a format as requested by the Department, as follows:

3.2.1. A monthly report on opioid-related poisoning calls, or as requested by the Department, to be submitted to the Department's Injury Prevention Program.

3.2.2. A quarterly report on progress toward performance measures and call activity data, including call data specified above in Subparagraph 1.4.1.7., to the Department's Injury Prevention Program.

3.2.3. An annual report on progress toward performance measures and call activity, including call data specified above in Subparagraph 1.4.1.7., to the Department's Injury Prevention Program.

3.2.4. Call information on poisoning topics within three (3) business days upon requested by the Department for legislative briefings and/or media queries. Upon receiving these types of requests, the Contractor shall contact the Department's Public Information Office (PIO) to keep the PIO informed regarding the data requested and by whom.

4. Performance Measures

4.1. The Contractor shall ensure that following performance indicators are achieved annually and monitored monthly. The Contractor shall:

4.1.1. Maintain an overall, age-adjusted annual penetrance for human exposure cases of 7.2, equal to, or greater than the national age-adjusted penetrance.

4.1.2. Send the Contractor's Poison Educator or other representative to at least ninety percent (90%) of the monthly Injury Prevention Advisory Council Meetings.

4.1.3. Ensure the Poison Educator presents or attends as a panel member during at least ten (10) educational or community outreach opportunities per year.

4.1.4. Regarding call rate, ensure that:

4.1.4.1. For all non-emergent cases, for all callers, at least ninety percent (90%) are managed in the home setting to decrease health care costs.

4.1.4.2. For all non-emergent cases regarding children under age six (6) years of age, at least ninety percent (90%) are managed at home.

4.1.4.3. For all non-emergent cases for adults age sixty (60) years and older, who are living independently in the community, at least ninety percent (90%) are managed at home.

4.1.5. The Contractor shall maintain or exceed the percentage of human poisoning exposure cases managed at health care facilities at a baseline of twenty-three percent (23%) of all calls.

4.1.6. The Contractor shall respond to Department notification alerts sent during quarterly drills within thirty (30) minutes, one hundred percent (100%) of the time.

4.2. Annually, the Contractor shall develop and submit a corrective action plan to the Department for any performance measure that was not achieved.

5. Additional Terms

5.1. Impacts Resulting from Court Orders or Legislative Changes

5.1.1. 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.

5.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate

Programs and Services

5.2.1. 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.

5.3. Credits and Copyright Ownership

5.3.1. 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."

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

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

5.3.3.1. Brochures.

5.3.3.2. Resource directories.

5.3.3.3. Protocols or guidelines.

5.3.3.4. Posters.

5.3.3.5. Reports.

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

6. Contract End-of-Life Transition Services

6.1. If applicable, upon termination or expiration of the Contract the Parties agree to cooperate in good faith to effectuate a smooth secure transition of the Services from the Contractor to the Department and, if applicable, the Vendor engaged by the Department to assume the Services previously performed by the Contractor for this section the new vendor shall be known as "Recipient"). Contract end of life services shall be provided at no additional cost. Ninety (90) days prior to the end-of the contract or unless otherwise specified by the

Department, the Contractor shall begin working with the Department and if applicable, the new Recipient to develop a Data Transition Plan (DTP). The Department shall provide the DTP template to the Contractor.

6.2. The Contractor shall use reasonable efforts to assist the Recipient, in connection with the transition from the performance of Services by the Contractor and its Affiliates to the performance of such Services. This may include assistance with the secure transfer of records (electronic and hard copy), transition of historical data (electronic and hard copy), the transition of any such Service from the hardware, software, network and telecommunications equipment and internet-related information technology infrastructure ("Internal IT Systems") of Contractor to the Internal IT Systems of the Recipient and cooperation with and assistance to any third-party consultants engaged by Recipient in connection with the Transition Services.

6.3. If a system, database, hardware, software, and/or software licenses (Tools) was purchased or created to manage, track, and/or store State Data in relationship to this contract said Tools will be inventoried and returned to the Department, along with the inventory document, once transition of State Data is complete.

6.4. The internal planning of the Transition Services by the Contractor and its Affiliates shall be provided to the Department and if applicable the Recipient on a timely manner. Any such Transition Services shall be deemed to be Services for purposes of this Contract.

6.5. Should the data Transition extend beyond the end of the Contract, the Contractor and its affiliates agree Contract Information Security Requirements, and if applicable, the Department's Business Associates Agreement terms and conditions remain in effect until the Data Transition is accepted as complete by the Department.

6.6. In the event where the contractor has comingled Department Data and the destruction or Transition of said data is not feasible, the Department and Contractor will jointly evaluate regulatory and professional standards for retention requirements prior to destruction.

7. Background Checks and Screening

7.1. The Contractor shall conduct criminal background checks, at its own expense, and not utilize any staff, including subcontractors, to fulfill the obligations of the Contract who have been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or misdemeanor offense for which incarceration for up to 1 year is an authorized penalty. The Contractor shall promote and maintain an awareness of the importance of securing the State's information among the Contractor's employees and agents.

7.2. The Contractor's workforce shall not be permitted to handle, access, view, store

or discuss NH DHHS Confidential Data until an attestation is received by the Contractor that all Contractor workforce associated with fulfilling the obligations of this Contract are, based on NH DHHS provided criteria herein and their job responsibility requirements, eligible to participate in work associated with this Contract. The Contractor agrees it will initiate a criminal background check investigation of all workforce assigned to this Contract. The period will be based on the date of the last Criminal Background Check conducted by the Contractor or its Agent.

7.3. The State may, at its sole expense, conduct reference and background screening of the Contractor's Project Manager and Key Project Staff. The State shall maintain the confidentiality of background screening results in accordance with the Contract Agreement.

8. Privacy Impact Assessment

8.1. Upon request, the selected Vendor(s) must allow the Department to conduct a Privacy Impact Assessment (PIA) of systems if Department Personally Identifiable Information (PII) is collected, used, accessed, shared, or stored. To conduct the PIA the selected Vendor must provide the Department access to applicable systems and documentation sufficient to allow the Department to assess, at minimum, the following:

8.1.1. How PII is gathered and stored;

8.1.2. Who will have access to PII;

8.1.3. How PII will be used in the system;

8.1.4. How individual consent will be achieved and revoked; and

8.1.5. Privacy practices.

8.2. The Department may conduct follow-up PIAs in the event there are either significant process changes or new technologies impacting the collection, processing or storage of PII.

9. System and Information Security Plan Deliverables

9.1. The Contractor shall submit the following supporting documents in an agreed upon method to the Department no later than 30 days after contract execution.

No.	DELIVERABLE
1	Background Check Attestation
2	Systems Security Plan (SSP) (The SSP shall include security requirements of the system and describe the controls in place, or planned, for meeting those requirements. The SSP shall also delineates responsibilities and expected behavior of all individuals who access the system)
3	Disaster Recovery Plan (DRP)

4	Business Continuity of Operations Plan (COOP)
5	Certification of 3rd Party Pen Testing and Application Vulnerability Scanning.
6	Security Risk Assessment (SRA) Report o if PII is collected on behalf of the State, the SRA shall include a Privacy Impact Assessment (PIA)
7	Security Authorization Package

10. Records

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

10.1.1. 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.

10.1.2. 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.

10.1.3. 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.

10.2. 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
Poison Control Services

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 7% Federal Funding from the Biomonitoring New Hampshire Grant, as awarded on June 23, 2021, by the U.S. Department of Health and Human Services, Center for Disease Control, CFDA #93.070 FAIN#NU88EH001327 and from the NH Public Health Emergency Preparedness Program, as awarded on September 14, 2021, by the U.S. Department of Health and Human Services, Center for Disease Control, CFDA 93.069 FAIN #NU90TP22018.
   1.2. 89% General funds.
   1.3. 4% Other funds (include specific information if available).
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-2, Budget.
4. The Contractor shall submit an invoice and supporting documents to the Department no later than the fifteenth (15th) 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 dhhs.act@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 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

12.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 9 months (by June 30th) after the close of the Contractor's fiscal year.

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

Contractor Name: MaineHealth d/b/a Northern New England Poison Center

Project Title: Poison Control Services

Budget Period: July 1, 2022 - June 30, 2023 (SFY 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	$ 401,211	$ 40,121	$ 441,332	$ -	$ -	$ -	$ 401,211	$ 40,121	$ 441,332
2. Employee Benefits	$ 122,971	$ 12,297	$ 135,268	$ -	$ -	$ -	$ 122,971	$ 12,297	$ 135,268
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 5,700	$ 570	$ 6,270	$ -	$ -	$ -	$ 5,700	$ 570	$ 6,270
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ 1,734	$ 173	$ 1,907	$ -	$ -	$ -	$ 1,734	$ 173	$ 1,907
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ 2,442	$ 244	$ 2,686	$ -	$ -	$ -	$ 2,442	$ 244	$ 2,686
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ 9,333	$ 933	$ 10,266	$ -	$ -	$ -	$ 9,333	$ 933	$ 10,266
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 700	$ 70	$ 770	$ -	$ -	$ -	$ 700	$ 70	$ 770
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 544,090	$ 54,409	$ 598,500	$ -	$ -	$ -	$ 544,091	$ 54,409	$ 598,500
Indirect As A Percent of Direct		10.0%							

Contractor Initials AGS

Date 7/25/2022

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

Contractor Name: MaineHealth d/b/a Northern New England Poison Center

Project Title: Poison Control Services

Budget Period: July 1, 2023 - June 30, 2024 (SFY 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	$ 400,940	$ 40,094	$ 441,034	$ -	$ -	$ -	$ 400,940	$ 40,094	$ 441,034
2. Employee Benefits	$ 122,889	$ 12,289	$ 135,178	$ -	$ -	$ -	$ 122,889	$ 12,289	$ 135,178
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 5,700	$ 570	$ 6,270	$ -	$ -	$ -	$ 5,700	$ 570	$ 6,270
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ 1,734	$ 173	$ 1,907	$ -	$ -	$ -	$ 1,734	$ 173	$ 1,907
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ 2,516	$ 252	$ 2,768	$ -	$ -	$ -	$ 2,516	$ 252	$ 2,768
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ 9,612	$ 961	$ 10,574	$ -	$ -	$ -	$ 9,612	$ 961	$ 10,574
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 700	$ 70	$ 770	$ -	$ -	$ -	$ 700	$ 70	$ 770
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 544,091	$ 54,409	$ 598,501	$ -	$ -	$ -	$ 544,091	$ 54,409	$ 598,500
Indirect As A Percent of Direct		10.0%							

Contractor Initials AGS

Date 7/25/2022

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

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Vendor Initials _____
7/25/2022
Date _____

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: MaineHealth

7/25/2022
Date

DocuSigned by:
Albert G. Swallow III
285ED62ABC114AD...
Name: Albert G. Swallow III
Title: CFO

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: MaineHealth

7/25/2022
Date

DocuSigned by:
Albert G. Swallow III
205E807A86134AB...
Name: Albert G. Swallow III
Title: CFO

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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7/25/2022
Date

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: MaineHealth

7/25/2022
Date

DocuSigned by:
Albert G. Swallow III
205E802AB614AB...
Name: Albert G. Swallow III
Title: CFO

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contractor Name: MaineHealth

7/25/2022
Date

DocuSigned by:
Albert G. Swallow III
293EB02A8B7144B...
Name: Albert G. Swallow III
Title: CFO

Contractor Initials DS AGS
Date 7/25/2022

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: MaineHealth

7/25/2022
Date

DocuSigned by:
Albert G. Swallow III
Name: Albert G. Swallow III
Title: CFO

Contractor Initials DS
Date 7/25/2022

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	MaineHealth
The State by:	Name of the Contractor
Patricia M. Tilley	Albert G. Swallow III
846FD36F5BFD4C8...	235ED02AB0114AB...
Signature of Authorized Representative	Signature of Authorized Representative
Patricia M. Tilley	Albert G. Swallow III
Name of Authorized Representative	Name of Authorized Representative
Director	CFO
Title of Authorized Representative	Title of Authorized Representative
7/25/2022	7/25/2022
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 (UEI #)
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: MaineHealth

7/25/2022
Date

DocuSigned by:
Albert G. Swallow III
Name: Albert G. Swallow III
Title: CFO

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 UEI (SAM.gov) number for your entity is: MAYKB1LWD5U9

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

   _____ NO _____X_____ 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 _____X_____ 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: _____

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 the time specified within Section III.B of this Exhibit 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 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 61 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 MAINEHEALTH is a Maine Nonprofit Corporation registered to do business in New Hampshire as NORTHERN NEW ENGLAND POISON CENTER on February 21, 2008. 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: **591877**

Certificate Number: **0005789798**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 10th day of June A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATE OF AUTHORITY

I, Beth Kelsch, being the duly elected Secretary of MaineHealth Services, a corporation organized and existing under and by virtue of the Laws of the State of Maine (hereinafter called this Corporation) do hereby certify as follows:

1. The Chief Executive Officer/President or the Treasurer has the authority to execute deeds, contracts and other documents on behalf of the Corporation pursuant to Section 11.1 of the Corporation's bylaws which remain in full force and effect on the date hereof as follows:

> Execution of Papers. All deeds, leases, transfers, contracts, bonds, notes, checks, drafts and other obligations made, accepted or endorsed by the Corporation shall be signed by the CEO/President or the Treasurer, or by persons designated in writing by the CEO/President or Treasurer, except that the Board of Trustees may by resolution restrict such power or authorize others to execute such documents.

2. Each of the following officers has been duly elected or appointed and is now legally holding the office opposite his or her name:

NAME	OFFICE
Dr. Andrew T. Mueller	Chief Executive Officer/President
Albert G. Swallow, III	Treasurer

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

DATED: July 19, 2022

Beth Kelsch, Secretary

CERTIFICATE OF AUTHORITY

I, Beth Kelsch, being the duly elected Secretary of MaineHealth, a corporation organized and existing under and by virtue of the Laws of the State of Maine (hereinafter called this Corporation) do hereby certify as follows:

1. The Chief Executive Officer/President or the Treasurer has the authority to execute deeds, contracts and other documents on behalf of the Corporation pursuant to Section 11.1 of the Corporation's bylaws which remain in full force and effect on the date hereof as follows:

> Execution of Papers. All deeds, leases, transfers, contracts, bonds, notes, checks, drafts and other obligations made, accepted or endorsed by the Corporation shall be signed by the CEO/President or the Treasurer, or by persons designated in writing by the CEO/President or Treasurer, except that the Board of Trustees may by resolution restrict such power or authorize others to execute such documents.

2. Each of the following officers has been duly elected or appointed and is now legally holding the office opposite his or her name:

NAME	OFFICE
Dr. Andrew T. Mueller	Chief Executive Officer/President
Albert G. Swallow, III	Treasurer

3. This authority remains valid for thirty (30) days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

DATED: July 28, 2022

Beth Kelsch, Secretary

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/01/2021

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 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
Medical Mutual Insurance Company of Maine
One City Center PO Box 15275
Portland, ME 04112

CONTACT NAME:
PHONE (A/C, No, Ext): 2077752791 FAX (A/C, No): 2075238320
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Medical Mutual Ins Co of Maine	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
MaineHealth Services
110 Free Street
Portland ME 04101

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	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR			ME CHL 004693	10/01/2021	10/01/2022	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [ ] LOC						GENERAL AGGREGATE	$ 12,000,000
							PRODUCTS - COMP/OP AGG	$ 12,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE						EACH OCCURRENCE	$
	DED [ ] RETENTION $						AGGREGATE	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [ ] N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE [ ] OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			ME CHL 004693	10/01/2021	10/01/2022	$2,000,000/$12,000,000	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

It is hereby understood and agreed that Northern New England Poison Control of MaineHealth is covered as an additional insured under the above described policy

CERTIFICATE HOLDER

State of NH
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, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Frank W Lavoie

DocuSign Envelope ID: 6C5572F1-7946-4C0B-892A-7AB0A4C6EC50

MAINE

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/13/2022

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Mary Roy
USI Insurance Services, LLC 75 John Roberts Road, Building C South Portland, ME 04106 855 874-0123	PHONE (A/C, No, Ext): 855 874-0123 FAX (A/C, No): 877-775-0110 E-MAIL ADDRESS: Mary.Roy@usi.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Phoenix Insurance Company — 25623
INSURED MaineHealth Services 22 Bramhall Street Portland, ME 04102-3175	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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [N] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		UB5K2905132243G	03/01/2022	03/01/2023	X PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

This certificate is issued for insured operations usual to MaineHealth Services.

CERTIFICATE HOLDER

State of NH
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, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

HZBCX

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MaineHealth

Mission and Vision

Our Vision

Working together so our communities are the healthiest in America.

Our Mission

MaineHealth is a not-for-profit health system dedicated to improving the health of our patients and communities by providing high-quality affordable care, educating tomorrow's caregivers, and researching better ways to provide care.

BAKER NEWMAN NOYES

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

Consolidated Financial Statements
and Supplemental Information

For the Years Ended September 30, 2021 and 2020
With Independent Auditors' Report

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL FINANCIAL INFORMATION

For the Years Ended September 30, 2021 and 2020

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BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE I MASSACHUSETTS I NEW HAMPSHIRE
800.244.7444 I www.bnncpa.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
MaineHealth Services and Subsidiaries

We have audited the accompanying consolidated financial statements of MaineHealth Services and Subsidiaries, which comprise the consolidated balance sheets as of September 30, 2021 and 2020, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these 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 these 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 the auditors' 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, the auditor considers internal control relevant to the entity'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 entity'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.

Board of Directors
MaineHealth Services and Subsidiaries

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of MaineHealth Services and Subsidiaries as of September 30, 2021 and 2020, and the results of their operations, changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter - Report on Supplemental Consolidating Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The 2021 supplemental consolidating information is presented for the purpose of additional analysis and is not a required part of the consolidated financial statements. Such supplemental consolidating information is the responsibility of MaineHealth Services' management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. This information has been subjected to the auditing procedures applied in our 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, based on our audit, such supplemental consolidating information is fairly stated in all material respects in relation to the consolidated financial statement as a whole.

Baker Newman + Noyes LLC

Portland, Maine
February 4, 2022

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED BALANCE SHEETS

September 30, 2021 and 2020
(In thousands)

Assets	2021	2020
Current assets:		
Cash and cash equivalents	$ 435,441	$ 547,872
Investments	1,195,752	868,416
Accounts receivable	367,554	286,156
Current portion of investments whose use is limited	200,695	256,272
Inventories, prepaid expenses and other current assets	147,717	120,312
Total current assets	2,347,159	2,079,028
Investments whose use is limited by:		
Debt agreements	198,255	253,844
Board designation	155,405	139,138
Self-insurance trust agreements	47,006	49,904
Specially designated specific purpose funds	77,827	77,077
Plant replacement funds	1,648	961
Funds functioning as endowment funds	156,219	133,328
Pooled life income funds	2,546	2,417
Beneficial interest in perpetual and charitable remainder trusts	56,782	48,302
	695,688	704,971
Less current portion	(200,695)	(256,272)
	494,993	448,699
Property, plant and equipment - net	1,445,798	1,396,118
Right of use assets	160,178	176,780
Other assets	184,173	171,549
Total assets	$ 4,632,301	$ 4,272,174

Liabilities and Net Assets	2021	2020
Current liabilities:		
Current portion of long-term debt	$ 41,994	$ 42,842
Current portion of lease obligation	17,406	21,079
Accounts payable and other current liabilities	378,361	210,735
Accrued payroll, payroll taxes and amounts withheld	101,392	62,500
Accrued earned time	106,852	90,149
Accrued interest payable	6,374	5,737
Estimated amounts payable under reimbursement regulations	57,925	52,265
Self-insurance reserves	34,888	33,877
Deferred revenue	17,080	16,202
Total current liabilities	762,272	535,386
Accrued retirement benefits	296,716	411,113
Self-insurance reserves – less current portion	55,136	46,209
Estimated amounts payable under reimbursement regulations	–	4,984
Long-term debt, less current portion	755,585	797,595
Long-term lease obligation – less current portion	146,366	157,633
Other liabilities	74,847	270,629
Total liabilities	2,090,922	2,223,549
Net assets:		
Without donor restrictions	2,232,624	1,774,871
With donor restrictions	308,755	273,754
Total net assets	2,541,379	2,048,625
Total liabilities and net assets	$ 4,632,301	$ 4,272,174

See accompanying notes to consolidated financial statements.

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Revenue:		
Patient service revenue	$3,016,241	$2,474,304
Direct research revenue	16,914	17,832
Indirect research revenue	5,508	4,676
Other revenue	413,038	388,047
Total revenue and other support	3,451,701	2,884,859
Expenses:		
Salaries	1,603,003	1,469,471
Employee benefits	422,666	370,734
Supplies	564,232	462,461
Professional fees and purchased services	320,936	261,541
Facility and other costs	137,026	119,133
State taxes	51,381	50,431
Interest	18,654	17,720
Depreciation and amortization	161,645	153,600
Total expenses	3,279,543	2,905,091
Income (loss) from operations	172,158	(20,232)
Nonoperating gains (losses):		
Gifts and donations – net of related expenses	1,990	2,860
Interest and dividends	27,151	15,794
Recognized gain (loss) on cash flow hedge instruments	4,191	(2,499)
Nonservice periodic pension costs	(15,748)	(19,639)
Equity in earnings of joint ventures	7,293	6,983
Increase in fair value of investments	78,192	63,655
Contribution of net assets from acquired affiliates	–	157,646
Other	3,180	(728)
Total nonoperating gains - net	106,249	224,072
Excess of revenue and nonoperating gains – net over expenses	278,407	203,840
Net assets released from restrictions for property, plant and equipment	52,102	11,494
Retirement benefit plan adjustments	127,244	17,092
Increase in net assets without donor restriction	$ 457,753	$ 232,426

See accompanying notes to consolidated financial statements.

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Net assets without donor restrictions:		
Excess of revenue and nonoperating gains – net over expenses	$ 278,407	$ 203,840
Net assets released from restrictions for property, plant and equipment	52,102	11,494
Retirement benefit plan adjustments	127,244	17,092
Increase in net assets without donor restriction	457,753	232,426
Net assets with donor restrictions:		
Gifts and donations	56,730	24,297
Interest and dividends	2,652	1,301
Change in value of perpetual and beneficial interest trusts	9,372	920
Realized and unrealized gains on investments	33,369	16,177
Net assets released for operations	(15,020)	(10,795)
Net assets released for property, plant and equipment	(52,102)	(11,494)
Contribution of net assets from acquired affiliates	–	30,290
Increase in net assets with donor restrictions	35,001	50,696
Increase in net assets	492,754	283,122
Net assets – beginning of year	2,048,625	1,765,503
Net assets – end of year	$2,541,379	$2,048,625

See accompanying notes to consolidated financial statements.

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Cash flows from operating activities:		
Increase in net assets	$ 492,754	$ 283,122
Adjustment to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	161,645	153,600
Accretion of bond issuance cost and premium, net	(3,267)	(1,590)
Equity in earnings of joint ventures	(7,293)	(6,983)
Net realized and change in unrealized gains on investments	(111,561)	(79,832)
Net (gain) loss on cash flow hedge instruments	(4,191)	2,499
Net gain on charitable remainder and perpetual trusts	(8,481)	(2,010)
(Gain) loss on disposal of fixed assets	(493)	94
Noncash lease expense	(20,252)	(24,795)
Restricted contributions and investments income	(59,382)	(25,657)
Retirement benefit plan adjustments	(127,244)	(17,092)
Increase in asset retirement obligations	(62)	–
Net assets of acquired affiliates	–	(187,936)
Increase (decrease) in cash resulting from a change in:		
Patient accounts receivable	(81,398)	16,905
Inventories, prepaid expenses and other current assets	(27,405)	(2,460)
Other assets	(12,475)	(18,942)
Accounts payable and other current liabilities	221,182	87,761
Operating lease liability	21,914	26,727
Amounts (receivable) payable under reimbursement regulations	676	(5,408)
Self-insurance reserves	9,938	8,401
Accrued retirement benefits	12,847	29,939
Other liabilities	(191,529)	203,141
Net cash provided by operating activities	265,923	439,484
Cash flows from investing activities:		
Purchase of investments	(1,290,407)	(1,049,527)
Proceeds from sale of investments	1,092,396	833,282
Increase in other assets	27	6,586
Distributions from joint ventures	7,430	5,736
Contributions to joint ventures	(4,082)	–
Purchases of property, plant and equipment	(209,468)	(226,195)
Proceeds from sale of fixed assets	2,137	531
Cash and cash equivalents of acquired affiliates	–	7,561
Net cash used by investing activities	(401,967)	(422,026)
Cash flows from financing activities:		
Payments of long-term debt	(59,104)	(33,008)
Payments of finance lease obligations	(2,406)	(2,637)
Proceeds from issuance of long-term debt	21,563	282,812
Amounts paid to refinance	–	(33,915)
Restricted contributions and investment income	63,560	24,544
Net cash provided by financing activities	23,613	237,796
Net (decrease) increase in cash and cash equivalents	(112,431)	255,254
Cash and cash equivalents – beginning of year	547,872	292,618
Cash and cash equivalents – end of year	$ 435,441	$ 547,872

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 32,784	$ 23,188
Supplemental disclosure of noncash activities:		
Right of use assets obtained in exchange for lease obligations:		
Operating leases	$ –	$ 205,755
Financing leases	$ 895	$ 94
Purchases of property, plant and equipment in accounts payable and other current liabilities	$ 19,922	$ 16,368

See accompanying notes to consolidated financial statements.

1. Reporting Entity

Organization

The MaineHealth System (the System) is comprised of MaineHealth Services, the parent organization, and its subsidiaries. The subsidiaries of MaineHealth Services include MaineHealth, NorDx, MaineHealth Care at Home, and The Memorial Hospital at North Conway, N.H. The subsidiary MaineHealth includes nine acute care hospitals that were formerly individual entities until the execution of a unification merger effective January 1, 2019 at which time eight of the nine hospitals merged. Mid Coast Hospital merged in a separate transaction on January 1, 2021. These hospitals are now local health systems within the subsidiary named MaineHealth utilizing d/b/a's of Maine Medical Center, Southern Maine Health Care, Mid Coast–Parkview Health (Mid Coast Hospital), LincolnHealth, Western Maine Healthcare (Stephens Memorial Hospital), Franklin Community Health Network (Franklin Memorial Hospital), Maine Behavioral Healthcare, and Coastal Healthcare Alliance (Waldo County General Hospital and Pen Bay Medical Center). The merger enables the combined resources of the merging entities to be allocated in a manner that is consistent with the System's vision of helping make the communities it serves the healthiest in America.

MaineHealth Services, together with its controlled subsidiaries, MaineHealth and The Memorial Hospital at North Conway, N.H., maintained a controlling interest in MaineHealth Accountable Care Organization, LLC (MaineHealth ACO), a value based contracting entity.

Since all the merged entities had been under the common control of the parent organization, formerly known as MaineHealth, and were already included in the System's consolidated financial statements, there was no impact on the financial reporting resulting from unification.

The purpose of the System is to lead the development of a premier community care network that provides a broad range of integrated health care services for populations in Maine and northern New England. Through the System's member organizations, the network provides services along the full continuum of care as necessary to improve the health status of the populations it serves. As such, revenue includes those generated from direct patient care services, amounts earned from incentive and risk arrangements, the provision of medical education and training services, federal and state grants and contracts, sundry revenue generated from the operations of the subsidiaries, fund-raising conducted to support the activities of the System and its subsidiaries, and investment earnings.

Acquisitions

On March 1, 2020, MaineHealth Services became the sole corporate member of Mid Coast–Parkview Health (MCPH). Membership in the MaineHealth System will provide MCPH with opportunities to improve the health of the communities in the Mid Coast region and strengthen the ability to provide high quality, safe patient care to local communities, while striving to increase access to tertiary services and lowering health care costs. No consideration was transferred in connection with the MCPH acquisition. A second transaction occurred on January 1, 2021, in which Mid Coast Hospital merged into MaineHealth. The remaining MCPH subsidiaries, Community Health and Nursing Services (CHANS), Mid Coast Geriatric Services Corporation (MCGSC), Mid Coast Medical Group, Thornton Oaks Development Corp. and Mid Coast Health Management Corporation became subsidiaries of MaineHealth.

1. Reporting Entity (Continued)

The consolidated statement of operations for 2020 includes seven months of operations of MCPH. In 2020, the consolidated statement of operations includes unrestricted revenue and other support of $117,725,000, and a deficit of revenues over expense of $9,427,000.

The amounts assigned to major assets and liabilities at the acquisition date were as follows (in thousands):

Current assets	$ 61,745
Property and equipment	72,728
Other noncurrent assets	86,178
Current liabilities	(35,784)
Long-term liabilities	(27,221)
Contribution of net assets from acquired affiliates	$157,646

As a result of the acquisition, the System's net assets without donor restrictions were increased by $157,646,000 as a contribution of net assets from acquired affiliates and net assets with donor restrictions were increased by $30,290,000.

The MCPH transaction was accounted for as an acquisition in accordance with Financial Accounting Standards Board Accounting Standards Codification (ASC) 958-805, *Not-for-profit Mergers and Acquisitions*, which required the assets and liabilities to be accounted for at fair value, as of the date of the acquisition. The fair value of the net assets at the date of the acquisition was recognized as a contribution of net assets from acquired affiliates as part of nonoperating gains, and net assets with donor restrictions.

COVID-19 Pandemic and CARES Act and Other Relief Funding

In February 2020, the Center for Disease Control (CDC) confirmed the spread of the COVID-19 disease to the United States. On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic. The State of Maine confirmed its first case on March 12, 2020. In an effort to slow the spread of the disease, the Governor of the State of Maine declared a state of emergency on March 15, 2020, followed by orders requiring schools and nonessential businesses to close, limiting gatherings, and ordering people to stay at home. On March 18, 2020, the Centers for Medicare and Medicaid Services (CMS) issued guidance that all elective surgeries and procedures, including medical and dental, should be postponed nationwide to mitigate the burden on health systems of increasing COVID-19 incidence and to make necessary facilities, equipment, supplies (including personal protective equipment, or "PPE") and personnel available to treat patients presenting COVID-19 symptoms. In response to the pandemic, MaineHealth began delaying or cancelling all nonemergent or elective procedures on March 16, 2020 and followed subsequent guidance issued by CMS. No such state or federal requirements were placed on MaineHealth in the fiscal year ended September 30, 2021. However, throughout the year, on an as needed basis, MaineHealth deferred nonurgent activity in order to maintain sufficient available beds for the most emergent admissions.

1. **Reporting Entity (Continued)**

During the year ended September 30, 2020, the System received $243,707,000 of accelerated Medicare payments. Payments under the Medicare Accelerated and Advanced Payment program are advances that must be repaid. At September 30, 2021, $50,554,000 had been repaid. The balance of the funds remaining of $193,153,000 was recorded as a short-term liability at September 30, 2021. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) also authorized the deferral of employment tax payment. At September 30, 2021, $27,169,000 in deferred payroll taxes was recorded as a short term liability and $27,169,000 was recorded as a long-term liability. At September 30, 2020, $36,553,000 in deferred payroll taxes was recorded as a long-term liability.

In addition, during the years ended September 30, 2021 and 2020, the System received $84,897,000 and $138,117,000, respectively, in relief funds and grants from federal and state sources that is not required to be repaid, subject to use towards eligible expenses and lost revenues incurred as a result of the COVID-19 pandemic. During the year ended September 30, 2021, the System has recognized $85,128,000 in relief funding as revenue. During the year ended September 30, 2020, the System recognized $134,906,000 in relief funding as revenue. MaineHealth's assessment of meeting the terms and conditions of each grant was based on incurrence of eligible uses under the terms and conditions of each grant. MaineHealth's assessment of whether the terms and conditions have been met for amounts received in CARES Act PRF payments were based on the Post-Payment Notice of Reporting Requirements issued by Health and Human Services (HHS) on January 15, 2021. Additionally, MaineHealth has completed the required reporting for Reporting Period 1, for all payments received through June 30, 2020. Subsequent Reporting Periods are planned to be opened by Health Resources and Services Administration (HRSA) in January 2022. Under such guidance, and in the HRSA reporting portal for Reporting Period 1, PRF payments were applied first to healthcare related expenses attributable to the coronavirus that another source has not reimbursed and is not obligated to reimburse. PRF payment amounts not fully expended on healthcare related expenses attributable to the coronavirus were then applied to lost revenues, calculated on a quarterly basis for each reporting tax identification number (TIN). HRSA allows for such lost revenue calculations to be performed as the difference between actual 2019 and actual current year quarterly revenues, the difference between 2020 budget and actual current year quarterly revenues, or by any alternate reasonable method of estimating lost revenues. Each MaineHealth reporting TIN has calculated lost revenues using one of these three methodologies. As of September 30, 2021, MaineHealth recognized all CARES Act PRF payments that were required to be used by September 30, 2021 and MaineHealth does not anticipate repaying PRF payments received through September 30, 2021. As of September 30, 2021, MaineHealth recorded $2,980,000 in relief funds as deferred revenue. The majority of the relief funds, $2,593,000, were state funds received near the end of the fiscal year 2021 for which MaineHealth has not yet identified eligible expenditures.

2. Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of the System. The consolidated financial statements have been presented in conformity with accounting principles generally accepted in the United States of America (GAAP) consistent with the FASB ASC Topic 954, *Health Care Entities*, and other pronouncements applicable to health care organizations. The assets of any member of the consolidated group may not be available to meet the obligations of other members in the group, except as disclosed in Note 10. Upon consolidation, intercompany transactions and balances have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates are made in the areas of patient accounts receivable, the fair value of financial instruments, amounts receivable and payable under reimbursement regulations, asset retirement obligations (AROs), retirement benefits and self-insurance reserves.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt securities purchased with a maturity at the date of purchase of three months or less, excluding amounts classified as investments whose use is limited.

Investments

Investments are stated at fair value. The recorded value of investments in hedge funds and limited partnerships is based on fair value as estimated by management using information provided by external investment managers. The System has applied the provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities that Calculate Net Asset Value (NAV) per Share (or its Equivalent)*. This standard allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using NAV per share or its equivalent as a practical expedient. The System has utilized the NAV reported by each of the underlying funds as a practical expedient to estimate the value of the investment for each of these funds. The System believes that these valuations are a reasonable estimate of fair value as of September 30, 2021 and 2020, but are subject to uncertainty and, therefore, may differ from the value that would have been used had a market for the investments existed. Such differences could be material. Certain of the hedge fund and limited partnership investments have restrictions on the withdrawal of the funds (see Note 8). Investments are classified as current assets based on the availability of funds for current operations. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in the excess of revenues and nonoperating gains – net over expenses, unless the income or loss is restricted by donor or law. The accounting for the pension plan assets is disclosed in Note 8.

2. **Significant Accounting Policies (Continued)**

As provided for under ASC Topic 825, *Financial Instruments*, the System made the irrevocable election to report investments and investments whose use is limited at fair value with changes in value reported in the excess of revenues and nonoperating gains – net over expenses. As a result of this election, the System reflects changes in the fair value, including both increases and decreases in value whether realized or unrealized, in its excess of revenues and nonoperating gains – net over expenses.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated financial statements.

Investments Whose Use is Limited

Investments whose use is limited primarily include investments held by trustees under debt agreements, self-insurance trust agreements, and designated investments set aside by the Board of Trustees (of member Boards) for purposes over which those Boards retain control and may at their discretion subsequently use for other purposes. In addition, investments whose use is limited include investments restricted by donors for specific purposes or periods, as well as investments restricted by donors to be held in perpetuity by the System, and the related appreciation on those investments. Amounts required to meet current liabilities of the System have been classified as current assets.

Property, Plant and Equipment

Property, plant, and equipment are recorded at cost, or at fair value at the date of acquisition, if acquired in a business combination accounted for using the acquisition method of accounting. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Interest costs incurred on borrowed funds during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets. MaineHealth recorded capitalized interest of $11,500,000 and $3,610,000 for the years ended September 30, 2021 and 2020, respectively.

Gifts of long-lived assets, such as land, building, or equipment, are reported as increases in net assets without restrictions and are excluded from the excess of revenues and nonoperating gains – net over expenses. Gifts of long-lived 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 long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment of Long-Lived Assets

Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less cost to sell.

2. **Significant Accounting Policies (Continued)**

Asset Retirement Obligations

AROs, which are included in other liabilities in the accompanying consolidated balance sheets, are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, the System records period-to-period changes in the ARO liability resulting from the passage of time, increases or decreases in interest expense, and revisions to either the timing or the amount of the original expected cash flows to the related assets.

Accounting for Defined Benefit Pension and Other Postretirement Plans

The System recognizes the overfunded or underfunded status of its defined benefit and postretirement plans as an asset or liability in its consolidated balance sheets. Changes in the funded status of the plans are reported as a change in net assets without restrictions presented below the excess of revenues and nonoperating gains – net over expenses in its consolidated statements of operations and changes in net assets in the year in which the changes occur.

The measurement of benefit obligations and net periodic benefit cost is provided by third-party actuaries based on estimates and assumptions approved by the System's management. These valuations reflect the terms of the plans and use participant-specific information, such as compensation, age, and years of service, as well as certain assumptions, including estimates of discount rates, expected long-term rate of return on plan assets, rate of compensation increases, interest-crediting rates, and mortality rates.

Assets Limited or Restricted as to Use

Assets limited or restricted as to use include assets held by trustees under bond indenture agreements, assets restricted for self-insurance, assets held for supplemental retirement benefits, and assets restricted by donors for specific purposes or endowment. Amounts required to meet current liabilities of the System are classified as current assets.

Beneficial Interests in Perpetual Trusts

Beneficial interests in perpetual trusts consist of the System's proportionate share of the fair value of assets held by trustees in trust for the benefit of the System in perpetuity, the income from which is available for distribution to the System periodically. The assets held in trust consist primarily of cash equivalents and marketable securities. The fair values of perpetual trusts are measured using the net asset value as a practical expedient. Such amounts are included in assets whose use is limited in the accompanying consolidated balance sheets. Distribution from beneficial interests in perpetual trusts is included in nonoperating gains, unless restricted by donors.

2. **Significant Accounting Policies (Continued)**

Excess of Revenues and Nonoperating Gains – Net Over Expenses

The consolidated statements of operations include excess of revenues and nonoperating gains – net over expenses as the performance indicator. Changes in net assets without donor restrictions, which are excluded from excess of revenues and nonoperating gains – net over expenses, consistent with industry practice, include retirement benefit plan adjustments, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and capital grants.

Consolidated Statements of Operations

For purpose of display, transactions deemed by management to be ongoing, major, or central to the provision of health care and related services are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating gains and losses.

Patient Service Revenue

Revenues generally relate to contracts with patients in which the System's performance obligations are to provide health care services to patients. Revenues are recorded during the period obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over a period of days. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by Medicare and Medicaid or negotiated with managed care health plans and commercial insurance companies, the third-party payors. The payment arrangements with third-party payors for the services provided to related patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the revenue recognition process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

2. **Significant Accounting Policies (Continued)**

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payors and patients is the System's primary source of cash and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of hospital revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of our accounts receivable. Management performs the hindsight analysis for contractual reserves every six months and a twenty-four month hindsight analysis for accounts receivable collection and write-off data. Management believes its regular updates to the estimated implicit price concession amounts provide reasonable estimates of revenues and valuations of accounts receivable. These routine, regular changes in estimates have not resulted in material adjustments to the valuations of accounts receivable or period-to-period comparisons of operations. At September 30, 2021 and 2020, estimated implicit price concessions of $156,766,000 and $122,514,000, respectively, had been recorded as reductions to patient service revenue to enable the System to record revenues and accounts receivable at the estimated amounts expected to be collected.

Free Care

The System provides care without charge to patients who meet certain criteria under its Board-established free care policies. Because the System does not pursue collection of amounts determined to qualify as free care, they are not reported as patient service revenue.

Direct and Indirect Research Revenue and Related Expenses

Revenue related to research grants and contracts is recognized as the related costs are incurred. Indirect costs relating to certain government grants and contracts are reimbursed at fixed rates negotiated with the government agencies. Research grants and contracts are accounted for as exchange transactions or contributions. Amounts received in advance of incurring the related expenditures are recorded as unexpended research grants and are included in deferred revenue.

Other Revenue

Revenue which is not related to patient medical care but is central to the day-to-day operations of the System is included in other revenue. This revenue includes pharmacy sales, cafeteria sales, medical school revenue, grant revenue, rental revenue, net assets released from restrictions for operations, COVID-19 relief revenue and other support services revenue.

2. **Significant Accounting Policies (Continued)**

Gifts and Donations

Unconditional promises to give cash and other assets to the System are reported at fair value at the date the promise is received. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The discounts on those amounts are computed using a risk-free rate applicable to the year in which the promise is received. Amortization of the discount is included in contribution revenue. Conditional promises to give are recognized when the conditions are substantially met. The gifts are reported as net assets 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 as net assets released from donor restrictions, which is included in other revenue. Donor-restricted contributions whose restrictions are met within the same year received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Self-Insurance Reserves

The liabilities for outstanding losses and loss-related expenses and the related provision for losses and loss-related expenses include estimates for losses incurred but not reported as well as losses pending settlement. Such liabilities are based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be greater than or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making the workers compensation and malpractice estimates and the resulting liability are actuarially reviewed on an annual basis, and any necessary adjustments are reflected in current operations.

Income Tax Status

The Internal Revenue Service has previously determined that the System and its subsidiaries (except Maine Medical Partners (MMP) (a subsidiary of MaineHealth) are organizations as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the IRC. MMP had significant net operating loss carryovers as of September 30, 2021 and 2020. A valuation allowance has been provided for the entire deferred tax benefit for the net operating losses, due to uncertainty of realization. MMP did not have material taxable income in 2021 and 2020. Accordingly, a provision for income taxes has not been made in the accompanying consolidated financial statements.

The System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in measurement are reflected in the period in which the change in judgment occurs. The System did not recognize the effect of any income tax positions in either 2021 or 2020.

2. Significant Accounting Policies (Continued)

Subsequent Events

Events occurring after the consolidated balance sheet date are evaluated by management to determine whether such events should be recognized or disclosed in the consolidated financial statements. Management has evaluated subsequent events through February 4, 2022, which is the date the consolidated financial statements were available to be issued.

3. Liquidity and Availability of Financial Assets

The System's working capital and cash flows are subject to variability during the year attributable to changes in volume and cash receipts. The System maintains investments portfolios without donor restrictions to manage fluctuations in cash flow.

The following table (in thousands) reflects the System's financial assets for the period ending September 30, 2021, reduced by amounts not available for general use within one year because of contractual or donor-imposed restrictions or internal designations. Investment amounts would be available, subject to liquidity of the underlying investments.

Cash and cash equivalents	$ 435,441
Investments	1,195,752
Accounts receivable	367,554
Financial assets available to meet cash needs for general expenditures within one year	$1,998,747

Cash and cash equivalents includes $193,153,000 of accelerated Medicare payments received under the Medicare Accelerated and Advanced Payment program. A liability of $193,153,000 has been recorded in accounts payable and other current liabilities.

In addition to the amounts listed above, the System has available to it lines of credit in the amount of $100,000,000 which it could draw upon to meet the current needs of the System.

4. Community Benefit Programs

As a nonprofit organization dedicated to community health improvement, the System provides many services for the community in addition to its range of health care services and programs. The System supports improvement in community health by implementing best practice interventions ranging from prevention and wellness to disease management. These services include evidence-based programs to improve care and outcomes for people suffering from chronic diseases such as diabetes, asthma, chronic obstructive pulmonary disease and behavioral health issues. The System also provides training and education opportunities for physicians and other providers that focus on achieving patient-centered healthcare. In addition, the System works to ensure patients receive excellent coordination of care through transitions of care programs. The System also offers, through its Access to Care program, donated healthcare services and free or low-cost medications to low-income and uninsured patients.

A wide range of community health improvement and prevention programs support the efforts to promote healthy lifestyles. The System's healthy lifestyle programs include initiatives that target both children and adults. Engaging community health professionals and provider organizations, community partners, family members and local and state government is a key component to the successful implementation and continued effectiveness of these programs. The System's tobacco cessation program, through highly trained Tobacco Treatment Educators, provides ongoing support to the community healthcare providers with the goal of reducing tobacco use. This program also offers a free confidential coaching service in support of Maine residents who seek to quit the use of tobacco. Over the past four years, the System has also invested significant resources in implementing a multi-faceted approach to addressing the opioid crises experienced by Maine and New Hampshire. Other community health improvement programs include healthy lifestyle, oral health, healthy weight, and childhood immunization initiatives.

5. Patient Service Revenue

The System records patient service revenue at the amount that reflects the consideration to which the System expects to be entitled to in exchange for providing patient care. Patient service revenue consists of amounts charged for services rendered less estimated discounts for contractual and other allowances for patients covered under Medicare, Medicaid and other health plans and discounts offered to patients under the System's uninsured discount program.

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors is as follows:

5. Patient Service Revenue (Continued)

Medicare and State Medicaid Programs

Maine Medical Center, Southern Maine Health Care, Pen Bay Medical Center, Mid Coast—Parkview Health and Franklin Memorial Hospital are paid at prospectively determined rates for inpatient and outpatient services rendered to Medicare and Medicaid beneficiaries. Inpatient rates vary according to a patient classification system that is based on clinical diagnosis and other factors. Outpatient services are paid based on a prospective rate per ambulatory visit or procedure. LincolnHealth, Waldo County General Hospital, Stephens Memorial Hospital and The Memorial Hospital are Critical Access Hospitals reimbursed at cost for services provided to Medicare and Medicaid beneficiaries for certain services. Cost reimbursable services are paid at an interim rate with final settlement determined after submission, review and audit of annual cost reports by the System and audit thereof by the Medicare administrative contractor, the State of Maine and the State of New Hampshire.

Several System hospitals receive Disproportionate Share Hospital (DSH) payments. These payments are made to qualifying hospitals to cover the costs of providing care to low income patients. These payments are subject to audit by CMS and are, therefore, subject to change. These amounts are recorded as patient service revenue.

In 2004, the State of Maine established several health care provider taxes (State taxes). The enactment of the State taxes allowed the State of Maine to add revenues to the State of Maine General Fund while minimizing the potential of lost federal matching funds in the MaineCare program. The hospital-specific portion of the State taxes on Maine hospitals is based on a percentage of patient service revenue. Taxes on nursing homes are based on 6.0% of patient service revenue.

The State of New Hampshire established a Medicaid Enhancement Tax program in 1991. This program taxes hospital services at approximately 2.3% of patient service revenue. The State of New Hampshire also levies a tax on intermediate care facilities at approximately 5.5%.

For the years ended September 30, 2021 and 2020, the System recorded State taxes of $51,381,000 and $50,431,000, respectively.

Nongovernmental Payors

The System also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the System under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

5. Patient Service Revenue (Continued)

Uninsured Patients

For uninsured patients who do not qualify for free care, the System recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). Based on historical experience, a significant portion of uninsured patients will be unable or unwilling to pay for the services provided.

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. The System has determined it has provided self-pay allowances to uninsured patients and patients with other uninsured balances (e.g. copays and deductibles). The self-pay allowances included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with those patients.

The System provides care without charge to patients who meet certain criteria under its Board-established free care policy. Because the System does not pursue collection of amounts determined to qualify as free care, they are not reported as patient service revenue. The System estimates the costs associated with providing charity care by calculating a ratio of total cost to total gross charges, and then multiplying that ratio by the gross charges associated with providing care to patients eligible for free care. The estimated cost of caring for free care patients for the years ended September 30, 2021 and 2020, was $28,533,000 and $43,757,000, respectively. Funds received from gifts and grants to subsidize charity services provided for the years ended September 30, 2021 and 2020, were $250,000 and $434,000, respectively.

Patient service revenue from these major payor sources recognized during the years ended September 30, 2021 and 2020 was as follows (in thousands):

	2021	2020
Medicare	$1,064,004	$ 860,547
State Medicaid Programs	412,067	340,418
Anthem Blue Cross and Blue Shield	634,447	545,416
Other third-party payors	827,131	684,372
Patients	78,592	43,551
Total patient service revenue	$3,016,241	$2,474,304

Patient service revenue in 2021 and 2020 included $5,783,000 and $493,000, respectively, of favorable settlements with third-party payors regarding prior year activities.

6. Concentration of Credit Risk

Receivables

Financial instruments, which potentially subject the System to concentration of credit risk, consist of patient accounts receivable, estimated amounts receivable under reimbursement regulations, and certain investments. Investments, which include government and agency securities, stocks, and corporate bonds, are not concentrated in any corporation or industry. The System grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at September 30, 2021 and 2020, was as follows:

	2021	2020
Medicare	35%	34%
State Medicaid Programs	13	15
Anthem Blue Cross and Blue Shield	12	12
Other third-party payors	23	24
Patients	17	15
Total patient receivables	100%	100%

Cash

The System maintains its cash accounts at various financial institutions. As of September 30, 2021 and 2020, the System had cash balances of $171,112,000 and $37,512,000, respectively, in uninsured accounts. The System has not experienced any losses in such accounts and evaluates the credit worthiness of the financial institutions with which it conducts business. Management believes the System is not exposed to any significant credit risk with respect to its cash balances.

Labor Force

The System's unionized labor workforce are members of the Maine State Nurses Association/National Nurses Organizing Committee and National Nurses United. It is approximately 9.1% of the System's work force. The union is currently without a contract and is actively in contract negotiations.

7. Investments and Investments Whose Use is Limited

The composition of investments and investments whose use is limited at September 30, 2021 and 2020, is set forth as follows (in thousands):

	2021	2020
Investments (current assets)	$1,195,752	$ 868,416
Investments whose use is limited	695,688	704,971
	$1,891,440	$1,573,387
Cash equivalents	$ 261,471	$ 312,366
Fixed income securities – bonds	702,146	511,013
Equity investments – stocks	582,469	485,034
Investment in real property	1,874	2,125
Limited partnerships	128,758	91,856
Hedge funds	157,940	122,691
Beneficial interest in perpetual and charitable remainder trusts	56,782	48,302
	$1,891,440	$1,573,387

Investments whose use is limited include amounts required by debt agreements, amounts restricted by donors, assets designated by the Board for future capital improvements, assets to fund self-insured professional and general liability and workers' compensation risks, and to provide for other specific purposes.

Investments whose use is limited by debt agreements include debt service funds, which are composed of semiannual deposits to fund principal and interest payments, and construction funds. These investments are held pursuant to the requirements of the outstanding Revenue Bonds and Revenue Refunding Bonds.

The amounts reported as trusteed under debt agreements consisted of construction funds from the 2020 and 2018A Series bond issues, capitalized interest funds that will be used to pay future payments on the 2018A and 2018B Series bond issues, and funds accumulated for future principal and interest payments on the 2014A, 2018A and 2018B, and the 2020 Series bond issues.

8. Fair Value of Financial Instruments

Fair Value Measurements

The System classifies its investments into Level 1, which refers to securities valued using quoted prices from active markets for identical assets, Level 2, which refers to securities not traded on an active market, but for which observable market inputs are readily available, and Level 3, which refers to securities with unobservable inputs that are used when little or no market data is available. Assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

Asset Valuation Techniques

Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs. The following is a description of the valuation methodologies used for assets measured at fair value:

Cash equivalents – The investments strategy for these are low-risk, low-return, highly liquid investments, typically with a maturity of three months or less, including U.S. Government, T-bills, bank certificates, corporate commercial paper or other money market instruments that are based on quoted prices and are actively traded.

Fixed income securities-bonds – These securities are investments in corporate or sovereign bonds and notes, certificates of deposit, or other loans providing a periodic payment and eventual return of principal at maturity. Certain corporate bonds and notes are valued at the closing price reported in the active market in which the bond is traded. Other corporate bonds and notes are valued based on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for identical or similar bonds, the bond is valued under a discounted cash flow approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks.

Equity investments-stocks – These investments include marketable equity securities, mutual funds, exchange traded, and closed-end funds. The fair value of marketable equity securities are principally based on quoted market prices. Exchange-traded funds and closed-end funds are valued at the last sale price or official closing price on the exchange or system on which they are principally traded. Investments in mutual funds are valued at their NAV at year end. These funds are required to publish their daily NAV and to transact at that price. The mutual funds held are deemed to be actively traded.

Investment in real property – Investments in real property are valued yearly at fair value, using the market approach, as determined by comparable sales data beginning on the date of acquisition.

Common/collective trusts – These include diverse investments in securities issued by the U.S. Treasury and global bond funds using the Common Collective Trust vehicle to obtain lower expense ratios. These investments are designed to generate attractive risk-adjusted returns. The fair value of common collective trusts are based on the NAV of the fund, representing the fair value of the underlying investments, which are generally securities traded on an active market. The NAV as provided by the trustee, is used as a practical expedient to estimate fair value.

8. Fair Value of Financial Instruments (Continued)

Limited partnerships – These include investments in offshore and private equity funds. They have objectives of capital appreciation with absolute returns over the medium and long term. These investments are designed to generate attractive risk-adjusted returns. The estimated fair values of limited partnerships for which quoted market prices are not readily available, are determined based upon information provided by the fund managers. Such information is generally based on NAV of the fund, which is used as a practical expedient to estimate fair values. The limited partnerships invest primarily in readily available marketable equity securities. The limited partnerships allocate gains, losses, and expenses to the partners based on ownership percentage as described in the respective partnership agreements.

Hedge funds – The investments are inclusive of a variety of types of equity, debt, and derivative investments, designed to mitigate volatility while generating equity like returns. The estimated fair values of limited partnerships and hedge funds, for which quoted market prices are not readily available, are determined based upon information provided by the fund managers. Such information is generally based on NAV of the fund, which is used as a practical expedient to estimate fair value. The hedge funds invest primarily in readily marketable equity securities. The hedge funds allocate gains, losses, and expenses to the partners based on ownership percentage as described in the respective hedge fund agreements.

The following methods and assumptions were used by the System in estimating the fair value of the System's financial instruments that are not measured at fair value on a recurring basis for disclosures in the consolidated financial statements:

Interest rate swaps – The System uses inputs other than quoted prices that are observable to value the interest rate swaps. The System considers these inputs to be Level 2 inputs in the context of the fair value hierarchy. The fair value of the net interest rate swap liabilities was $11,151,000 and $15,342,000 at September 30, 2021 and 2020, respectively. These values represent the estimated amounts the System would receive or pay to terminate agreements, taking into consideration current interest rates and the current creditworthiness of the counterparty. The fair value of the interest rate swap agreements are reported in other long-term liabilities.

Pledges receivable – The current yields for 1 to 10-year U.S. Treasury notes are used to discount pledges receivable. The System considers these yields to be a Level 2 input in the context of the fair value hierarchy. Pledges received were discounted at rates ranging from 0.90% to 2.08% in fiscal year 2021 and from 0.12% to 3.50% in fiscal year 2020. Outstanding pledges receivable in 2021 and 2020, which have been recorded within other long-term assets at fair value, totaled $26,904,000 and $25,830,000, respectively.

Receivables and payables – The carrying value of the System's receivables and payables approximate fair value, as maturities are very short term.

8. Fair Value of Financial Instruments (Continued)

The System's investments at fair value set forth by level within the fair value hierarchy as of September 30, 2021 and 2020 are as follows (in thousands):

	Invest-ments Measured at NAV	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Unob-servable Inputs (Level 3)	Total
September 30, 2021					
Cash equivalents	$ –	$ 261,471	$ –	$ –	$ 261,471
Investments:					
Fixed income securities – bonds	116	261,875	440,155	–	702,146
Equity investments – stocks	–	528,501	53,968	–	582,469
Investment in real property	1,874	–	–	–	1,874
Limited partnerships	128,758	–	–	–	128,758
Hedge funds	157,940	–	–	–	157,940
Beneficial and charitable remainder trusts	–	–	–	56,782	56,782
Total investments	288,688	790,376	494,123	56,782	1,629,969
Total cash equivalents and investments	$288,688	$1,051,847	$494,123	$56,782	$1,891,440
September 30, 2020					
Cash equivalents	$ –	$ 312,366	$ –	$ –	$ 312,366
Investments:					
Fixed income securities – bonds	315	158,921	351,777	–	511,013
Equity investments – stocks	–	437,464	47,570	–	485,034
Investment in real property	2,125	–	–	–	2,125
Limited partnerships	91,856	–	–	–	91,856
Hedge funds	122,691	–	–	–	122,691
Beneficial and charitable remainder trusts	–	–	–	48,302	48,302
Total investments	216,987	596,385	399,347	48,302	1,261,021
Total cash equivalents and investments	$216,987	$ 908,751	$399,347	$48,302	$1,573,387

The net change in the beneficial interest in perpetual and charitable remainder trusts of $8,480,000 and $1,730,000, in 2021 and 2020 respectively, represents the change in the fair value of the trusts, net of distributions.

8. **Fair Value of Financial Instruments (Continued)**

The information regarding the fair value measurements of the assets held by the System's defined benefit pension plan (see Note 13) at September 30, 2021 and 2020, is as follows (in thousands):

	Investments Measured at NAV	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total
September 30, 2021					
Cash equivalents	$ –	$ 11,608	$ –	$ –	$ 11,608
Investments:					
Fixed income securities – bonds	–	34,770	43,575	–	78,345
Equity investments – stocks	–	334,206	42,294	–	376,500
Common/collective trusts	26,634	–	–	–	26,634
Limited partnerships	109,683	–	–	–	109,683
Hedge funds	256,736	–	–	–	256,736
Total investments	393,053	368,976	85,869	–	847,898
Total cash equivalents and investments	$393,053	$380,584	$85,869	$ –	$ 859,506
September 30, 2020					
Cash equivalents	$ –	$ 23,384	$ –	$ –	$ 23,384
Investments:					
Fixed income securities – bonds	–	27,445	40,762	–	68,207
Equity investments – stocks	–	293,555	38,534	–	332,089
Common/collective trusts	29,206	–	–	–	29,206
Limited partnerships	87,358	–	–	–	87,358
Hedge funds	205,971	–	–	–	205,971
Total investments	322,535	321,000	79,296	–	722,831
Total cash equivalents and investments	$322,535	$344,384	$79,296	$ –	$ 746,215

Liquidity

Equity investments, fixed income investments, investments in real property, common collective trusts, limited partnerships and hedge funds are redeemable at NAV under the terms of the subscription and/or partnership agreements. Investments, including short-term investments, with daily liquidity generally do not require any notice prior to withdrawal. Investments with monthly, quarterly or annual redemption frequency typically require notice periods ranging from 30 to 180 days. The long term investments fair value are broken out below by their redemption frequency as of September 30, 2021 and 2020 for both the investments and the System's defined benefit pension plan (in thousands):

8. **Fair Value of Financial Instruments (Continued)**

Investments Liquidity – NAV Measured Investments	Daily	Bi-Monthly	Monthly	Quarterly	Illiquid	Annually	Total
September 30, 2021							
Fixed income securities – bonds	$ –	$ –	$ –	$ –	$ 116	$ –	$ 116
Investment in real property	–	–	–	–	1,874	–	1,874
Limited partnerships	–	64,272	11,906	37,927	14,653	–	128,758
Hedge funds	2,131	–	42,400	106,973	6,436	–	157,940
	$ 2,131	$ 64,272	$ 54,306	$144,900	$ 23,079	$ –	$288,688
September 30, 2020							
Fixed income securities – bonds	$ –	$ –	$ –	$ –	$ 315	$ –	$ 315
Investment in real property	–	–	–	–	2,125	–	2,125
Limited partnerships	–	46,985	9,756	24,420	10,695	–	91,856
Hedge funds	2,259	–	29,902	89,170	1,360	–	122,691
	$ 2,259	$ 46,985	$ 39,658	$113,590	$ 14,495	$ –	$216,987

Defined Benefit Pension Investments Liquidity – NAV Measured Investments	Daily	Bi-Monthly	Monthly	Quarterly	Illiquid	Annually	Total
September 30, 2021							
Common/collective trusts	$ –	$ –	$ 26,634	$ –	$ –	$ –	$ 26,634
Limited partnerships	–	59,543	–	49,757	–	383	109,683
Hedge funds	54,983	–	38,875	146,542	16,336	–	256,736
	$ 54,983	$ 59,543	$ 65,509	$196,299	$ 16,336	$ 383	$393,053
September 30, 2020							
Common/collective trusts	$ –	$ –	$ 29,206	$ –	$ –	$ –	$ 29,206
Limited partnerships	–	52,577	–	33,907	–	874	87,358
Hedge funds	48,057	–	40,701	117,213	–	–	205,971
	$ 48,057	$ 52,577	$ 69,907	$151,120	$ –	$ 874	$322,535

8. Fair Value of Financial Instruments (Continued)

Investments with a redemption frequency of illiquid may include lock-ups with definite expiration dates, restricted shares and side pockets, as well as private equity and real assets funds where the System has no liquidity terms until the investments are sold by the fund manager. The System has total capital commitments for alternative investments outstanding of $8,804,000 and $6,491,000 as of September 30, 2021 and 2020 respectively. Specific short-term investments within the System's portfolio will be used to fund this commitment. Investments associated with beneficial interests in perpetual trust agreements have been categorized as illiquid because they are not available to support operations.

Transfers Between Levels

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. There were no transfers between Level 1 and Level 2 for the years ended September 30, 2021 and 2020.

The valuation methods as described above may produce a fair value calculation that may not be indicative of what the management would realize upon disposition or reflective of future fair values. Furthermore, although management believes its valuation methods are appropriate and consistent with methods employed by 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.

9. Property, Plant and Equipment

Property, plant, and equipment at September 30, 2021 and 2020, consist of the following (in thousands):

	2021	2020
Land and land improvements	$ 118,451	$ 116,781
Buildings	1,760,081	1,646,066
Equipment	1,391,986	1,339,290
Construction in progress	160,921	134,478
	3,431,439	3,236,615
Less accumulated depreciation and amortization	(1,985,641)	(1,840,497)
Total property, plant and equipment, net	$ 1,445,798	$ 1,396,118

9. **Property, Plant and Equipment (Continued)**

As of September 30, 2021 and 2020, the remaining commitment on construction contracts was approximately $185,273,000 and $242,191,000, respectively. The value of property, plant, and equipment acquisitions in accounts payable at September 30, 2021 and 2020, was $19,922,000 and $16,368,000, respectively.

Information Technology Investment

The System has nearly completed a significant investment in its information technology systems. A significant project to acquire and implement an ambulatory electronic health record began in 2007, was expanded in 2010 to include the inpatient electronic health record system and other financial systems and then was expanded again in 2016 to include Maine Behavioral Healthcare and System members who joined the System since 2010. As of September 30, 2021, $334,000,000 had been expended. The expected remaining amount to complete the project is $9,500,000.

10. Long-Term Debt and Revolving Lines of Credit

Long-term debt at September 30, 2021 and 2020 consists of the following (in thousands):

Name of Issue	Interest Rate	Type of Rate	Final Maturity	2021	2020
Revenue bonds:					
Maine Health and Higher Educational Facilities Authority (MHHEFA):					
Franklin Memorial Hospital – Series 2016A	3.0%-5.0%	Fixed	2034	$ 7,789	$ 8,274
Maine Medical Center – MaineHealth – Series 2020	4.0%-5.0%	Fixed	2050	205,214	205,213
Maine Medical Center – Series 2018A	5.0%	Fixed	2048	164,330	164,330
Maine Medical Center – Series 2018B	3.84%-3.94%	Fixed	2028	10,930	10,930
Maine Medical Center – Series 2018C	(81.5%* 1 Month Libor)+0.652%	Variable	2036	36,735	36,735
Maine Medical Center – Series 2014	3.0%-5.0%	Fixed	2044	79,675	79,675
Quarry Hill – Series 2017A	4.0%-5.0%	Fixed	2030	5,959	6,589
Pen Bay Medical Center – Series 2017B	3.0%-5.0%	Fixed	2038	5,653	6,113
Waldo County General Hospital – Series 2014A	3.0%-5.0%	Fixed	2028	2,982	3,412
Southern Maine Health Care – Maine Health – Series 2020	4.0%-5.0%	Fixed	2050	7,487	7,487
Southern Maine Health Care – Series 2016A	4.0%-5.0%	Fixed	2026	3,925	5,665
Stephens Memorial Hospital – Series 2014	2.0%-5.0%	Fixed	2039	3,385	3,735
Finance Authority of Maine:					
MaineHealth – Series 2017	2.11%	Fixed	2027	38,586	45,252
MaineHealth – Series 2014	2.36%	Fixed	2025	48,793	60,045
Southern Maine Health Care – Series 2013	2.91%	Fixed	2033	11,028	11,796
New Hampshire Health and Education Facilities Authority:					
The Memorial Hospital at North Conway (sub. of TMH) – Series 2016	4.0%-5.5%	Fixed	2036	12,455	12,990
Note payable:					
MaineHealth – Series 2020A	1.5%	Fixed	2030	–	21,115
MaineHealth – Series 2020B	1.7%	Fixed	2031	13,875	15,260
MaineHealth – Series 2021A	1.47%	Fixed	2030	18,830	–
MaineHealth	3.0%	Fixed	2025	3,464	4,258
MaineHealth	Adj Libor + 95 basis pts	Variable	2031	8,251	8,962
MaineHealth	Adj Libor + 95 basis pts	Variable	2031	7,928	8,612
Mid Coast-Parkview Health	3.2%	Fixed	2027	19,750	23,042
Other, including finance leases				24,191	31,316
Total bonds, loans, notes payable and finance leases before bond issuance costs and premiums				741,215	780,806
Less unamortized bond issuance costs				(7,358)	(7,860)
Unamortized premiums net of discounts				63,722	67,491
Total bonds, loans, notes payable and finance leases				797,579	840,437
Less portion classified as current liabilities				(41,994)	(42,842)
				$755,585	$797,595

10. Long-Term Debt and Revolving Lines of Credit (Continued)

Annual principal maturities of long-term debt for the five fiscal years after September 30, 2021, and the years thereafter, are as follows (in thousands):

	Bonds and Notes	Finance Lease Obligation
2022	$ 36,761	$ 2,449
2023	36,971	1,397
2024	35,611	1,394
2025	36,221	1,382
2026	17,870	1,350
Years thereafter	569,726	1,546
	$733,160	9,518
Less amounts representing interest under finance lease obligations		(1,463)
		$ 8,055

In 1999, the Board of Trustees of MaineHealth adopted a Parent Model Master Trust Indenture (the Indenture), and the Boards of Trustees of MaineHealth, MMC and certain other MaineHealth subsidiaries adopted a System Funding Agreement. The legal name of the corporation then known as MaineHealth is currently known as MaineHealth Services. For ease of reference, the corporation will be referred to as "MaineHealth Services" in this note. Adoption of the Indenture and the System Funding Agreement resulted in the creation of an Obligated Group for the MaineHealth System (the Obligated Group), with certain MaineHealth subsidiaries established as Designated Affiliates of the Obligated Group (the Designated Affiliates). Designated Affiliates have access to lower cost capital and less restrictive debt covenants. MaineHealth Services is the only member of the Obligated Group. Effective with the unification merger described in Note 1, the following Designated Affiliates merged into MMC (renamed MaineHealth as part of the unification merger): Stephens Memorial Hospital Association, Maine Behavioral Healthcare, LincolnHealth and Southern Maine Health Care. Quarry Hill was approved as a new Designated Affiliate. As a result, the Designated Affiliates under the Indenture and the System Funding Agreement as of January 1, 2019 are MaineHealth Services, MaineHealth, LincolnHealth Cove's Edge, Inc., and Quarry Hill. The Designated Affiliates under the Indenture and the System Funding Agreement are indirectly liable for the debt service on the obligations issued under the Indenture for the benefit of any Designated Affiliate. MaineHealth must remain a Designated Affiliate under the Indenture and the System Funding Agreement and has approval authority over any additional MaineHealth subsidiary requesting designation as a Designated Affiliate under the System Funding Agreement. As of September 30, 2021 and 2020, debt issued under the System Funding Agreement was $583,740,000 and $594,025,000, respectively. Debt issued under the Indenture as of September 30, 2021 and 2020 was $572,712,000 and $582,229,000, respectively. In 2019, the Indenture was revised to include a pledge of gross revenues from MaineHealth and MaineHealth Services. As of September 30, 2021 and 2020, $695,566,300 and $728,225,000, respectively, of debt obligations were covered by the pledge of gross revenues.

10. Long-Term Debt and Revolving Lines of Credit (Continued)

MaineHealth Services subsidiaries that were not Designated Affiliates prior to the unification merger had outstanding debt related to MHHEFA Revenue Bonds and Revenue Refunding Bonds that was not issued under the terms of the Indenture. Under the terms of this debt, these MaineHealth Services subsidiaries were required to maintain deposits with the related bond trustee. Such deposits are included with investments whose use is limited in the consolidated balance sheets. In addition, the terms of this debt also required that these MaineHealth Services subsidiaries satisfy certain measures of financial performance (including a minimum debt service coverage ratio) and other financial covenants as long as the bonds were outstanding. For the year ended September 30, 2020, these measures of financial performance have been suspended. Upon the January 1, 2019 unification merger of these subsidiaries into MaineHealth, which is a Designated Affiliate, the various loan agreements for these outstanding obligations were amended to bring them under the terms of the Indenture and the System Funding Agreement. Mid Coast Hospital, which was not a member of the Obligated Group as of September 30, 2020, was required in accordance with its separate loan agreement with Key Bank to maintain a minimum debt service coverage ratio. Effective January 1, 2021, Mid Coast Hospital merged into MaineHealth, and the loan agreement for this outstanding obligation was amended to bring it under the terms of the Indenture and the System Funding Agreement and all covenants were met.

In July 2020, MHHEFA issued Series 2020 bonds for the amount of $212,700,000, with the proceeds being used to fund a portion of the MMC master facilities project and the construction of an inpatient behavior health unit at Southern Maine Health Care. Of the Series 2020 bonds, $205,213,000 will be used to fund MMC's master facilities project that includes a seven story patient tower consisting of 128 single patient rooms that are both private and universal allowing standard, intermediate and critical care in addition to updated clinical procedure rooms and a 108,000 square foot ambulatory care building at its Scarborough campus. Of the Series 2020 bonds, $7,487,000 will be used to fund the renovation and construction of 42 inpatient behavioral health beds at Southern Maine Health Care's Sanford campus. This debt is secured by the Indenture, the System Funding Agreement and the MaineHealth Gross Revenue Pledge.

In September 2020, MaineHealth advanced the defeasement of the 2011A, 2011C and 2012A MHHEFA tax-exempt bonds with two taxable loans payable to TD Bank. The two TD Bank loans are forward purchase agreements with principal amounts paid to TD Bank by MaineHealth to be held until the MHHEFA bonds can be called, at which time MHHEFA will issue new tax exempt bonds to be purchased by TD Bank at a lower interest cost than the prior bonds. The defeasement of the 2011A and 2011C MHHEFA bonds was financed with a $21,115,000 TD Bank loan with a forward purchase agreement date of July 1, 2021, herein referred to as "Series 2020A". The defeasement of the 2012A MHHEFA bonds was financed with a $15,260,000 TD Bank loan with a forward purchase agreement date of July 1, 2022, herein referred to as "Series 2020B". On April 5, 2021, in an in-kind exchange, the Series 2020A taxable loan was prepaid in full with the MHHEFA Series 2021A tax-exempt bonds purchased by TD Bank, in the amount of $21,115,000. Both the Series 2020B taxable TD Bank loan and the Series 2021A tax-exempt TD Bank direct purchase bonds are secured by the Indenture, the System Funding Agreement and MaineHealth Gross Revenue Pledge.

In July 2018, MHHEFA issued its Series 2018A and 2018B bonds totaling $175,260,000, the proceeds of which are being used to fund a portion of the MMC master facilities project. The project includes the financing, construction, renovation and equipment of 64 new patient rooms, additional visitor parking, a new employee parking garage, and the acquisition and renovation of an office building. This debt was issued under the Indenture and the System Funding Agreement.

10. Long-Term Debt and Revolving Lines of Credit (Continued)

In August 2018, MHHEFA issued its Series 2018C term bonds totaling $36,735,000 for private placement with TD Bank, N.A., the proceeds of which were used to refinance MMC's outstanding MHHEFA Series 2008A Revenue Bonds. This debt was issued under the Indenture and the System Funding Agreement.

MHHEFA Revenue Bonds, including the Series 2018A, 2018B and 2018C Bonds, are generally secured under a Bond Indenture. These Bond Indentures are contracts among MHHEFA, the Bond Trustee and the bondholders of that series of bonds, and the respective pledges and covenants made therein are for the equal and ratable benefit and security of the bondholders. The Bond Indentures for the Series 2018A, 2018B and 2018C Bonds provide that such bonds shall be special obligations of MHHEFA, payable solely from and secured solely by the payments made by MMC under the respective Bond Indenture, and the funds available in the Bond Fund established under such Bond Indenture.

In January 2015, MHHEFA issued its Series 2014 bonds totaling $85,105,000 for the benefit of MMC and Stephens Memorial Hospital Association. The MMC portion, $79,675,000, was used to finance renovations and equipment for the Bean Building and to refinance a portion of MHHEFA's, Series 2008A bonds totaling $42,760,000. The Stephens Memorial Hospital Association portion, $5,430,000, was used to finance construction of and equipment for a new medical office building. Stephens Memorial Hospital Association, a subsidiary at the time of Western Maine Health Care Corporation, has since been merged into MMC as part of the unification merger. This debt was issued under the Indenture and the System Funding Agreement.

Deferred financing costs of $7,358,000 in 2021 and $7,860,000 in 2020 are reported as a component of long term debt and represent the costs incurred in connection with the issuance of the bonds. These costs are being amortized over the term of the bonds. Amortization expense for the years ended September 30, 2021 and 2020 was $502,000 and $637,000, respectively. The original issue discount/premium is amortized/accreted over the term of the related bonds using the effective interest method.

Effective January 1, 2019, following the unification merger, all existing lines of credit for the merged subsidiaries were terminated and replaced with a single System line of credit in the amount of up to $50,000,000 which expired on June 30, 2020 and renewed to expire on August 31, 2022. In May 2020, an additional $100,000,000 System line of credit was established due to expire in May 2021. All lines of credit were terminated and replaced in fiscal year 2021 with a single $100,000,000 line of credit effective June 22, 2021 and due to expire August 31, 2023.

The line of credit is secured by a MaineHealth gross revenue pledge. There were no amounts outstanding on the lines of credit as of September 30, 2021 and 2020.

11. Leases

The System utilizes operating and finance leases for the use of certain hospitals, medical office buildings, and medical equipment. All lease agreements generally require the System to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the right of use (ROU) asset or lease liability. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation. Most leases include one or more options to renew the lease at the end of the initial term, with renewal terms that generally extend the lease at the then market rate of rental payment. Certain leases also include an option to buy the underlying asset at or a short time prior to the termination of the lease. All such options are at the System's discretion and are evaluated at the commencement of the lease, with only those that are reasonably certain of exercise included in determining the appropriate lease term.

The following table presents lease-related assets and liabilities at September 30, 2021 and 2020 (in thousands):

Balance Sheet Classification

		2021	2020
Assets:			
Operating leases:	Right of use assets	$160,178	$176,780
Finance leases:	Property, plant and equipment:		
	Buildings	$ 11,211	$ 11,211
	Equipment	6,965	6,716
		18,176	17,927
	Less accumulated depreciation and amortization	(11,029)	(10,776)
	Property, plant and equipment, net	$ 7,147	$ 7,151
Total assets		$167,325	$183,931
Liabilities:			
Current:			
Operating lease liabilities	Current portion of lease obligation	$ 17,406	$ 21,079
Finance lease obligations	Current portion of long-term debt	2,018	2,270
Long-term:			
Operating lease liabilities	Long-term lease obligation	146,366	157,633
Finance lease obligations	Long-term debt	6,037	7,322
Total liabilities		$171,827	$188,304

11. Leases (Continued)

The components of lease cost and rent expense for the years ended September 30 are as follows (in thousands):

Statement of Operations Classification

		2021	2020
Operating lease expense	Facility and other costs	$ 28,855	$ 28,508
Short-term lease cost	Facility and other costs	6,156	4,956
Finance lease expense:			
Amortization of ROU assets	Depreciation and amortization	$ 2,858	$ 2,247
Interest on finance lease liabilities	Interest expense	577	607

The weighted-average lease terms and discount rates for operating and finance leases are as follows for the years ended September 30:

	2021	2020
Weighted-average remaining lease term:		
Operating leases	20.3 years	19.8 years
Finance leases	5.6 years	5.5 years
Weighted-average discount rate:		
Operating leases	3.4%	3.3%
Financing leases	5.7%	5.8%

Supplemental cash flow and other information related to leases as of and for the years ended September 30 is as follows (in thousands):

	2021	2020
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases (liability reduction)	$21,914	$ 26,727
Operating cash flows from finance leases (fixed payments)	27,267	21,687
Operating cash flows from finance leases (liability reduction)	525	789
Financing cash flows from finance leases	2,406	2,637
Right-of-use assets obtained in exchange for lease obligations:		
Finance lease	895	94
Operating lease	–	205,755

11. Leases (Continued)

Commitments relating to noncancellable operating and finance leases obligations for each of the next five fiscal years after September 30, 2021, and the years thereafter, are as follows (in thousands):

	Operating Leases	Finance Leases
2022	$ 21,700	$ 2,449
2023	19,512	1,397
2024	17,386	1,394
2025	15,133	1,382
2026	13,933	1,350
Thereafter	157,310	1,546
Total minimum future payments	244,974	9,518
Less imputed interest	(81,202)	(1,463)
Total liabilities	163,772	8,055
Less current portion	(17,406)	(2,018)
Long-term liabilities	$146,366	$ 6,037

12. Self-Insurance Trusts and Reserves

Prior to unification, certain System members were partially self-insured for professional and general liability risks. These entities shared risk above certain amounts with an insurance company for all claims related to the partially self-insured plans. Post-unification, the professional and general liability policy has excess coverage whereby the System is responsible for the first $200,000 of a professional general liability claim; 50% of amounts between $200,000 and $2,000,000; and 25% of amounts over $2,000,000 and up to $7,000,000.

The professional and general liability trust funds of the unified entities have been combined and will be used to pay claims from anywhere in the System with the exception of The Memorial Hospital at North Conway, N.H. who insures its medical malpractice risks on a claims-made basis. In fiscal year 2020, the System maintained separate trust funds for both the professional and general liability insurance. The System funds these trusts based upon actuarial valuations and historical experience. Self-insurance reserves for self-insured unpaid claims and incidents are estimated using actuarial valuations, historical payment patterns, and current trends. Self-insurance reserves are recorded in the period the claim or incident occurs and adjusted in future periods as additional data becomes known. The general liability trust as originally created has met its original purpose and MaineHealth determined in fiscal year 2021 that it was no longer needed. The trust was dissolved in July 2021 and the proceeds were distributed to MaineHealth.

12. Self-Insurance Trusts and Reserves (Continued)

As of September 30, 2021 and 2020, there are no known claims outstanding, which, in the opinion of management, will be settled for amounts in excess of insurance coverage. As of September 30, 2021 and 2020, an accrual for estimated claims incurred but not reported was recorded. An estimated recovery related to such claims is included in the consolidated financial statements as of September 30, 2021 and 2020.

The System provides health and dental insurance for its employees through a self-insured plan administered by the System. Self-insurance reserves for unpaid claims and incidents are carried at MaineHealth.

With the exception of The Memorial Hospital at North Conway, N.H., the System provides workers compensation insurance for its employees through a self-insured plan administered by MaineHealth. Self-insurance reserves are carried at MaineHealth for unpaid claims and settlements are estimated using actuarial valuations. Self-insurance reserves are recorded in the period the incident occurs and adjusted in future periods as additional data becomes known. The Memorial Hospital at North Conway, N.H. is fully insured through New Hampshire Employers Insurance Company.

13. Retirement Benefits

Defined Benefit Pension Plan

The System sponsors a defined benefit pension plan (the Plan), which was previously sponsored by Maine Medical Center, covering all grandfathered employees that work 750 or more hours in a plan year. Effective January 1, 2014, the Plan was amended to exclude from participation all employees hired on or after January 1, 2014. Such employees are eligible to participate in the defined contribution plan (the MaineHealth 403(b) Retirement Plan). The Plan was also amended effective January 1, 2011, to change the basis of a participant's accrued benefit. Prior to January 1, 2011, accrued benefits were based on the highest five years of final average pay. Effective January 1, 2011, for participants hired on or before December 31, 2009, there is a benefit based on the participant's final average pay through December 31, 2020, and years of service through December 31, 2010. This final average pay benefit is frozen as of December 31, 2020.

For participants currently employed or hired on or after January 1, 2010, but before January 1, 2014, accrued benefits are based on a cash balance formula that became effective January 1, 2011. A participant's cash balance account is increased by an annual cash balance contribution for participants with 750 hours of service, and interest credits in accordance with the terms of the amended Plan Document. The annual cash balance contribution is determined by applying a rate based on age and years of service to the participant's annual compensation. Interest credits are equal to a percentage of the participant's cash balance account on the first day of the Plan year and are credited on the last day of the Plan year prior to payment of the annual cash balance contribution. Except for certain instances, the rate of interest used to determine the interest credit for a Plan year is 5%. Retiring or terminating employees have the option to receive a lump-sum payment, annuity, or transfer to another qualified plan in accordance with the terms of the amended Plan Document.

13. Retirement Benefits (Continued)

The System's funding policy is to contribute amounts to fund current service cost and to fund over 30 years the estimated accrued benefit cost arising from qualifying service prior to the establishment of the Plan. The assets of the Plan are held in trust and are invested in a diversified portfolio that includes temporary cash investments, marketable equity securities, mutual funds, U.S. Treasury notes, corporate bonds and notes, hedge funds, and other funds.

Defined Benefit Postretirement Medical Plan

As of May 1, 2015, eligible retirees who were enrolled in the Over 65 Retiree Group Companion Plan have transitioned to supplemental retiree health insurance options offered through a private Medicare Exchange engaged by the System and the Companion Plan was curtailed. Transitioned retirees, and certain future retirees, are eligible for an employer contribution to a Health Reimbursement Account (HRA) if they meet certain eligibility requirements. All other eligible System retirees who become Medicare eligible are also eligible to obtain supplemental coverage through the private Medicare Exchange but are not eligible for the employer contribution to the HRA.

Effective January 1, 2016, under age 65 retirees no longer have the option to enroll in the Under 65 Retiree Medical Plan. Retirees enrolled in the plan on or before December 1, 2015 are grandfathered until such time as they age into Medicare coverage at age 65. Grandfathered retirees continue to pay 100% of the cost (with the exception of those retirees enrolled as a result of the Voluntary Early Retirement Window in 2013). These retirees by a special arrangement pay the active employee rate for either three years or until they turn 65 whichever is sooner.

The activity in the Plan and Postretirement Medical Plan using valuation dates of September 30, 2021 and 2020, consists of the following (in thousands):

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2021	2020	2021	2020
Net periodic benefit cost:				
Service cost	$ 33,973	$ 33,318	$ –	$ –
Interest cost	28,806	31,486	105	134
Expected return on plan assets	(50,395)	(46,688)	–	–
Amortization of actuarial loss	38,173	36,304	22	28
Prior service credit	(836)	(1,462)	(193)	(193)
Net periodic benefit cost	$ 49,721	$ 52,958	$ (66)	$ (31)

13. Retirement Benefits (Continued)

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2021	2020	2021	2020
Change in benefit obligation:				
Benefit obligation, beginning of year	$1,040,877	$ 971,081	$ 3,883	$ 4,238
Service cost	33,973	33,318	–	–
Interest cost	28,806	31,486	105	134
Actuarial (gain) loss	(13,616)	61,502	(245)	(91)
Benefits paid	(69,119)	(49,851)	(374)	(398)
Expenses paid	(5,372)	(6,659)	–	–
Benefit obligation, end of year	1,015,549	1,040,877	3,369	3,883
Change in plan assets:				
Net assets of plan, beginning of year	746,215	652,909	–	–
Actual return on plan assets	126,612	90,516	–	–
Employer contribution	61,170	59,300	374	398
Benefits paid	(69,119)	(49,851)	(374)	(398)
Expenses paid	(5,372)	(6,659)	–	–
Net assets of plan, end of year	859,506	746,215	–	–
Net amount recognized	$ (156,043)	$(294,662)	$(3,369)	$(3,883)

The additional defined benefit pension plan and Postretirement Medical Plan disclosure information for the years ended September 30, 2021 and 2020, is as follows (in thousands):

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2021	2020	2021	2020
Amounts recognized in the consolidated balance sheets – accrued retirement benefits	$ (156,043)	$ (294,662)	$ (3,369)	$ (3,883)
Additional information – accumulated benefit obligation	(986,452)	(1,011,047)	–	–

Net assets without donor restrictions at September 30, 2021 and 2020, include unrecognized losses of $273,693,000 and $401,699,000, respectively, related to the Plan. Of this amount, $30,015,000 is expected to be recognized in net periodic pension cost in 2022. The aggregate gain in 2021 was primarily due to the improved funded status resulting from the better-than-expected return on assets, and the aggregate loss in 2020 was due to the decrease in the long-term interest rates underlying the discount rate.

13. Retirement Benefits (Continued)

The assumptions of the Plan as of September 30, 2021 and 2020 are as follows:

	2021	2020
Measurement date	September 30	September 30
Census date	January 1	January 1
Used to determine net periodic pension cost:		
Discount rate	2.86%	3.35%
Rate of compensation increase	3.50%	3.50%
Expected long-term rate of return on plan assets	7.00%	7.00%
Used to determine benefit obligation:		
Discount rate	2.98%	2.86%
Rate of compensation increase	3.50%	3.50%

The expected long-term rate of return on plan assets for the Plan reflects the System's estimate of future investment returns (expressed as an annual percentage) taking into account the allocation of plan assets among different investment classes and long-term expectations of future returns on each class.

The targeted allocation for the Plan investments are: debt securities – 30%, U.S. equity securities – 22.5%, international equity securities – 17.5%, emerging market equity securities – 5%, natural resources – 5%, and alternative investments – 20%. The Plan's investments as of September 30, 2021 and 2020 are disclosed in Note 8.

The Plan's overall financial objective is to provide sufficient assets to satisfy the retirement benefit requirements of the Plan's participants. This objective is to be met through a combination of contributions to the Plan and investment returns. The long-term investment objective for the Plan is to attain a total return (net of investment management fees) of at least 5% per year in excess of the rate of inflation measured by the Consumer Price Index. The nature and duration of benefit obligations, along with assumptions concerning asset class returns and return correlations, are considered when determining an appropriate asset allocation to achieve the investment objectives.

Investment policies and strategies governing the assets of the Plan are designed to achieve the financial objectives within prudent risk parameters. Risk management practices include the use of external investment managers, the maintenance of a portfolio diversified by asset class, investment approach, and security holdings, and the maintenance of sufficient liquidity to meet benefit obligations as they come due.

The medical inflation assumption used for measurement purposes in the per capita cost of covered health care benefits for the Postretirement Medical Plan was 6.5% annual rate of increase respectively, for the years ended September 30, 2021 and 2020. This rate was assumed to gradually decrease to 4.5% by 2023 and remain at that level thereafter.

13. Retirement Benefits (Continued)

Future benefits are expected to be paid as follows at September 30, 2021 (in thousands):

	Defined Benefit Pension Plan	Postretirement Medical Plan (net of Retiree Contributions)
Years ended September 30:		
2022	$ 70,102	$ 387
2023	68,970	372
2024	71,456	349
2025	70,393	326
2026	72,830	303
2027 – 2031	356,454	1,185

The estimated expected contribution to be made during the year ending September 30, 2022 is $40,587,000.

Defined Contribution Pension Plans

The System sponsors the MaineHealth 403(b) Retirement Plan, which benefits substantially all of their employees. This plan assumed the Maine Medical Center 403(b) Retirement Plan and subsequently over the course of several years merged in the various 403(b) plans of the various subsidiaries. Amounts expensed under these plans were $49,127,000 and $39,970,000 in 2021 and 2020, respectively. The Plan is a MaineHealth sponsored plan but each local health system contributes its own employer contribution level for its local employees.

Nonqualified Deferred Compensation Plan

The System offers a 457(b) nonqualified deferred compensation plan to certain eligible employees. Eligible employees may elect up to the maximum dollar amount as defined by Section 402(g) of the Internal Revenue Service code. The plan is funded solely by employee contributions that are invested in various marketable securities at the direction of the employees. These investments are classified as Level 1 and Level 2 investments which are valued using quoted prices for active markets of identical assets. The assets of the plan are the legal assets of the System until they are distributed to participants, and therefore the plan assets and corresponding liability are reported as other assets and accrued retirement benefits in the accompanying consolidated balance sheet. As of September 30, 2021 and 2020 the balances of the plan were $137,304,000 and $113,328,000, respectively.

14. Net Assets

Resources are classified for reporting purposes as net assets without donor restrictions and net assets with donor restrictions, according to the absence or existence of donor-imposed restrictions. Resources arising from the results of operations or assets set aside by the Board of Trustees are not considered to be donor restricted. Net assets with donor restrictions represent funds including contributions and accumulated investment returns, whose use has been restricted by donors to a specific period or purpose or that have been restricted by donors to be maintained in perpetuity to provide a permanent source of income. Generally, the donors of these donor restricted assets permit the use of part of the income earned on related investments for specific purposes. Net assets are as follows at September 30 (In thousands):

	2021	2020
Without donor restrictions	$2,232,624	$1,774,871
With donor restrictions:		
Perpetual in nature	120,374	106,292
Purpose restricted	185,784	165,089
Time restricted	2,597	2,373
Net assets	$2,541,379	$2,048,625

Endowment Funds

The System's endowment consists of funds established for a variety of purposes. For the purposes of this disclosure, endowment funds include donor-restricted endowment funds. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

The System has interpreted state law as requiring realized and unrealized gains on net assets with donor restrictions to be retained in a net assets with donor restrictions classification until appropriated by the Board and expended. State law allows the Board to appropriate so much of the net appreciation of net assets with donor restrictions as is prudent considering the System's long-and short-term needs, present and anticipated financial requirements, and expected total return on its investments, price level trends, and general economic conditions.

As a result of this interpretation, the System classifies as net assets with donor restrictions (a) the original value of the gifts donated to the endowment when explicit donor stipulations requiring permanent maintenance of the historical fair value are present and (b) the original value of the subsequent gifts to the endowment when explicit donor stipulations requiring maintenance of the historical fair value are present. The remaining portion of the donor-restricted endowment fund composed of accumulated gains not required to be maintained in perpetuity is classified as net assets with donor restrictions until those amounts are appropriated for expenditure in a manner consistent with the donor's stipulations. The System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: duration and preservation of fund, purposes of the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the System, and the investment policies of the System.

14. Net Assets (Continued)

Endowment Investment Return Objectives

The System has adopted investment policies for endowment assets that attempt to provide a predictable stream of funding to the programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the System must hold in perpetuity or for a donor-specified period(s) as well as board-designated funds. Under this policy, the endowment assets are invested in a manner to attain a total return (net of investment management fees) of at least 5.0% per year in excess of inflation, measured by the Consumer Price Index. To satisfy its long-term rate of return objectives, the System targets a diversified asset allocation that places a greater emphasis on equity-based investments within prudent risk constraints.

Endowment Investment Asset Composition

The following is a summary of the endowment asset composition by type of fund at September 30, 2021 and 2020, and the changes therein for the years then ended (in thousands):

	With Donor Restrictions
Endowment investment, end of year, September 30, 2019	$109,500
Investment return, net	15,232
Contributions	533
Contribution of net assets from acquired affiliates	15,073
Changes in interest in perpetual trust	72
Net assets transferred	174
Appropriation of endowment assets for expenditure	(7,256)
Endowment investment, end of year, September 30, 2020	133,328
Investment return, net	27,974
Contributions	1,994
Changes in interest in perpetual trust	(419)
Appropriation of endowment assets for expenditure	(6,658)
Endowment investment, end of year, September 30, 2021	$156,219

Funds With Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the System to retain as a fund of perpetual duration.

15. Functional Expenses

The System provides health care services through its acute care, specialty care, and ambulatory care facilities. Expenses relating to providing these services for the years ended September 30, 2021 and 2020, are as follows (in thousands):

	Program Services		Supporting Activities	
	Healthcare Services	Research	Management and General	Total Expenses
September 30, 2021				
Salaries, wages and fringe benefits	$1,385,485	$18,892	$621,292	$2,025,669
Patient care supplies	542,624	1,833	19,775	564,232
Professional fees and purchased services	183,398	6,673	130,865	320,936
Depreciation and amortization	121,091	1,259	39,295	161,645
Other operating expenses	123,704	695	64,008	188,407
Interest expense	11,953	–	6,701	18,654
	$2,368,255	$29,352	$881,936	$3,279,543
September 30, 2020				
Salaries, wages and fringe benefits	$1,227,977	$17,157	$595,071	$1,840,205
Patient care supplies	443,745	1,500	17,216	462,461
Professional fees and purchased services	146,334	8,322	106,885	261,541
Depreciation and amortization	114,975	1,324	37,301	153,600
Other operating expenses	101,394	636	67,534	169,564
Interest expense	10,034	–	7,686	17,720
	$2,044,459	$28,939	$831,693	$2,905,091

16. Contingencies

The System is subject to complaints, claims, and litigation, which have risen in the normal course of business. In addition, the System is subject to compliance with laws and regulations of various governmental agencies. Recently, governmental review of compliance with these laws and regulations has increased resulting in fines and penalties for noncompliance by individual health care providers. Compliance with these laws and regulations is subject to future government review, interpretation, or actions, which are unknown and un-asserted at this time.

SUPPLEMENTAL CONSOLIDATING INFORMATION

MaineHealth and Subsidiaries Consolidating Balance Sheet September 30, 2021 (In thousands)	Maine Health	Maine Medical Center	Southern Maine Health Care	Mid Coast-Parkview Health	Coastal Healthcare Alliance	Franklin Community Health Network	Lincoln Health Group	The Memorial Hospital North Conway, NH	Western Maine Health Care Corporation	Maine Behavioral Healthcare	NorDx	Maine Health Care at Home	Other	Eliminations	Consolidated
Assets															
Current assets:															
Cash and cash equivalents	$ 322,252	$ 2,644	$ 847	$ 15,614	$ 2,848	$ 322	$ 38,388	$ 38,278	$ 160	$ 28	$ 4,474	$ 848	$ 8,738	$ –	$ 435,441
Investments	1,024,134	68,500	–	1,652	1	–	–	16,469	–	–	78,234	1,748	5,014	–	1,195,752
Investments held for members	403,947	–	–	–	–	–	–	–	–	–	–	–	–	(403,947)	–
Patient accounts receivable	–	201,624	34,190	45,694	27,992	14,245	10,887	10,583	7,152	6,811	2,785	5,591	–	–	367,554
Current portion of investments whose use is limited	6,264	184,123	9,315	–	712	214	67	–	–	–	–	–	–	–	200,695
Inventories, prepaid expenses and other current assets	16,259	90,087	5,356	7,791	6,927	3,079	4,282	3,132	2,058	2,144	3,430	272	14,885	(11,985)	147,717
Estimated amounts receivable under reimbursement regulations	–	42,110	13,539	(195)	14,762	8,416	12,817	–	1,861	1,529	–	(760)	–	(94,079)	–
Current portion of notes and amounts receivable from affiliated entities	13,219	2,116	1,544	156	902	100	49	3,531	66	28	10,319	6	33	(32,069)	–
Total current assets	1,786,075	591,204	64,791	70,712	54,144	26,376	66,490	71,993	11,297	10,540	99,242	7,705	28,670	(542,080)	2,347,159
Assets whose use is limited by:															
Debt agreements	3,695	184,123	9,315	–	712	214	67	–	129	–	–	–	–	–	198,255
Board designation	5,005	–	–	92,270	26,638	–	5,728	20,932	662	–	–	4,170	–	–	155,405
Self-insurance trust agreements	46,901	–	–	105	–	–	–	–	–	–	–	–	–	–	47,006
Specially designated specific purpose funds	2,711	28,168	12,680	13,003	12,020	1,597	2,138	520	2,692	1,367	–	931	–	–	77,827
Plant replacement funds	–	667	–	827	–	–	–	–	–	154	–	–	–	–	1,648
Funds functioning as endowment funds	55	125,470	1,903	18,134	3,914	1,724	2,449	664	558	1,103	–	245	–	–	156,219
Pooled life income funds	–	2,546	–	–	–	–	–	–	–	–	–	–	–	–	2,546
Beneficial interest in perpetual and charitable remainder trusts	–	879	15,301	–	34,048	387	4,240	–	–	161	–	1,766	–	–	56,782
	58,367	341,853	39,199	124,339	77,332	3,922	14,622	22,116	4,041	2,785	–	7,112	–	–	695,688
Less current portion	(6,264)	(184,123)	(9,315)	–	(712)	(214)	(67)	–	–	–	–	–	–	–	(200,695)
	52,103	157,730	29,884	124,339	76,620	3,708	14,555	22,116	4,041	2,785	–	7,112	–	–	494,993
Property, plant and equipment - net:	216,332	754,229	84,333	74,430	110,285	25,669	48,164	30,330	31,332	38,726	4,658	788	1	26,521	1,445,798
Right of use assets	157,963	–	–	–	–	–	–	250	–	–	–	1,965	–	–	160,178
Other assets	150,843	56,835	28,424	7,257	23,152	8,728	7,803	5,949	4,595	1,556	1,864	559	–	(113,392)	184,173
Notes and amounts receivable from affiliates – less current portion	93,191	–	–	–	62	–	–	–	–	–	–	–	–	(93,253)	–
Total assets	$ 2,456,507	$ 1,559,998	$ 207,432	$ 276,738	$ 264,263	$ 64,481	$ 137,012	$ 130,638	$ 51,265	$ 53,607	$ 105,764	$ 18,129	$ 28,671	$ (722,204)	$ 4,632,301

MaineHealth and Subsidiaries
Consolidating Balance Sheet
September 30, 2021
(In thousands)

	Maine Health	Maine Medical Center	Southern Maine Health Care	Mid Coast-Parkview Health	Coastal Healthcare Alliance	Franklin Community Health Network	Lincoln Health Group	The Memorial Hospital North Conway, NH	Western Maine Health Care Corporation	Maine Behavioral Healthcare	NorDx	Maine Health Care at Home	Other	Elimiantions	Consolidated
Liabilities and net assets															
Current liabilities:															
Current portion of long-term debt	$ 24,552	$ 3,891	$ 4,452	$ 3,547	$ 3,204	$ 620	$ 423	$ 714	$ 424	$ 179	$ –	$ –	$ –	$ (12)	$ 41,994
Current portion of SelHR purchased services	–	9,460	3,837	–	2,525	1,300	575	–	430	–	394	173	–	(18,694)	–
Current portion of lease obligation	16,804	–	–	–	–	–	–	139	–	–	–	463	–	–	17,406
Accounts payable and other current liabilities	236,219	73,536	9,037	9,017	9,002	1,558	2,545	11,319	1,825	1,330	6,679	688	15,832	(226)	378,361
Accrued payroll, payroll taxes and amounts withheld	86,051	4,532	3,018	3,155	(480)	403	193	1,374	195	666	1,474	811	–	–	101,392
Accrued earned time	21,447	39,251	7,230	6,828	12,292	2,776	3,610	1,856	2,776	3,654	2,674	1,870	558	–	106,852
Accrued interest payable	225	5,243	164	156	220	83	18	226	39	–	–	–	–	–	6,374
Estimated amounts payable under reimbursement regulations	10,643	60,037	16,654	1,208	11,035	4,719	8,081	26,970	9,321	3,249	–	86	–	(94,078)	57,925
Self-insurance reserves	34,888	–	–	–	–	–	–	–	–	–	–	–	–	–	34,888
Deferred revenue	49	10,449	39	1,253	1,406	150	202	797	2,064	303	–	34	334	–	17,080
Investments held for members	403,947	–	–	–	–	–	–	–	–	–	–	–	–	(403,947)	–
Amounts payable to affiliated entities	36	10,617	3,311	3,865	2,383	683	749	2,933	640	107	1,960	2,949	1,613	(31,846)	–
Total current liabilities	834,861	217,016	47,742	29,029	41,587	12,292	16,396	46,358	17,714	9,488	13,181	7,074	18,337	(548,803)	762,272
Accrued retirement benefits	130,352	159,412	–	6,952	–	–	–	–	–	–	–	–	–	–	296,716
Self-insurance reserves – less current portion	55,136	–	–	–	–	–	–	–	–	–	–	–	–	–	55,136
Long-term debt, less current portion	117,115	546,866	29,384	16,352	16,596	8,951	2,793	12,668	3,376	1,534	–	–	–	(50)	755,585
Long-term lease obligation – less current portion	144,765	–	–	–	–	–	–	89	–	–	–	1,512	–	–	146,366
Other liabilities	157,257	27,342	–	1,631	563	–	2,223	1,425	69	151	–	–	125	(115,939)	74,847
Amounts payable to affiliates – long-term	–	32,654	14,343	6,753	9,617	5,807	1,991	–	1,481	–	1,232	618	–	(74,496)	–
Total liabilities	1,439,486	983,290	91,469	60,717	68,363	27,050	23,403	60,540	22,640	11,173	14,413	9,204	18,462	(739,288)	2,090,922
Net assets:															
Without donor restrictions	1,014,237	403,307	93,372	182,944	143,986	33,723	104,443	68,914	25,375	37,650	91,351	6,029	10,209	17,084	2,232,624
With donor restrictions	2,784	173,401	22,591	33,077	51,914	3,708	9,166	1,184	3,250	4,784	–	2,896	–	–	308,755
Total net assets	1,017,021	576,708	115,963	216,021	195,900	37,431	113,609	70,098	28,625	42,434	91,351	8,925	10,209	17,084	2,541,379
Total liabilities and net assets	$ 2,456,507	$ 1,559,998	$ 207,432	$ 276,738	$ 264,263	$ 64,481	$ 137,012	$ 130,638	$ 51,265	$ 53,607	$ 105,764	$ 18,129	$ 28,671	$ (722,204)	$ 4,632,301

MaineHealth and Subsidiaries
Consolidating Statement of Operations
September 30, 2021
(In thousands)

	Maine Health	Maine Medical Center	Southern Maine Health Care	Mid Coast-Parkview Health	Coastal Healthcare Alliance	Franklin Community Health Network	Lincoln Health Group	The Memorial Hospital North Conway, NH	Western Maine Health Care Corporation	Maine Behavioral Healthcare	NorDx	Maine Health Care at Home	Other	Eliminations	Consolidated
Operating revenue:															
Patient service revenue	$ –	$ 1,638,572	$ 325,011	$ 230,431	$ 275,891	$ 93,979	$ 107,247	$ 87,176	$ 87,794	$ 82,422	$ 59,886	$ 32,029	$ –	$ (4,197)	$ 3,016,241
Direct research revenue	–	16,913	–	–	1	–	–	–	–	–	–	–	–	–	16,914
Indirect research revenue	–	5,508	–	–	–	–	–	–	–	–	–	–	–	–	5,508
Other revenue	368,972	272,325	27,151	15,804	38,146	7,792	11,661	7,146	8,851	17,840	75,277	3,307	13,821	(455,055)	413,038
Total operating revenue	368,972	1,933,318	352,162	246,235	314,038	101,771	118,908	94,322	96,645	100,262	135,163	35,336	13,821	(459,252)	3,451,701
Expenses:															
Salaries	190,712	741,494	142,445	115,096	129,896	41,998	52,468	33,254	35,609	62,350	33,676	19,819	5,029	(843)	1,603,003
Employee benefits	56,191	202,307	33,175	29,092	32,802	11,115	14,616	8,519	10,001	16,769	9,946	5,299	1,547	(8,713)	422,666
Supplies	1,629	390,590	32,986	31,166	38,842	11,740	9,266	12,500	9,972	2,092	21,627	1,634	198	(10)	564,232
Professional fees and purchased services	78,403	336,012	78,284	41,135	64,998	25,290	25,932	19,679	19,759	15,106	20,455	5,754	3,209	(413,080)	320,936
Facilities and other costs	17,785	57,727	13,502	11,705	10,387	2,984	4,207	3,678	2,273	4,637	6,750	2,248	952	(1,809)	137,026
State taxes	–	25,490	6,072	4,352	5,391	1,722	2,263	3,440	1,393	1,258	–	–	–	–	51,381
Interest	3,199	11,947	1,739	902	968	571	343	694	179	328	43	21	–	(2,280)	18,654
Depreciation and amortization	36,917	91,751	16,006	7,970	14,412	5,473	5,797	4,651	4,316	3,119	2,246	519	11	(31,543)	161,645
Total expenses	384,836	1,857,318	324,209	241,418	297,696	100,893	114,892	86,415	83,502	105,659	94,743	35,294	10,946	(458,278)	3,279,543
(Loss) income from operations	(15,864)	76,000	27,953	4,817	16,342	878	4,016	7,907	13,143	(5,397)	40,420	42	2,875	(974)	172,158
Nonoperating gains (losses), net:															
Gifts and donations – net of related expenses	39	782	122	398	376	1	266	–	–	–	–	6	–	–	1,990
Interest and dividends	18,913	(221)	730	4,468	1,603	16	328	137	12	7	1,016	63	79	–	27,151
Recognized gain (loss) on cash flow hedge instruments	973	3,218	–	–	–	–	–	–	–	–	–	–	–	–	4,191
Nonservice periodic pension costs	(630)	(15,118)	–	–	–	–	–	–	–	–	–	–	–	–	(15,748)
Equity in earnings of joint ventures	3,310	5,183	190	–	221	24	68	–	60	–	–	–	–	(1,763)	7,293
Increase (decrease) in fair value of investments	59,457	4,576	(117)	6,083	(355)	–	4	4,083	22	(1)	3,491	1,078	(66)	(63)	78,192
Other	(31)	–	2,964	156	10	(53)	351	(31)	(178)	(8)	–	–	–	–	3,180
Total nonoperating gains (losses), net	82,031	(1,580)	3,889	11,105	1,855	(12)	1,017	4,189	(84)	(2)	4,507	1,147	13	(1,826)	106,249
Excess of revenue and nonoperating gains – net over expenses	66,167	74,420	31,842	15,922	18,197	866	5,033	12,096	13,059	(5,399)	44,927	1,189	2,888	(2,800)	278,407
Net assets released from restrictions for property, plant and equipment	–	35,837	60	–	9,709	31	486	17	1,866	4,096	–	–	–	–	52,102
Retirement benefit plan adjustments	–	127,244	–	–	–	–	–	–	–	–	–	–	–	–	127,244
Equity transfer from (to) affiliates	(6,311)	(24,131)	(10,199)	15,013	(32,592)	2,673	46,145	–	(11,273)	23,175	(2,500)	–	–	–	–
Increase (decrease) in net assets without donor restriction	$ 59,856	$ 213,370	$ 21,703	$ 30,935	$ (4,686)	$ 3,570	$ 51,664	$ 12,113	$ 3,652	$ 21,872	$ 42,427	$ 1,189	$ 2,888	$ (2,800)	$ 457,753

MaineHealth Board of Trustees

At their annual meeting on October 24, 2018, the Corporators of MaineHealth gave their approval to a plan to unify our Maine-based local health systems under a single Board of Trustees effective January 1, 2019. Unification puts the strength of the entire MaineHealth system behind our efforts in each and every community to ensure the delivery of integrated, high-quality, well-coordinated care.

While the MaineHealth Board of Trustees provides governance for our Maine-based local health systems, Local Boards also play an important role in our communities. Local Boards are organized as committees of the MaineHealth Board and participate in quality oversight, oversight of local medical staffs, planning, budgeting and the hiring of key executives, local fundraising initiatives, among other duties.

MaineHealth Officers

- Chief Executive Officer: Andrew T. Mueller, MD
- Chief Operating Officer: Kelly Elkins
- Chair: Greg Dufour
- Vice Chair: George Isaacson
- Treasurer: Albert Swallow, III
- Secretary: Beth Kelsch

The following individuals are elected members of the MaineHealth Board of Trustees as of 12/31/21:

Lisa Tran Beaule, MD

Lisa Beaule, MD is an experienced medical leader and strategic partner committed to Patient Experience, Quality, and Operational Excellence with management experience of both clinical and nonclinical staff. As a respected and practicing surgeon, she brings deep and front line understanding of the operations and work flows in Preop, OR and PACU, with record of clinical excellence. She is recognized for demonstrated results in identifying areas of improvement, developing and implementing initiatives with

successful execution strategy. She is also a skilled communicator and collaborator across multiple disciplines while building, motivating and developing high-performing teams. As core faculty for residency, she is known as an experienced teacher, trainer and mentor. Lisa was the Associate Medical Director for MMP Urology from 2008 to 2017. She received her bachelor's in Psychology at Boston University in 1990, her medical degree in 1994 from UVM College of Medicine and will receive her MBA in 2019 from the Massachusetts Institute of Technology, Sloan School of Management.

L. Clint Boothby

L. Clinton Boothby, Esq. is the senior partner at Boothby Silver, LLC, a rural law firm with offices in Turner and Farmington. Clint is a 1980 graduate of the University of Maine at Orono with a degree in Agriculture and Resource Economics and a 1999 graduate of the University of Maine School of Law. Clint practices in the areas of small business and corporate law, estate planning and business succession, family law, and real estate, both transactional and litigation. He is a member of Androscoggin, Oxford, Franklin and Maine Bar Associations. He has served as President of the Oxford County Trial Lawyers Association. He currently chairs the Franklin County Health Network, which includes Franklin Memorial Hospital. He is an occasional guest speaker at the law school. In the past, he served as facilitator for the RSU #73 regional planning committee, Chair of the MSAD #36 Board of Directors, Chair of the Livermore Board of Appeals and as a member of the Board of Directors of Farm Family Insurance Company. Before attending law school, Clint and his brother Rob managed the family farm which has been in continuous operation since 1849. He and his incredibly patient wife of 40 years, Susan, have two adult children and five grandchildren. Susan is a third-grade teacher.

Matthew Chin

Matthew Chin has years of experience in managing operations, food sourcing, finance, information technology and business analytics. He has also worked in international

business marketing and project coaching. Currently, he serves as President of Yarmouth-based Harvesting Good, a wholly owned subsidiary of Good Shepherd Food Bank. He has also worked for Goodwill Industries of Northern New England.

Matt received his B.S. in Engineering at Brown University in Providence, R.I. He received his Masters of Business Administration at University of Southern California in Los Angeles. Matt sits on the Maine Medical Center Planning and Programs committee. He is on the board at Maine Farm to Institution and Fork Food Labs.

Katherine B. Coster

Kathy Coster has experience as a board member at both for-profit and nonprofit institutions. She currently is Chair of the Board of Gorham Savings Bank.

On the Board at Maine Medical Center since 2013, Kathy is Local Board Vice Chair and a member of the Finance, Quality and Safety and Credentials committees.

She has had a long affiliation with the Boys and Girls Clubs of Southern Maine, having served as President of the Board and co-chair of the $3 million Great Futures Campaign. Kathy has also held a number of roles as a volunteer for her alma mater, Dartmouth College, including representative to the Alumni Council and President of the Dartmouth Alumni Club of Maine. She is active in her church, as a past president of the Parish Council and a member of the Diocesan Review Board of the Diocese of Maine.

Professionally, Kathy worked as a commercial banker at institutions in New York, California, and Massachusetts. She and her husband Mike live in Falmouth and have three adult children.

Greg Dufour

Gregory A. Dufour has served as President and Chief Executive Officer of Camden National Corporation and Camden National Bank since January 2009. After joining the company in April 2001 as Senior Vice President of Finance, he assumed the additional responsibility for Operations and Technology from August 2002 until December 2003. In January 2004, Greg was named Chief Banking Officer for Camden National Corporation and President and Chief Operating Officer for Camden National Bank. In January 2006, he became President and CEO of Camden National Bank. He also serves on the board of directors of Camden National Bank and Camden National Corporation.

Prior to joining the company, Greg was Managing Director of Finance at IBEX Capital Markets in Boston, Massachusetts. In addition to his experience at IBEX, he held various financial management positions with FleetBoston Corporation including Vice President and Controller of Investment Banking and Banking Group Controller.

Greg has also served in various volunteer capacities for numerous community-related and trade organizations. He currently serves as vice chair and trustee of MaineHealth and as a Local Board member of Coastal Healthcare Alliance. Greg is a former chair of the Maine Bankers Association and a former member of several other non-profit organizations.

Morris Fisher

Morris Fisher is President, Boulos Asset Management. His experience includes real estate development, operations, leasing, and finance. In addition to providing strategic real estate advice to clients, he is responsible for directing a property management company with 50 employees and real estate projects under management totaling 5 million square feet of commercial space. His experience includes the development, marketing, leasing, and sale of major retail, office, and industrial properties in both downtown and suburban locations.

In addition to his service as an MMC Local Board member, Morris is a former officer and board member of The Park Danforth, Portland Public Library, Catholic Charities of Maine, and Portland's Downtown District. Prior to joining Boulos Asset Management, Morris was a senior accountant with KPMG Peat Marwick.

Nancy Hasenfus, MD

Dr. Hasenfus attended the University of Maine at Orono and received a bachelor's in Psychology in 1971, a master's in Education in 1973 (Special Education-Learning Disabilities), a PhD in Psychology in 1979 and went on to earn her MD in 1981 from Tufts School of Medicine in Boston, Massachusetts. She was then a resident in Internal Medicine at Maine Medical Center from 1981 to 1984.

Dr. Hasenfus served as the Medical Director of Bath Internal Medicine, a section of MidCoast Medical Group in Bath, Maine from 1997 to 2016. She was the Medical Director of Primary Care at MidCoast from 2016 until she retired in 2017. She was affiliated with Mid Coast Hospital, Bath and Brunswick from 1987 until her retirement. She served as President of the Medical Staff at Mid Coast Hospital from 2005 to 2007. She was a Board Member at Mid Coast Hospital for 10 years. She was a Clinical Assistant Professor for Tufts University School of Medicine from 2011 to 2017.

She was the Governor of the Maine Chapter of the American College of Physicians from May 2010 to May 2014. She became a Master of the American College of Physicians in October of 2017.

She has served on the Spring Harbor Hospital Board of Trustees since 2007, serving as the Vice Chair of the Spring Harbor Board for one year and then Vice Chair of MBH for two years. She has been Chair of Maine Behavioral Healthcare since November 2016.

Dr. Hasenfus resides in Brunswick and is married to Dr. Robert Anderson. They have two daughters.

Quincy Hentzel

Quincy Hentzel has close to 20 years of community advocacy and outreach leadership experience. She currently serves as Chief Executive Officer of the Portland Regional Chamber of Commerce, where she provides strategic leadership and direction for its six community chambers and 1,300 members. She has served in this role since February 2017.

She was previously President of the Portland Community Chamber of Commerce from 2015-17, where she provided leadership and advocacy for this 600-member business community organization. Quincy has also held leadership positions at Industrium and Maine Credit Union League.

Quincy holds a B.A. in Economics from University of Illinois at Champaign-Urbana and a Juris Doctor from Chicago-Kent College of Law. She serves on the Board of ProsperityME, Maine Community Foundation, cPort Credit Union, and Boys and Girls Club in Portland.

Kathleen A. Herlihy, MD, MHP

Kate Herlihy, MD is the current Medical Staff President and board member of Western Maine Health. She is the Medical Director of Pediatrics for Western Maine Pediatrics. As a general pediatrician, she has worked with a team to set up a patient centered medical home for children in her area which provides for medical, dental and mental health needs. She plays an active role in educating pediatric residents from Maine Medical Center, having 2-5 residents per year. Kate is actively participating in the Tufts Medical School/MMC teaching program for Tufts medical students as well as teaching medical students from various other medical schools. She is director of the Oxford Hills School Based Health Center as well school physician for SAD 17. She has served on many hospital committees including Executive Committee, Pediatric Services Committee, Obstetrics/Perinatal Committee, Physician Recruitment Committee, Performance Improvement and Patient Safety Council, Strategic Planning and Finance Committees. She has served in MaineHealth system-wide boards and task forces.

Kate lives in Norway, Maine with her husband and has three college-aged children. She enjoys running, hiking, camping, skiing, kayaking, and teaching Zumba to community members.

George (Ted) Hissong

George (Ted) Hissong serves on the Southern Maine Health Care (SMHC) Local Board as chairman and is chairman of the SMHC Governance Committee. He is president and CEO of Greystone, Inc. located in Wells. he has served as a trustee of the Kennebunk Light and Power District, two years as chair as well as a trustee of the Kennebunk Sewer District. He is currently a member of the Sanford Industrial Development Commission.

George graduated with a bachelor of science in physical chemistry from Heidelberg University, Tiffin, OH and attended graduate school at Purdue University, W. Lafayette, IN.

Ann Hooper

Ann Hooper retired in 2017 after 43 years, 41 years as the Director of Medical Imaging, at Waldo County General Hospital. Her career started as a student at the Thayer Hospital School of Radiology in Waterville and from there to the New England Deaconess Hospital specializing in Interventional Medicine and Management. Her love of medicine was found at Waldo – the hospital, the community and the dedication to patient care. Ann worked with the Oncology Department to help raise monies for those unable to pay for services and worked with the Imaging staff and administrative team to develop and open the Ann Hooper Center for Women's Imaging specializing in breast health. Ann and her husband, Ken, live in Searsport.

George Isaacson

George Isaacson, a graduate of Bowdoin College and the University of Pennsylvania Law School, is a senior partner in the law firm of Brann & Isaacson. He serves as General Counsel to L.L. Bean, Inc. and represents direct marketing companies throughout the United States. He has regularly been listed in "The Best Lawyers in America," a peer-selected referral guide. George is a Senior Lecturer on the Bowdoin College faculty, teaching courses on Constitutional Law and Comparative Constitutional Law. He is a member of the Board of Trustees of MaineHealth and its Strategic Planning Committee. He is also a member of the Board of Trustees of the Maine Public Broadcasting Network. He is a past President of the Bowdoin International Music Festival, and a former member of the governing boards of Maine Medical Center, Pine Tree Legal Assistance, Casinos No!, Livermore Falls Trust Company, Friends of Retarded, Inc., and Congregation Beth Abraham.

David James Kumaki, MD, FACP

David James Kumaki, MD, is an active member of the medical staff at Stephens Memorial Hospital specializing in internal medicine. In the past, he simultaneously served as chair of both the Stephens Memorial Physician Hospital Organization (PHO) and the Maine PHO. Kumaki is a physician leader on MaineHealth's Shared Health Record project (SeHR) and a member of the SeHR executive committee. He is also chief medical information officer for Western Maine Health. Previously on the staff at New Hampshire's Androscoggin Valley Hospital, his experience extends well beyond New England. Kumaki is a long-time member of the Wilderness Medical Society and Nepal Studies Association. His experience includes several positions in Kathmandu, Nepal as well as in Greater Boston, first as an intern and resident at Boston City

Hospital, and later on the staff at East Boston Neighborhood Health Center, New England Baptist Hospital and Symmes Hospital.

Brett M. Loffredo, MD

Brett Loffredo, MD, is a primary care physician for Maine Medical Partners – Westbrook Primary Care.

Born and raised in Massachusetts, Dr. Loffredo has been affiliated with Maine Medical Center and Maine Medical Partners since starting his family medicine residency at MMC in 2004, after completing his medical degree at Boston University. Since that time, he has pursued leadership roles within the organization, serving as the Chief Resident of Family Medicine in 2007 before becoming the Medical Director of Maine Medical Partners – Gorham Family Medicine, and then MMP Westbrook Primary Care. He now serves as the Medical Director of Physician Financial Sustainability Initiatives for MMP.

Dr. Loffredo completed his MaineHealth Physician Leadership Development Fellowship in 2011 and is currently enrolled in the MBA program at the University of Massachusetts. He has been an active member of the MMP Board of Trustees, including serving as Vice-Chairman, and as a member of the Executive, Operations, and Finance Committees. He also sits on the Planning and Programming and Finance Committees of the MMC Board.

Dan Loiselle, MD

Dr. Dan Loiselle is the Chief Medical Officer of InterMed, where he has practiced internal medicine since 1998.

Dr. Loiselle grew up in Eddington, Maine. He completed undergraduate studies at Bowdoin College, is a 1995 graduate of Dartmouth Medical School and did his residency at MMC before joining InterMed in 1998.

He provides general internist preventive medicine for adult patients and enjoys the longitudinal care of multiple family members and trying to improve the health of our patient population, as well as the lives of InterMed's providers and staff.

Dr. Loiselle chairs both InterMed's Information Technology Committee and its Quality Improvement Committee. He is a member of the InterMed Board of Directors, and sits on InterMed's Executive Committee, Department Chiefs, Finance Committee, Compliance Committee, and Workflow Committee, ASC Committee, Preventive Health Task Force and Quality Improvement Committee. He is also a member of the Maine Medical Association and the American College of Physicians.

In his free time, Dr. Loiselle enjoys using his backyard smoker, and skiing at Sugarloaf.

Peter Manning, MD

Dr. Manning is board certified as an obstetrician/gynecologist with Southern Maine Healthcare Physician Services. He has worked for SMHC (and formerly PrimeCare) for 10 years. Prior to his job in Biddeford, he completed his residency at Maine Medical Center. He is a graduate of the University of Vermont College of Medicine and Colby College.

He has served as the Maine Section Chair for the American College of Obstetricians and Gynecologists, has completed the MaineHealth Physician Leadership Development Fellowship, and serves on the MaineHealth Board Education Advisory Committee. Since 2012, Dr. Manning has served on the board of directors for SMHC Physician Services and currently serves as its president. He also is the Quality/Safety leader for SMHC Women's Health and the secretary of the SMHC Local Board.

He lives in Kennebunk with his wife, Dr. Christina Manning (SMHC Pediatrics), and his two children, Kate and Noah. In his free time he enjoys skiing, cycling and photography.

Marie J. McCarthy

Marie McCarthy is Chief Operations and People Officer at L.L.Bean, and has been with the company since 1993. Working primarily in Human Resources throughout her career, her role has expanded in recent years to include current oversight of Operations, including Fulfillment, Returns, Manufacturing, Customer Satisfaction, and Corporate Facilities, in addition to Human Resources, and Health, Safety and Wellness. She is a member of the company's Investment Committee, is Chair of the Benefits Committee, is a member of the Retail Real Estate Committee that governs store selection/construction, and convenes the Corporate Real Estate Committee that oversees all corporate holdings. She currently serves on the Board of Maine Medical Center, is a member of United Way's Kenneth Jordan Higgins Scholarship Committee and was formerly on the non-profit Boards of Lift360 and Youth and Family Outreach. Marie holds a bachelor's degree in Psychology from the University of Wisconsin-Madison and a master's degree in Industrial Relations from the University of Rhode Island.

Jere Michelson

Jere Michelson is President of Libra Foundation, with oversight responsibility for all operating and financial aspects of the Foundation's interests.

Prior to joining Libra Foundation, Jere was a member of the management group at the accounting firm of Baker Newman Noyes, LLC in Portland, where he consulted primarily on closely-held corporations and shareholders with multi-state operations in that firm's corporate tax department. In 2001, he left public accounting to join Libra Foundation in its pursuit for the betterment of Maine's citizenry.

Jere is the chairman of the Maine Medical Center Board of Trustees and is also a member of its Executive Committee. He also sits on the Audit and Finance committees

at MaineHealth. Through appointment from Sen. Susan Collins, Jere serves on the United States Military Service Academy Nomination Committee for the first district of Maine. Mr. Michelson also serves on the boards of Pineland Farms Natural Meats, Inc., Pineland Farms Dairy Company, Inc., and Gorham Savings Bank.

He received his bachelor's degree in accounting from the University of Southern Maine in Portland and his master's degree in taxation from Thomas College in Waterville.

Brian H. Noyes

Brian Noyes serves as Vice President and Shareholder of R.M. Davis, Inc. Brian has a long and distinguished history in financial planning and investment management. He has earned numerous professional distinctions, including a designation of Certified Investment Management Consultant in 1988, Chartered Financial Analyst in 1993, and Chartered Investment Counselor in 1996.

He was educated at Governor Dummer Academy in Byfield, Mass., then went on to earn bachelor of science degrees in Business Administration and Communications from the University of New Hampshire.

He is a member of numerous investment organizations such as the Maine Security Analysts Society and the Boston Security Analyst Society. His other board affiliations include the Maine Public Employees Retirement System, where he is serving as Chair, and the Baxter State Park Investment Committee, which he also chairs.

Brian lives in Freeport with his wife and two daughters. He enjoys hunting, fishing, Nordic skiing and other sports.

Sandra (Sandy) Morrell-Rooney

Sandy grew up in Brunswick and graduated from Brunswick High School. She attended Bowdoin College and graduated from Muhlenberg College in Allentown, Penn., with a degree in Political Science. She worked for Congressman David Emery both in Washington D.C. and Augusta, Maine, before joining her family's business in the late 1970s. When the business, Downeast Energy Corp, was sold in 2012, Sandy retired. She held various administrative positions within the company and retired as Vice President for Human Resources and Administration. While employed, she was Chair of the Maine Oil Dealers' Workers Compensation Trust and served on the Maine Chamber of Commerce Human Resources Committee.

Sandy is the immediate past Chair of the Mid Coast-Parkview Health Board; she serves on its Executive, Human Resources (which she chairs) and Planning Committees. She co-chaired the recently completed Mid Coast-Parkview Capital Campaign. In addition, she is a trustee of Bath Savings Institution and Bath Savings Trust Company. Sandy is Trust Emeritus of the Maine State Music Theater Board. She currently serves as Chair of the Human Resources Committee. She is a past Chair of the Board and has served on various MSMT committees. She belongs to the Brunswick Rotary Club.

Thomas J. Ryan Jr., MD, FACC

Dr. Ryan is a graduate of Dartmouth College and the Tufts University School of Medicine. He completed his training in Internal Medicine and Cardiology at Brigham and Women's Hospital in Boston and left the faculty at Harvard Medical School in 1992 to move to Maine with his wife Maribeth Hourihan-a pediatric cardiologist. He is board certified in Internal Medicine, Cardiovascular Disease and Interventional Cardiology. He is the current medical director of the catheterization laboratory at Maine Medical Center and is an interventional cardiologist with Cardiovascular Consultants of Maine. His clinical and research interests focus on ischemic heart disease, coronary angioplasty/stents and heart attack care.

Dr. Ryan is a graduate of the MaineHealth Physician Leadership training program and has served on the MaineHealth Clinical Integration Committee for ten years. He has served on the MaineHealth board since 2006 and is a member of the governance and strategic planning committees.

Melissa Smith

Melissa Smith is the President and CEO of WEX, a global corporate payments company. A finance expert by training, Smith joined WEX in 1998 and played a pivotal role as WEX's chief financial officer, leading the company through a highly successful initial public offering and focusing on its growth as a public company. Her record of execution, continuous improvement, and increased responsibilities for WEX's business operations led to her appointment as president of the Americas, and ultimately as president and CEO of the entire company. As CEO, Smith has responsibility for the company's day-to-day global operations and its long-term strategic growth. She also serves as a WEX board member.

Smith is an active member of her community and was named The Girl Scouts of Maine's 2013 Woman of Distinction, and a Mainebiz 2012 Woman to Watch. Recognized as an industry leader, Melissa was named the PYMNTS.com 2014 Most Innovative Woman in Payments and a PaymentsSource 2014 Most Influential Woman in Payments. She serves on the Center for Grieving Children's Board of Directors and participates in the Executive Women's Forum, which she co-founded to provide a support network for female executives in her local community.

Melissa began her career at Ernst & Young and earned a bachelor's degree in business administration from the University of Maine.

Susannah Swihart

Susannah Swihart spent two decades at BankBoston Corporation in a wide variety of leadership roles, including vice chairman and CFO. Previous responsibilities at BankBoston included management of a variety of corporate banking businesses and

risk functions. Since returning to Maine in 2000, she has committed her efforts to corporate and community boards. She is lead independent director for Dead River Company, a former chair of the boards of MaineHealth and the Boys and Clubs of Southern Maine, and a former trustee of Maine Medical Center and Preble Street. Susannah graduated from high school in Naples, Maine and is also a graduate of Harvard College and Harvard Business School.

Linda Terry

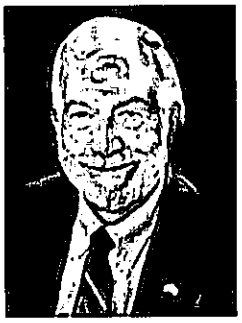
Linda serves on the Board of Trustees of Memorial Hospital in North Conway, NH. She chairs the Finance Committee and serves on the Governance Committee and the Executive Committee. Prior to her retirement, Linda held the positions of Assistant Vice President and Counsel at Massachusetts Mutual Life Insurance Company, with responsibility for providing legal advice on private placement and mezzanine investments. Previous to that, she acted in a similar capacity as Senior Counsel at Cigna Corporation. She is a graduate of the University of Connecticut School of Law and a member of the American College of Investment Counsel.

Linda's community activities in Jackson, NH include chairing the Jackson Public Library Board of Trustees and membership in The Friends of the Jackson Public Library.

Stuart Watson

Stuart is the Founder and Chief Executive Officer of zFlo Inc., a medical device and software distribution company with offices in Westbrook. In addition to serving on MaineHealth and Maine Medical Center's Board, Stuart is an overseer of the Brigham and Women's Hospital, as well as a member of the Harvard School of Public Health's

Nutrition Round Table and Dean's Leadership Council. He also serves as a director of the Thomas J. Watson Foundation. He is a former Chairman of the National Wildlife Refuge Association and a former Trustee of the Hotchkiss School, an independent boarding school located in Lakeville, Connecticut. Stuart also served on the corporation of Mass General Hospital. He is married to Karen, and they have five children and four grandchildren.



Peter W. Wood

Peter retired in 2013 after 18 years as the Executive Director of the Maine Medical Center Physician-Hospital Organization (MMC PHO), now the MaineHealth ACO, and the Maine Physician Hospital Organization. Following retirement, he consulted with health care organizations interested in establishing ACOs. He developed and served as Interim Executive Director for the ACO at Southeast Alabama Medical Center in Dothan, Alabama.

In April 2013, Peter received the Maine Quality Counts Quality Improvement Leadership Award for the programs and initiatives he led at the MMC PHO.

Before moving to Maine in 1995, Peter was with Blue Cross and Blue Shield of the Rochester (NY) area for 12 years, where he was the VP of Claims Operations for six years, and then VP of Blue Choice, a 400,000 member IPA model HMO. From 1994-1995, he served as the President of the Rochester Mental Health Association.

Prior to Blue Cross, Peter was the VP for administration with the Rochester Area Hospitals' Corporation, a multi-hospital group in Rochester. He was also the Executive Director of the Clifton Springs Hospital and Clinic, a 180-bed hospital in the Finger Lakes Region of New York.

Peter served on active duty as a Second Lieutenant in the Medical Service Corps of the U.S. Army from 1972-1974.

He is a graduate of Middlebury College and has an MBA with focus on health care administration from Cornell University. Peter lives in Topsham with his wife, Ellen, and golden retriever, Jeb.

CURRICULUM VITAE
Karen Simone, PharmD, DABAT, FAACT

FULL NAME AND DEGREE/S: Karen E. Simone, PharmD, DABAT, FAACT (formerly Karen S. Krummen)
CURRENT ADMINISTRATIVE TITLE: Director, Northern New England Poison Center
OFFICE ADDRESS: Northern New England Poison Center, 22 Bramhall Street, Portland, ME 04102
OFFICE PHONE NUMBER: (207) 662-7221
E-MAIL ADDRESS: simonk@mmc.org
FAX ADDRESS: (207) 662-5941

EDUCATION

Undergraduate

1992	*Bachelor of Science in Pharmacy*	*University of Cincinnati*

Medical School and/or Graduate School (for graduate degrees note field or discipline)

1994	*Doctor of Pharmacy*	*University of Cincinnati*

POSTDOCTORAL TRAINING

Experiential

LICENSURE AND CERTIFICATION

Pharmacy:

1992 – present	*Ohio*	*RPH.03219505*
2000 – present	*California*	*RPH 52158*
2001 – present	*Maine*	*PR4981*

Toxicology:

Diplomate of the American Board of Applied Toxicology
1998 – present *National/International*

Specialist in Poison Information, Certified by American Association of Poison Control Centers
1993 - 2000 *National*

Preparedness:

Homeland Security Exercise and Evaluation Program (HSEEP), certified as trained by the Maine Emergency Management Agency
2008 *National*

ACADEMIC APPOINTMENTS

2009 – present, Assistant Professor of Emergency Medicine, School of Medicine, Tufts University
2010 – 2013, Clinical Assistant Professor of Emergency Medicine, College of Osteopathic Medicine, University of New England
2000 – 2011, Assistant Professor of Emergency Medicine, College of Medicine, University of Vermont
1998 – 2000, Assistant Professor of Clinical Drug Information, College of Pharmacy, University of Cincinnati

HOSPITAL APPOINTMENTS

2000 – present, Director, Northern New England Poison Center, Maine Medical Center
1994 – 2000, Manager/Clinical Coordinator of Drug and Poison Information Services, Cincinnati Drug & Poison Information Center, Cincinnati Children's Hospital Medical Center
1992 – 1994, Senior Drug and Poison Information Specialist, Cincinnati Drug & Poison Information Center, University Hospital in Cincinnati
1989 – 1992, Drug and Poison Information Provider, Cincinnati Drug & Poison Information Center, University Hospital in Cincinnati

AWARDS AND HONORS

2020, Husson University School of Pharmacy Preceptor of the Year
2012, Advocacy in Action Award,' New Futures
2011, Designation as a Fellow of the American Academy of Clinical Toxicology
2009, Award on behalf of the Northern New England Poison Center for Collaboration, Quality Service and Contribution to the Knowledge in the Field, presented at the 2009 International Symposium on Pharmaceuticals in the Home and Environment
2008, Dr. John Snow Epidemiological Contribution Award, 2008, Maine Health and Human Services, Public Health Division of Infectious Disease
2008, Arkansas Traveler Award, State of Arkansas
1994, Student Fellowship Award, Cincinnati Drug and Poison Information
1991, AB, Dolly and Ralph Cohen Scholarship, University of Cincinnati
1991, Merck Sharp and Dohme Award, University of Cincinnati
1991, Procter & Gamble Research and Scholarly Activity Award, University of Cincinnati
1991, Plough Pharmacy Scholarship, University of Cincinnati
1991, Rho Chi Society, Beta Nu Chapter, University of Cincinnati
1990, David Uhlfelder Scholarship, University of Cincinnati

HOSPITAL, MEDICAL SCHOOL, OR UNIVERSITY COMMITTEE ASSIGNMENTS:

2021 – present: Vice Chair of the Maine Behavioral Healthcare Board
2014 – present: Chair of the Quality Excellence Committee for Maine Behavioral Healthcare
2013 – 2021: Member of the Board of Trustees for Spring Harbor Hospital (now a larger collaborative called Maine Behavioral Healthcare)
2006 – 2007: Maine Medical Center Pain Committee
2001 – 2005: Maine Injury Prevention Committee at Maine Medical Center

OTHER MAJOR COMMITEE ASSIGNMENTS:

2018 – present: Member of the Senior Editorial Board, Clinical Toxicology, The Official Journal of the American Academy of Clinical Toxicology, European Association of Poisons Centres and Clinical Toxicologists, American Association of Poison Control Centers and the Asia Pacific Association of Medical Toxicology
2016 – 2018: Immediate Past-President, American Academy of Clinical Toxicology
2014 – 2016: President, American Academy of Clinical Toxicology
2012 – 2014: President-Elect, American Academy of Clinical Toxicology
2010 – present: Member of the New Hampshire Injury Prevention Advisory Council
2009 – present: Government Affairs Committee, renamed Government Relations

Committee, American Association of Poison Control Centers
2008 – present: Strategic National Stockpile Advisory Group, State of Maine
2006 - present: Member of the Editorial Board, Clinical Toxicology, The Official Journal of the American Academy of Clinical Toxicology, European Association of Poisons Centres and Clinical Toxicologists, American Association of Poison Control Centers and the Asia Pacific Association of Medical Toxicology
2006 - 2015: State of Maine Integrated Core Injury Prevention, Injury Community Planning Group
2003 – 2015: Community Epidemiology Surveillance Network, State of Maine
2012 – 2014: President-Elect, American Academy of Clinical Toxicology
2007 – 2013: Fatality Reviewer, American Association of Poison Control Centers
2008 – 2012: Secretary, American Academy of Clinical Toxicology
2008 – 2012: Mushroom Task Force, State of Maine
2006 – 2011: American Board of Applied Toxicology Web Ad Hoc Web Task Force
2004 – 2011: Secretary/Treasurer, American Board of Applied Toxicology (ABAT)
2004 – 2010: Benzodiazepine Study Group, Steering Committee
2008 – 2009: LD1991 Workgroup, Co-Chair, Options for Ongoing Funding for the Northern New England Poison Center mandated by that State of Maine Joint Standing Committee on Appropriations and Financial Affairs, reporting to the Joint Standing Committee on Health and Human Services
2007 – 2009: Co-Chair of the Managers' Committee, American Association of Poison Control Centers
2007 – 2008: Cumberland County Public Health Assessment Data Workgroup
2007 – 2008: Member of the Board of Trustees, American Academy of Clinical Toxicology
2007 – 2008: Safe Medicine for ME Advisory Committee
2006 – 2007: HRSA Poison Help/Widmeyer Campaign AAPCC Expanded Review Committee Managing Directors' Representative Professional Advisory Committee Member appointed by the American Association of Poison Control Centers
2003 – 2007: Secretary, New England Chapter of the National Association of Drug Diversion Investigators
2002 - 2004: American Association of Poison Control Centers Certified Specialists in Poison Information Exam Committee
2002 - 2003: Poison Data Book Consolidation Committee, Northeast United States

TRAINING OF GRADUATE STUDENTS/POST DOCTORAL

2011 – present: Doctor of Pharmacy Clerkship for the University of New England College of Pharmacy in elective drug information and/or toxicology rotations
2010 – present: Toxicology and Poisoning for Maine Medical Center Medical Pharmacy Residents in elective toxicology rotations
2004 - present: Doctor of Pharmacy Clerkship for Creighton University, School of Pharmacy and Health Professions in elective drug information and/or toxicology rotations
2000 – present: Toxicology and Poisoning for Maine Medical Center Medical Students and Residents in elective toxicology rotations
2004 - 2011: Introduction to Toxicology and the Poison Center for Maine Medical Center Emergency Medicine Medical Students
1998 – 2000: Doctor of Pharmacy Drug Information Rotation for the University of Cincinnati College of Pharmacy

TEACHING RESPONSIBILITY

June 24, 2020, Two Fires, A Warrant and A Giant Fish Tank – Kind of like Four Weddings and a Funeral, but not . . . Maine Medical Center Emergency Department, Toxicology Rounds, Portland, ME (virtual)

July 20, 2016, Despite what you mother says, not all that is green and leafy is good for you . . . (plant and mushroom toxicity), Maine Medical Center Emergency Department, Toxicology Rounds, Portland, ME

April 5, 2016, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME

September 22, 2015, Toxicology – New Drugs, Pulmonary, Critical Care & Sleep Division Lecture Series, Tufts University School of Medicine in Boston, MA

September 18, 2015, Substance Abuse Trends in Maine, Psychobehavioral Conference, Maine Medical Center in Portland, ME

April 2, 2014, The Low-Down on Street Drugs in Maine, Social Worker Grand Rounds, Maine Medical Center in Portland, ME

April 10, 2012, Psychogenic Illness and Ticking Timebombs, Toxicology Rounds, Maine Medical Center in Portland, ME

March 4, 2014, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME

February 29, 2012, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

December 20, 2011, Bath Salts, Synthetic Cannabinoids (K2), Salvia divinorum and other natural/and not-so-natural highs, Psychiatry Rounds for Maine Medical Center in Portland, ME

December 14, 2011, Update on Significant Toxic Substances of Abuse in Maine – The Poison Center and Maine awash with Bath Salts, Grand Rounds for Mid Coast Hospital in Brunswick, ME

August 9, 2011, Opioids, Toxicology Rounds, Maine Medical Center in Portland, ME

April 28, 2011, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

November 9, 2010, Anion and Osmol Gaps, Iron and Isopropyl Alcohol – When you have more gaps than you think . . ., Toxicology Rounds, Maine Medical Center in Portland, ME

November 5, 2010, Aspirin, Toxic Alcohols, Sympathomimetics and Other Toxic Problems in the ICU, Fletcher Allen Health Care, Grand Rounds in Burlington, VT

November 5, 2010, Ethylene Glycol, Fletcher Allen Health Care, Medical Residents Morning Report in Burlington, VT

November 5, 2010, Aspirin and Other Dialyzable Toxins, Fletcher Allen Health Care, Lunch Conference with Nephrology and Pulmonary Residents, Fellows and Attendings in Burlington, VT

September 29, 2010, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

September 2, 2010, Substance Abuse and the Poison Center, presented to the Mercy Hospital Integrated Pain Management Group in Portland, ME

April 29, 2010, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

April 29, 2010, Drug Interactions, University of New England Medical Students, Pharmacology in Biddeford, ME

October 14, 2009, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

April 30, 2009, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

April 30, 2009, Drug Interactions, University of New England Medical Students, Pharmacology in Biddeford, ME

November 11, 2008, GI Decontamination: Evidence- and Theory-based or Magic, Maine Medical Center, Toxicology Rounds in Biddeford, ME

October 6, 2008, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

May 12, 2008, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

May 6, 2008, Drug Interactions, University of New England Medical Students, Pharmacology in Biddeford, ME

September 30, 2007, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

September 27, 2007, Paralytic Shellfish Poisoning – Case Series, Eastern Maine Medical Center, Clinical Pathological Conference in Bangor, ME

September 18, 2007, Grapes that Bite – Toxic Spider Bites, Maine Medical Center, Toxicology Rounds in Portland, ME

July 31, 2007, Topical Cantharides Leading to Toxic Toddler, Maine Medical Center, Pediatric Morning Rounds in Portland, ME

June 14, 2007, Decontamination, and Management of Tricyclic Antidepressants, and Calcium Channel and, Beta Blocker Overdoses, Eastern Maine Medical Center, Pediatric Rounds in Bangor, ME

May 15, 2007, Pesticides – Scabies can kill; you can't get away with killing your 4th wife, 5th wife and mother; if DEET can melt your sunglasses is it OK to put on your one year old, Maine Medical Center, Toxicology Rounds in Portland, ME

May 7, 2007, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

April 30, 2007, Drug Interactions, University of New England Medical Students, Pharmacology

April 6, 2006, Prescription Drug Abuse – In Your Backyard, University of New England Medical Students, Public Health Week on behalf of the Physicians for Social Responsibility in Biddeford, ME

April 6, 2006, Overview of Methamphetamine – Toxicological Concerns, University of New England Medical Students, Public Health Week on behalf of the Physicians for Social Responsibility in Biddeford, ME

March 16, 2006, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

September 30, 2005, Psychiatric Medications in Overdose, University of New England Medical Students, Psychiatry in Biddeford, ME

March 24, 2005, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

September 24, 2004, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

April 12, 2004, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME
September 26, 2003, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME
September 19, 2003, Kerosene Poisoning in Children, Maine Medical Center, Pediatric Morning Rounds in Portland, ME
April 12, 2003, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME
May 21, 2003, Analgesics and Pain Relief, University of New England Medical Students, Pharmacology in Biddeford, ME
May 2, 2003, Methadone Poisoning in Children, Maine Medical Center, Pediatric Morning Rounds in Portland, ME
February 21, 2003, New Trends in Drug Abuse, Maine General Medical Center - Augusta, Grand Rounds
January 23, 2003, Unusual Acetaminophen Toxicity, Maine Medical Center, Pediatric Morning Rounds in Portland, ME
January 7, 2003, NMS/Serotonin Syndrome, Maine Médical Center, Psychiatry Grand Rounds in Portland, ME
December 17, 2002, Toxicology and the Lab, Maine Medical Center, Toxicology Rounds in Portland, ME
December 10, 2002, Herbal and OTC Medications, Maine Medical Center, Pediatric Grand Rounds in Portland, ME
October 2, 2002, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME
April 26, 2002, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology
April 24, 2002, Introduction to Toxicology – Toxidromes, University of New England Medical Students, Pharmacology in Biddeford, ME

PROFESSIONAL SOCIETIES

American Board of Applied Toxicology
American Association of Clinical Toxicologists
American Association of Poison Control Centers

OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES

2016 – 2018: Immediate Past-President, American Academy of Clinical Toxicology
2014 – 2016: President, American Academy of Clinical Toxicology 2012 – 2014, American Academy of Clinical Toxicology, President-Elect
2012 – 2014: President-Elect, American Academy of Clinical Toxicology
2008 – 2012, American Academy of Clinical Toxicology, Secretary
2004 – 2011, American Board of Applied Toxicology, Secretary/Treasurer
2007 – 2009, American Association of Poison Control Centers Co-Chair of the Managers' Committee
2007 – 2008, American Academy of Clinical Toxicology, Member of the Board of Trustees
2003 – 2007, New England Chapter of the National Association of Drug Diversion Investigators, Secretary

MAJOR RESEARCH INTERESTS

Research interests are varied and include work in poisoning and toxicology, substance abuse, older adult medication concerns, public health, preparedness and surveillance. A current research and practice goal is to enhance data-sharing and utilization to improve community surveillance and public health through increasing interactions between local, county, state, regional and national partners. See research below for related funded projects in all areas.

GRANT/CONTRACT/RESEARCH SUPPORT

Title: In-Market Safety Surveillance of Laundry Detergent using Poison Control Center Data
Funding Agency: Cincinnati Children's Hospital Medical Center through the Cincinnati Drug & Poison Information Center, sponsored by Procter & Gamble
Period: March 15, 2012 – present
Role: Site Coordinator (Principal Investigator at Site)

Title: Interpretation of Urine and other Substances of Abuse Monitoring to Support Clinicians Managing Patients with Pain and Psychiatric Disorders receiving Prescription Drugs with Abuse Potential
Funding Agency: blinded
Period: April 1, 2010 – present
Role: Principal Investigator

Title: Northern New England Poison Prevention Project to Provide Quality Health Care Access to Hard-to-Reach Populations
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2009 – present
Role: Principal Investigator

Title: Maine Pharmaceutical Cache, Consulting, and 24/7 Phone Line
Funding Agency: State of Maine, Department of Health and Human Services
Period: August 10, 2008 – present
Role: Principal Investigator

Title: Poison Control Center: Assistance, Education and Surveillance Activities
Funding Agency: Vermont Department of Health
Period: September 1, 2004 – present
Role: Principal Investigator

Title: Poison Information Center Services
Funding Agency: State of New Hampshire, Department of Safety (initially) Department of Health and Human Services (currently)
Period: July 1, 2004 – present
Role: Principal Investigator

Title: Researched Abuse, Diversion and Addiction-Related Surveillance
Funding Agency: Denver Health and Hospital Authority
Period: November 3, 2002 – present
Role: Site Coordinator (Principal Investigator at Site)

Title: Northern New England Poison Center, Toxicology Consultation/Education Services
Funding Agency: State of Maine, Department of Health and Human Services
Period: July 1, 2000 – present
Role: Principal Investigator

Title: Social Marketing Enhancement using Social Media and Chat – Targeting the Computer-Savvy and Telephone-Averse

Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2010 – August 31, 2012
Role: Principal Investigator

Title: After Hours On Call Telephone Service for the Maine Center for Disease Control and Prevention
Funding Agency: State of Maine, Department of Health and Human Services, Maine Center for Disease Control & Prevention/Public Health Systems
Period: July 1, 2008 – August 9, 2008
Role: Principal Investigator

Title: Grant to Enhance Access to and Financial Stability of the Northern New England Poison Center (NNEPC) Serving Maine (ME), New Hampshire (NH) and Vermont (VT)
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2007 – August 31, 2009
Role: Principal Investigator

Title: Real Time Disease Detection
Funding Agency: Vermont Department of Health, Division of Health Improvement
Period: January 2, 2007 – August 8, 2008
Role: Principal Investigator

Title: Maine Pharmaceutical Stockpile
Funding Agency: State of Maine, Department of Health and Human Services
Period: April 1, 2007 – August 31, 2008
Role: Principal Investigator

Title: Substance Abuse Sentinel Surveillance and Reporting System associated with Researched Abuse, Diversion and Addiction-Related Surveillance
Funding Agency: Denver Health and Hospital Authority
Period: July 1, 2005 – December 31, 2008

Title: Evaluation of the value of real-time poison center data sharing between the Northern New England Poison Center and the State Public Health Agencies in Maine, New Hampshire and Vermont
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2005 – 2007
Role: Principal Investigator

Title: Northern New England Poison Center, Toxicology Consultation/Education Services; After Hours Call Answering Service
Funding Agency: State of Maine, Department of Health and Human Services
Period: July 1, 2004 – June 30, 2008
Role: Principal Investigator

Title: Grant to Certify (initially) to Stabilize (later) the Northern New England Poison Center Serving Maine, New Hampshire and Vermont
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2004 – August 31, 2007
Role: Principal Investigator

Title: Northern New England Poison Center, Toxicology Consultation/Education Services; After Hours Call Answering Service; Maine Pharmaceutical Stockpile

Funding Agency: State of Maine, Department of Health and Human Services
Period: July 1, 2002 – June 30, 2004
Role: Principal Investigator

Title: Certification Grant to form a Northern New England Poison Center serving Maine and Vermont
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2001 – August 31, 2004
Role: Principal Investigator

Title: Rural Outreach and Poison Center Training Grant for Maine, Vermont and Northeastern New York
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2001 – August 31, 2003
Role: Principal Investigator

EDITORIAL BOARDS AND ACTIVITY

2018 – present: Member of the Senior Editorial Board, Clinical Toxicology, The Official Journal of the American Academy of Clinical Toxicology, European Association of Poisons Centres and Clinical Toxicologists, American Association of Poison Control Centers and the Asia Pacific Association of Medical Toxicology

2006 - present: Member of the Editorial Board, Clinical Toxicology, The Official Journal of the American Academy of Clinical Toxicology, European Association of Poisons Centres and Clinical Toxicologists, and American Association of Poison Control Centers

2009 - 2014: Scientific Peer Reviewer, NIH Exploratory/Developmental Research Grant Award (R-21, R-49, U01), Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

2007 – 2013: Fatality Reviewer, American Association of Poison Control Centers

*BIBLIOGRAPHY

a) *Daly ER, Chan BP, Talbot EA, Nassif J, Bean C, Cavallo SJ, Metcalf E, Simone K, Woolf AD. Per- and polyfluoroalkyl substance (PFAS) exposure assessment in a community exposed to contaminated drinking water, New Hampshire, 2015. International Journal of Hygiene and Environmental Health 2018; 221(3):569-577.*

Simone KE, "Thirty U.S. Poison Center reports Later, Greater demand, more difficult problems," Clinical Toxicology, 2014 52(2) 91-92.

DeGrasse A, Rivera V, Roach J, White K, Callahan J, Couture D, Simone K, Peredy T, Poli M. Paralytic shellfish toxins in clinical matrices: Extension of AOAC official method 2005.06 to human urine and serum and application to a 2007 case study in Maine. Deep Sea Research Part II: Topical Studies in Oceanography 2014;103:368-75.

Cavallo S, et al. Exposure to Nitrogen Dioxide in an Indoor Ice Arena – New Hampshire, 2011. Morbidity and Mortality Weekly Report 2012;61(8):139-142.

Gersheimer KF, Rea V. Mills DA, Montagna CP, Simone K. Arsenic poisoning caused by intentional contamination of coffee at a church gathering – and epidemiological approach to a forensic investigation. Journal of Forensic Sciences 2010;44(4):11116-9.

Simone KE, Spiller HA. Poison center surveillance data: the good, the bad and ... the flu. Clin Toxicol 2010;48(5):415-7.

Daubert GP, Spiller H, Crouch BI, Seifert S, Simone K, Smolinske S. Pulmonary toxicity following exposure to waterproofing grout sealer. Journal of Medical Toxicology: Official Journal of the American College of Medical Toxicology 2009;4(3):125-9.

Tomassoni AJ, Simone KE. Herbal medicines for children: an illusion of safety? Curr Opin Pediatr 2001;13(2):162-9.

Simone KE, Tomassoni AJ. Administration of oral n-acetylcysteine intravenously. The Journal of Pediatric Pharmacology and Therapeutics 2001;6(1): 72-8.

c) Simone KE. Cyproheptadine. In: Brent J, ed. Critical Care Toxicology: Diagnosis and Management of the Critically Poisoned Patient, 2nd ed. Switzerland: Springer International Publishing, 2017:2747-2757.

Simone KE. Medical Consequences of Over-the-Counter Drug Abuse. In: Brick J, ed. Handbook of the Medical Consequences of Alcohol and Drug Abuse. 2nd ed. Routlege, New York, NY: Haworth Press, 2008:491-526.

d) Simone, KE, Peredy T. Bath Salts and Tasers, the Northern New England Poison Center's Northern Exposures. 1/12.

Wiegand T, Simone, KE, Miller R, Heinen M, Kramer M. "Suboxone" for the Northern New England Poison Center's Northern Exposures. 1/12.

Dart RC, Simone KE. The Challenge of Chronic Pain Management, newsletter with continuing pharmacy education for New Mexico pharmacists sponsored by the New Mexico Pharmacists Association and SynerMed® Communications supported by an educational grant from PriCara, Unit of Ortho McNeil, Inc. 10/08.

Simone KE. Cyanokit® To treat or not to treat? That is the question . . . Journal of Maine EMS, April 2008:23.

g) Krummen, KE. Albuterol Overdose in Children: Characterization and Management, presented at the University of Cincinnati Pharmacy College to faculty and students, Cincinnati, OH, 6/1/94.

h) Wilkosz C, Bonney, C, Neavyn MJ, Simone K. All set without Chemet®: the challenge of treating a pediatric exposure to lead paint during a shortage of succimer. Clin Toxicol 2021;59(11): 1179 (abstract).

Wang GS, Simone KE, Palmer RB. Description of edible marijuana products, potency ranges, and similarities to mainstream foods. Clin Toxicol 2014;52:805 (abstract).

Schaeffer TH, Bond AG, Earnshaw ME, Simone KE. Methemogobinemia and Hemolysis in an Undiagnosed G6PD Patient After Receiving Pegloticase. Clin Toxicol 2015;53(7): 686 (abstract).

Wiegand TC, Simone KE. Suboxone Exposure; How Long is the Initially Symptomatic Child at risk for Sequallae after Naloxone Reversal? A Case Report and Literature Review. In press for Clin Toxicol, to be presented at the XXIX International Congress of the European Association of Poisons Centres and Clinical Toxicologists Meeting in Stockholm Sweden in May 2009(abstract).

Tomassoni A, Simone K. Lessons Learned from Response to a Covert Chemical Threat. Clin Toxicol 2004;42(5): 703(abstract).

Simone, KE, Clement, C, Tomassoni AT. Financial Savings Associated with Videoconference Technology. Clin Toxicol 2004;4(5): 702(abstract).

Tomassoni AT, Simone KE. Development and Use of a Decentralized Antidote Stockpile in a Rural State. Clin Toxicol 2004;4(5): 710(abstract).

Smith HW, Simone KE, Aziz W, Lambert DA, Greene KA, Hayman M, The Role of Clinical Pharmacists in Mass Arsenic Poisoning, Pharmacotherapy 2003;23(10)(abstract).

Simone ,KE, Bond GR. Detection of Unusual Abuse Patterns Using Broad Searching of the Toxic Exposure Surveillance System. Clin Toxicol 2002;40(5):657-8(abstract).

Simone, KE, Bond GR. Dextromethorphan: A Successful Example of Monitoring for Emerging Abuse Using the Toxic Exposure Surveillance System. Clin Toxicol 2002;40(5):653-4(abstract).

Kemmerer D, Simone KE, Tomassoni A. Non-Anion Gap Metabolic Acidosis Associated with Acute on Chronic Topiramate Overdose. Clin Toxicol 2002;40(5):691(abstract).

Simone KE, Bottei EM, Siegel ES, Tsipis GB. "Coricidin Abuse in Ohio Teens and Young Adults," Journal of Toxicology Clinical Toxicology 2000; 38(5):532(abstract).

Finke D, Roll D, Sunshein M, Simone KE. The Internet: Sometimes Helpful, Sometimes Not. Clin Toxicol 2000;38(5):564(abstract).

Krummen KE, Tsipis G, Siegel E, Bottei E. Accuracy of Drug Abuse Call Patterns in Predicting Prescription Drug Abuse. Clin Toxicol 1999;37(5):643(abstract).

Krummen KE, Nelson E, Tsipis G, Siegel E, Bottei E. Tramadol Abuse in the Cincinnati Area. Clin Toxicol 1999;37(5):647(abstract).

Krummen KE, Bottei E, Whiteman P. Sex on the Streets of Cincinnati. Clin Toxicol 1999;37(5):647 (abstract).

Prybys K, Krummen KE. Airway Edema Resulting from Nonionic Laundry Soap Powder. Clin Toxicol 1996;34(5):567(abstract).

Krummen KE, Tsipis G, Siegel E, Sigell L. Description of Questions about Herbal Products and Other Nutritional Supplements Posed of a Consumer Information Service. Clin Toxicol 1996;34(5):596(abstract).

Tsipis G, Krummen KE, Sigell L. Telephone Medication Information Service for Older Adults. Clin Toxicol 1996;34(5):632(abstract).

Krummen KE, Tsipis G, Siegel E. Herbal Highs: Natural is Not Necessarily Nice, presented as a poster session at the National Parents' Resource Institute for Drug Education (PRIDE) World Drug Conference, Cincinnati, OH, March 28-30, 1996.

Tsipis G, Sigell L, Krummen KE. HOPEline An Internet-Accessible Drug Abuse/Chemical Dependency Database, presented as a poster session at the National Parents' Resource Institute for Drug Education (PRIDE) World Drug Conference, Cincinnati, OH, March 28-30, 1996.

Sigell L, Krummen KE. A Unique Drug Abuse Prevention, Intervention and Crisis Management Service, presented as a poster session at the National Parents' Resource Institute for Drug Education (PRIDE) World Drug Conference, Cincinnati, OH, March 28-30, 1996.

i) December 1, 2021, EMS – Non-opioid Overdose – It's Not All About Heroin And Fentanyl, Just Mostly, Exeter Hospital Paramedics, Exeter, NH (virtual)

March 9, 2021, Marijuana – THC, CBD, Medical, Recreational, Other . . ., Co-Occurring Collaborative Serving Maine, Portland, ME (virtual)

March 5, 2021, Mostly Substance Use – With Some Chemicals, Medications and Toys Thrown In, Maine Child Death & Serious Injury Review Panel, Augusta, ME (virtual)

January 19, 2021, Pediatric Fatalities – Concentration on Opioids, New Hampshire Child Fatality Review Committee, Concord, NH (virtual)

February 21, 2020, Today's Marijuana – Stronger, More Edibles and Confusing Information about Driving, Pen Bay Medical Centers Clinical Conference, Rockport, ME

September 25, 2019, AACT diversity and Inclusion in Toxicology/Women in Toxicology, North American Congress of Clinical Toxicology, Nashville, TN

February 7, 2016, Substance Abuse: Do we recognize what we are seeing in primary care?, 2016 Dartmouth CO-OP Project Annual Meeting, North Conway, NH

January 20, 2016, Substance Abuse Interventions – Responses from the Addicted, the Maine Medical Associations - Inside ME's Medicine Cabinet: What Prescription Monitoring Can Tell Us About Prescribers & Patients, Portland, ME

November 7, 2015, Substance Abuse Interventions – Responses of the Addicted; not always what we had planned, New Hampshire Medical Society Annual Scientific Conference, Portsmouth, NH

October 17, 2015, Synthetic Street Drugs and Sedation in the ICU, Exeter Hospital 3rd Annual Critical Care Conference, Exeter, NH

October 12, 2015, PEC: Drug Abuse Urinalysis Testing: Basic Introduction to Interpretation, North American Congress of Clinical Toxicology, San Francisco, CA

May 29, 2015, Debate: Should cannabis be legalized in terms of public health issues, XXXV International Congress of the European Association of Poisons Centres and Clinical Toxicologists, St. Julian's, Malta

April 3, 2014, Synthetic Street Drugs, Horizons 2014 Region 1 of the American Association of Critical Care Nurses, Portland, ME

April 2, 2014, Opioid Poisoning and Poison Center Data, RX Drug Summit, The Killer Co-Pay: The REAL Cost of Rx Drug Misuse, Strafford County Rx Taskforce Annual Prescription Drug Summit, Wentworth Douglas Hospital, Dover, NH

March 19, 2014, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

March 3, 2014, Update on Drugs of Abuse in northern New England, New England Organ Bank, Waltham, MA (by webinar)

November 21, 2014, Commonly Misused Drugs – What they are and what they Do, presented at the Shalom House in Portland, ME.

October 18, 2012, Commonly Misused Drugs – What they are and what they Do, presented at the Shalom House in Saco, ME.

July 25, 2012, New Trends in Drug Abuse, presented at the School Nurse Summer Institute at Bates College in Lewiston, ME.

July 19, 2012, Substance Abuse Trends and Interpretation of Urine Drug Screen Results, presented to medical staff at Spring Harbor Hospital in Westbrook, ME.

June 6, 2012, Substance Abuse and Poisoning – Same or Different, presented for pharmacy continuing education on behalf of the New Hampshire Board of Pharmacy at Frisbie Memorial Hospital in Rochester, NH.

March 21, 2012, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

March 7, 2012, Education Standards – Why do we need them?, presented at the American Association of Poison Control Centers Mid Year Meeting in Saint Petersburg, FL.

May 15, 2011, Prescription Drug Abuse, presented at the American Academy of Pediatrics Adolescent Medicine Conference for the Maine Chapter, Vermont Chapter and District 1 in Bar Harbor, ME.

March 23, 2011, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

December 9, 2010, K2, Salvia, Jagerbombs, Subies, Monster and other driving hazards – enhance your knowledge and increase you chances of detection, presented at the Drug Recognition Expert Training in Boise, ID.

November 9, 2010, Northern New England Poison Center Teen Poisonings – from RX Drugs to K2, Salvia and Monster, presented at the 2010 Maine Association for Health, Physical Education, Recreation and Dance Conference in Rockland, ME.

October 12, 2010, AACT Articles You May Have Missed, panel speaker at the 2010 North American Congress of Clinical Toxicology in Denver, CO.

March 18, 2010, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

October 10, 2009, Saturday's Dean's Lecture - Using Simulated Patient Learning to Recognize and Manage Drug-to-Drug Interactions, presented with colleagues to University of New England College of Osteopathic Medicine's 25th Continuing Medical Education/Reunion Weekend to Alumni in Portland, ME.

September 23, 2009, Maine Attempts to Treat Pain and Addiction – is treatment part of the problem? Presented at the 2009 North American Congress of Clinical Toxicology as part of the American Association of Poison Control Centers symposium on Emerging Opportunities for Poison Center Data in San Antonio, TX.

August 8, 2009, Herbal and Over-the-Counter Medications: Highs, Enhancements and Misadventures" Presented at the Fifteenth Annual International Association of Chiefs of Police Training Conference on Drugs, Alcohol & Impaired Driving "Dynamic, Revolutionary, Effective" in Little Rock, AR.

April 22, 2009, Maine Attempts to Treat Pain and Addiction – is treatment part of the problem? Presented at the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS®) Third Annual Scientific Meeting: Risk Management of Scheduled Drugs – Where Are We Now? Where Are We Headed? in Bethesda, MD.

March 25, 2009, Sports Supplements - Red Bull, 5-hour ENERGY, Yellow Jackets, Stacker, Mini Thins, Creatine and Amino Acids - what's the harm? on behalf of the Knox County Community Health Coalition for Rockland High School in Rockland, Maine.

March 11, 2009, Alcohol and Drug Abuse – Real Teen Risk for Chevrus High School in Portland, ME.

February 4, 2009, Drugs of Abuse and Resources of the Poison Center for the Maine Criminal Justice Academy ME Basic Law Enforcement Training Program in Vasselboro, ME.

January 26, 2009, Poisoning and Antidotes: Update on Toxicity and Managements (new antidotes and new ways to use old antidotes) for the University of Rhode Island College of Pharmacy and Maine Society of Health-System Pharmacists Continuing Pharmacy Education Program in Bethel, ME.

December 9, 2008, Pharmaceuticals in water: sources, impact, interventions for the Maine Rural Water Association's Pharmaceuticals in our water and wastewater conference in Freeport, ME.

December 7, 2008, Substance Abuse and the Pharmacy - Are you the Neighborhood Drug Supplier? for the Massachusetts College of Pharmacy & Health Sciences' New Hampshire Pharmacists Association Continuing Education Program in Manchester, NH.

December 4, 2008, Methamphetamine, other Drugs of Abuse and Resources of the Poison Center for the Maine Drug Enforcement Agency Laboratory Enforcement Team Refresher Course in Bangor, ME.

December 3, 2008, Inhalant Abuse for the Mercy Medical Center Department of EMS Refresher Training Education in Holyoke, MA.

November 21, 2008, Alcohol, Inhalants, Over-the-Counter and Prescription Drug Abuse for the Penobscot Job Corps Academy in Bangor, ME.

November 20, 2008, Energy Drinks on behalf of the Knox County Community Health Coalition for the Thomaston School District in Thomaston, ME.

November 19, 2008, Toxicology and Substance Abuse Laboratory Results for the Maine Medical Center Social Work Department in Portland, ME.

November 11, 2008, Facilitator for the Benzodiazepine and other Prescription Drugs Symposium on Prescription Drug Trends for the 2008 International Symposium on Pharmaceutical in the Home and Environment: Catalysts for Change – Sixth Annual Maine Benzodiazepine Study Group Conference in South Portland, ME.

October 22, 2008, A Career in Poison Control for the Maine Explorer Program at Maine Medical Center in Portland, ME.

October 13, 2008, Defining the Problem: What the Data Tell Us for the 2008 Symposium on preventing prescription and over the counter drug poisoning in South Burlington, VT.

September 24, 2008, Carbon monoxide exposure during house fire – pediatric patient with large anion gap acidosis – need to treat for cyanide? for physicians and pharmacists at the New England Regional Toxicology Meeting in Hartford, CT.

October 11, 2008, Substance Abuse and Emergency Preparedness for the Maine Pharmaceutical Association 2008 Fall Conference in Rockport, ME.

September 18, 1008, Basic Disaster Life Support Program, classes on chemical, biological and psychological issues associated with mass casualties related to terror, pandemic or industrial release on behalf of the National Center for Emergency Medical Preparedness & Response at Texas A & M Health Science Center for the New England Pharmacists Convention in Uncasville, CT.

September 14, 2008, Moderator for Platform Session 1:Poison Center at the North American Congress of Clinical Toxicology in Toronto, Canada.

July 5, 2008, SASRS, a home-grown toxicological surveillance system for the Maine Medical Center Information Systems Department in Portland, ME.

June 19, 2008, Herbal Highs for the 2008 Arkansas Drug Recognition Expert Conference for the Criminal Justice Institute in Little Rock, AR.

June 4, 2008, Substance Abuse and the Laboratory, for counselors and a physician at the Spring Harbor Access Program in Portland, ME.

June 1, 2008, Substance Abuse in Northern New England – Poison Center Perspective" for the 10th Annual Pharmacy Services Collaborative CE Program by Lahey Clinic supported by the Hitchcock Foundation in Fairlee, VT.

May 21, 2008, Substance Abuse and the Laboratory" for counselors and a physician at the Spring Harbor Access Program in Portland, ME.

April 24, 2008, Adolescent Drug Use Trends for the 23rd Maine Schoolsite Health Promotion in Carrabassett Valley, ME.

March 19, 2008, Social Hosting – It's more than taking the keys discussion of alcohol and caffeine on behalf of the Knox County Community Health Coalition for the Camden Hills Regional High School in Camden, ME.

February 29, 2008, Dangerous Drugs in Teens for physicians, nurses and counselors at Goodall Hospital in Sanford, ME.

February 25, 2008, Buprenorphine - Discussion between treatment providers and national experts for the University of Vermont Substance Abuse Treatment Center in Burlington, VT.

October 31, 2007, Current Trends and Concerns Surrounding Benzodiazepine Poisoning for the Fifth Annual Benzodiazepine Study Group Conference in Portland, ME.

October 17, 2007, Chronic Pain, Addiction, and the Law teleconference series for New Mexico Pharmacists' continuing education sponsored by the New Mexico Pharmacists Association and SynerMed® Communications supported by an educational grant from PriCara, Unit of Ortho McNeil, Inc.

October 14, 2007, Substance Abuse and Emergency Preparedness - Just Another Day at the Poison Center for the Annual Meeting of the Maine Pharmacy Association.

October 12, 2007, Chronic Pain, Addiction, and the Law teleconference series for New Mexico Pharmacists' continuing education sponsored by the New Mexico Pharmacists Association and SynerMed® Communications supported by an educational grant from PriCara, Unit of Ortho McNeil, Inc.

September 25, 2007, New Substance Abuse Trends in Teens and Early 20s for physicians, nurses, counselors and others working in the University of Southern Maine Health Clinic in Portland, ME.

July 30, 2007, Poisonings, Scope of the Problem for health care professionals and lay people at the Prescription Drug Misuse – A Community Challenge Conference for the Maine Injury Prevention Group in Hallowell, ME.

July 11, 2007, Current Trends in Substance Abuse" for Spring Harbor Hospital for nurses, physicians, social workers and other care-givers in Westbrook, ME.

June 25, 2007, Facilitated Sexual Assault for a sexual assault training course for detectives and counselors in Ellsworth, ME.

May 17, 2006, Interpretation of Substance of Abuse Laboratory Results for the Family Support Program of the Social Work Department of Maine Medical Center in Portland, ME.

May 5, 2006, Medication Administration on behalf of Youth Alternatives to care givers of institutionalized youth in Portland, ME.

April 2, 2006, Adverse Effects – Concentration on Older Adults for the Annual Maine Pharmacy Association Spring Conference in South Portland, ME.

March 24, 2006, Drugs Commonly Diverted for the New England Chapter of the National Association of Drug Diversion Investigators Conference in Newport, RI.

TUFTS UNIVERSITY SCHOOL OF MEDICINE
CURRICULUM VITAE AND BIBLIOGRAPHY FORMAT
FOR CLINICAL FACULTY

DATE PREPARED: June 13, 2022
FULL NAME AND DEGREES: Mark John Neavyn, M.D.
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OFFICE FAX NUMBER: (207) 662-5941
E-MAIL ADDRESS: mneavyn@mmc.org

EDUCATION AND TRAINING

Undergraduate

Year of Degree	*Degree*	*Institution, City, State or Country*	*Discipline*
2000	BA	Augustana College, Rock Island, IL	Biology

Graduate School and/or Medical School

Year of Degree	*Degree*	*Institution, City, State or Country*	*Discipline*
2006	MD	Jefferson Medical College (now Sidney Kimmel Medical College), Philadelphia, PA	

Postdoctoral Training

Internship and Residencies:

Years	*Institution, City, State or Country*	*Specialty*
2009	Drexel University, Philadelphia, PA	Emergency Medicine Residency

Fellowships:

Years	*Institution, City, State or Country*	*Specialty*
2012-2014	University of Massachusetts Medical School, Worcester, MA	Toxicology Fellowship

Other Professional Training

Years	*Institution, City, State or Country*	*Discipline*
2016-2017	University of Massachusetts Medical School, Worcester, MA	Peers of Promotion

Licensure and Certification

Medical Licensure:

Dates	*Location*	*Certificate Number*
2009-2012	Michigan	4301093671
2014-2016	Connecticut	52572
2012-Present	Massachusetts	250461

2020-Present	Maine	MD23807

Board Certification:

Dates	*Organization*	*Certificate Number*	*Specialty*
2010	American Board of Emergency Medicine	48855	Emergency Medicine
2014	American Board of Emergency Medicine Medical Toxicology	48855	Medical Toxicology

ACADEMIC APPOINTMENTS

Dates	*Titles/Primary or Secondary*	*Department*	*Institution, City, State or Country*
2010-2012	Assistant Professor	Emergency Medicine	Wayne State University, Detroit, MI
2012-2014	Clinical Instructor	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2014-2016	Assistant Professor	Emergency Medicine	University of Connecticut Medical School, Farmington, CT
2016	Assistant Professor	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2020	Associate Professor	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA

EMPLOYMENT

Dates	*Titles/Position*	*Department*	*Institution, City, State or Country*
2009-2012	Emergency Medicine Practice	Emergency Medicine	St. John Hospital & Medical Center, Detroit, MI
2012-2014	Emergency Medicine Practice	Emergency Medicine	University of Massachusetts Memorial Medical Group, Worcester, MA
2014-2016	Emergency Medicine Practice	Emergency Medicine	Hartford Hospital, Hartford, CT
2016	Emergency Medicine Practice	Emergency Medicine	University of Massachusetts Memorial Medical Group, Worcester, MA

ADMINISTRATIVE APPOINTMENTS

Dates	*Titles/Position*	*Department/Program*	*Institution, City, State or Country*
2014-2015	Director	Medical Toxicology	Hartford Hospital, Hartford, CT
2020-Present	Medical Director	Northern New England Poison Center	Maine Medical Center, Portland, ME

AWARDS AND HONORS

Dates	*Award/Honor*	*Organization, City, State or Country*
2000	Cum Laude	Augustana College, Rock Island, IL

2003	Foerderer Scholarship	Jefferson Medical College
2014	McNeill Travel Award	American College of Medical Toxicology

INSTITUTIONAL COMMITTEE SERVICE

Dates	*Role/Committee*	*Department/Program*	*Institution, City, State or Country*
2010-2012	Physician Member, Medication Safety Committee	Hospital Committee	St. John Hospital and Medical Center, Detroit, MI
2012-2014	Physician Member, Sedation Committee	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2012-Present	Physician Member, Alcohol Withdrawal Task Force	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2014-2015	Physician Leader, Cytotoxic and Hazardous Medications Policy Committee	Hospital Committee	Hartford Hospital, Hartford, CT
2014-2015	Physician Member, P&T Committee	Hospital Committee	Hartford Hospital, Hartford, CT
2014-2015	Physician Member, Ethics Committee	Hospital Committee	Hartford Hospital, Hartford, CT
2016-2020	Physician Member, Medication Safety Committee	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	Physician Member and Peer Supporter, Peer Support Network	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	Physician Appointee, Ethics and Treatment Issues Committee	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	Lead, Clinical Competency Committee	Hospital Committee	University of Massachusetts Medical Toxicology, Worcester, MA
2016-2020	Lead, Program Evaluation Committee	Hospital Committee	University of Massachusetts Medical Toxicology, Worcester, MA
2016-2020	Member, Clinical Competency Committee	Hospital Committee	University of Massachusetts Emergency Medicine, Worcester, MA
2018-2020	Member, Program Evaluation Committee	Hospital Committee	University of Massachusetts Emergency Medicine, Worcester, MA

2020-present	Pharmacy & Therapeutics Committee	Hospital Committee	Maine Medical Center Portland, ME

EXTERNAL COMMITTEE SERVICE

Local/Regional:

Dates	*Role/Committee Assignment*	*Organization/Membership*
2021-present	Physician, Medical Advisory Committee	Maine Board of Pesticide Control

National:

Dates	*Role/Committee Assignment*	*Organization/Membership*
2012-Present	Physician Member, Research Committee	American College of Medical Toxicology
2012-Present	Physician Member, Education Committee	American College of Medical Toxicology
2014-Present	Co-Chair, Position Statement on Brian Death	American College of Medical Toxicology
2015-2016	Physician Member, Ethics Committee	Society for Academic Emergency Medicine
2015-2018	Appointee, National Fatality Review Team	American Association of Poison Control Centers
2016-present	Physician Member, Fellowship Director Committee	American College of Medical Toxicology
2018-2019	Co-Chair, Planning Subcommittee, Education Committee	American College of Medical Toxicology

International:

Dates	*Role/Committee Assignment*	*Organization/Membership*
N/A		

PROFESSIONAL SOCIETIES

Dates	*Role/Committee Assignment*	*Organization/Membership*
2005-Present	Member	American College of Emergency Medicine
2012-Present	Member	European Association of Poison Centers and Clinical Toxicology
2012-Present	Member	American Academy of Clinical Toxicology
2012-Present	Member, Education Committee	American College of Medical Toxicology
2012-Present	Member	Society of Academic Emergency Medicine
2015	Member, Ethics Committee	Society of Academic Emergency Medicine
2016-Present	Member, Fellowship Directors Committee	American College of Medical Toxicology

GRANT REVIEW ACTIVITES

Dates	*Role*	*Organization*
N/A		

HEALTH-RELATED ADVOCACY & COMMUNITY SERVICE

Dates	*Organization, City, State or Country*	*Role*
2003	Helping Hands Health Education, Kathmandu, Nepal	Health Clinic Volunteer
2002-2006	JeffHOPE Philadelphia, PA	Free Health Clinic Volunteer
2012-2014	Massachusetts/Rhode Island Poison Information Center	Providing On-Call Toxicology Consult
2014-2016	Connecticut Poison Control Center	Providing On-Call Toxicology Consult
2016-Present	University of Massachusetts Overdose Prevention Fund	Physician Member

TRAINING OF STUDENTS/TRAINEES

Students/Mentees:

Dates	*Name of Student/Advisee*	*Level of Training*	*Role and Sponsor (if applicable)*	*Current Position of Advisee*
2017 to present	Keaton Cameron-Burr	MS1	Research supervisor	MS4
2017 to present	Graham Powell, M.D.	Resident	Emergency Medicine Residency Program	Fellow in Medical Toxicology

Postdoctoral Trainees:

Past/Current Trainee	*Trainee Name (Where Training Occurred)*	*Postdoc Research Training Period*	*Prior Academic Degree(s)*	*Prior Academic Degree Year(s)*	*Prior Academic Degree Institution(s)*	*Title of Research Project*	*Current Position of Past Trainees/Source of Support of Current Trainees*
2012-2017	Matt Griswold, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Connecticut School of Medicine		Assistant Professor of Emergency Medicine and Medical Toxicology
2012-2017	Eike Blohm, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	Larner College of Medicine		Assistant Professor of Emergency Medicine and Medical Toxicology
2012-2017	Alicia Lydecker, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	Albany Medical School		Assistant Professor of Emergency Medicine and Medical

2016-2018	Jeff Lai, M.D.	Medical Taxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Toxicology Assistant Professor of Emergency Medicine and Medical Toxicology
2016-2018	Katharine Devin-Holcomb, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2016-2020	Amelia Curtis, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2017-2021	Albert Conicella, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2017-2021	Eric Kaczor, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2018-2020	Charlotte	Medical	Fellow	MD	University of	Assistant

Goldfine, M.D.	Toxicology Fellowship Program	Massachusetts School of Medicine	Professor of Emergency Medicine and Medical Toxicology

EDUCATIONAL ACTIVITES

Dates	*Role/Course or Program Title*	*Department*	*Institution, City, State or Country*
2009-2012	Clinical Teaching and Supervision	Emergency Medicine	St. John Hospital & Medical Center, Detroit, MI
2012-2014	Clinical Teaching and Supervision	Emergency Medicine	University of Massachusetts Memorial Medical Center, Worcester, MA
2014-2016	Clinical Teaching and Supervision	Medical Toxicology	Hartford Hospital, Hartford, CT
2014-2016	Clinical Teaching and Supervision	Emergency Medicine	Hartford Hospital, Hartford, CT
2014-2016	Medical Toxicology Board Review	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016	Development of Curricula and Educational Materials, Medical Toxicology Board Review	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-Present	Clinical Teaching and Supervision	Medical Toxicology	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-Present	Clinical Teaching and Supervision	Emergency Medicine	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	EM_4004 (Emergency Clinical Problem Solver)	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2016-2020	Lead, EM_4448 (Medical Toxicology Sub-Internship)	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-2020	Lead, FCE_3007 (Flexible Clinical Elective)	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-2020	Program Director, Fellowship in Medical Toxicology	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-2020	Director, Medical Toxicology Clinical Course	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA

PRACTICE ACTIVITIES & INNOVATIONS

Dates	*Activity*	*Sponsor/Institution*
2012-2020	Alcohol Withdrawal Task Force to monitor and keep up-to-date safe protocols for the management of alcohol withdrawal	University of Massachusetts Memorial Medical Center, Worcester, MA
2009-2012	Providing Emergency Medical Care in a Tertiary Referral Center	Emergency Medicine Specialists, Detroit, MI
2012-2014	Providing Emergency Medical Care in a Tertiary Referral Center	University of Massachusetts Memorial Medical Group, Worcester, MA
2014-2015	Medical Toxicology Clinic created to support statewide	Hartford Hospital, Hartford, CT

	referrals from the Connecticut Regional Poison Control Center for outpatient management of chronic toxic exposures, including heavy metals, pesticides, hydrocarbons, and other environmental and occupational hazards	
2014-2015	Medication Safety Trigger Tool analysis used to monitor the incidence of medication safety events not reported by a centralized self-reporting system-randomized charts were reviewed monthly and analyzed for established medication safety triggers	Hartford Hospital, Hartford, CT
2014-2015	Hazardous Medications Task Force to monitor and keep up-to-date safe protocols for the management of cytotoxic and hazardous drugs used in cancer treatment	Hartford Hospital, Hartford, CT
2014-2016	Providing Emergency Medical Care in a Tertiary Referral Center	Hartford Healthcare Medical Group, Hartford, CT
2016-Present	Providing Emergency Medical Care in a Tertiary Referral Center	University of Massachusetts Memorial Medical Group, Worcester, MA
2020-Present	Emergency Medical Care in a Tertiary Referral Center	Maine Medical Center, Portland, ME

VISITING PROFESSORSHIPS & INVITED ACADEMIC PRESENATTIONS

Visiting Professorships

Dates	*Department*	*Institution*	*City, State or Country*
N/A			

Invited Academic Presentations

Local/Regional:

Dates	*Presentation Title*	*Presentation Type*	*Institution*	*City, State or Country*
2010-2011	Anemia in the Emergency Department	Emergency Medicine Residency	St. John Hospital	Detroit, MI
2010-2011	Board Review of Hematology Oncology	Emergency Medicine Residency	St. John Hospital	Detroit, MI

2014	Drug Interactions in Psychiatry	Psychosomatic Medicine Fellowship	Hartford Hospital	Hartford, CT
2014	Common Psychiatric Medications in Overdose	Psychosomatic Medicine Fellowship	Hartford Hospital	Hartford, CT
2014	Circling the Drain – Toxicology Resuscitation	Emergency Medicine Residency	University of Connecticut	Hartford, CT
2014	Review of Emergency Management of Toxic Alcohols	Emergency Medicine Residency	University of Massachusetts	Worcester, MA
2014	Brain Death in Medical Toxicology	New England Regional Toxicology Conference	University of Massachusetts	Worcester, MA
2014	Ethical Considerations in Medical Toxicology	Grand Rounds	Hartford Hospital	Hartford, CT
2017	Ethical Considerations in the Poisoned Patient	Grand Rounds	Institute of Living	Hartford, CT
2017	The Problem with Marijuana and Driving	7th Annual Research Retreat	University of Massachusetts Center for Clinical and Translational Science	Hartford, CT
2018	Medication Safety is No Accident: Extravasation Injuries	One-Day Conference	University of Massachusetts Memorial Medical Center	Worcester, MA
2018	Public Health Implications for Deregulating Marijuana	Keynote Speaker, Annual Medical Education Conference Cottle Lecture	Worcester District Medical Society	Worcester, MA

National:

Dates	*Presentation Title*	*Presentation Type*	*Institution*	*City, State or Country*
2014	Brian Death in the ToXIC Registry	Research Symposium	American College of Medical Toxicology Scientific	Phoenix, AZ

2018	Clinical Pathophysiologic Case	Clinical Case Presentation	Meeting North American Congress of Clinical Toxicology	Chicago, IL

International:

Dates	*Presentation Title*	*Presentation Type*	*Institution*	*City, State or Country*
2017	Twitter and Facebook groups: How we can maximize our toxicology education and engage learners	Medical Education	European Association of Poison Centres and Clinical Toxicologists	Basel, Switzerland
2018	Public Health Challenges and Impacts of NPS	Clinical Case Presentation	Novel Psychoactive Substances Symposium	Philadelphia, PA

MAJOR RESEARCH INTERESTS

My academic pursuits have been in the area of drug abuse, particularly with novel psychoactive substances and cannabis products. In addition, I have worked closely with the National Highway Traffic Safety Administration (NHTSA) to improve the Fatality Analysis Reporting System (FARS), which is the national data repository of all roadside fatalities. I have a keen interest in the effects of drugs on psychomotor performance. As well, as the medical director for the Northern New England Poison Center serving the state of Maine, New Hampshire and Vermont, I work to enhance medical education and outreach throughout the region regarding poisoning and access to uncommon antidotes.

RESEARCH SUPPORT

Dates	*Grant Title*	*PI Name*	*Funding Source*	*Grant Number*	*Amount*	*Role*
2016-2017	Changing Culture: A Medication Safety Initiative	Kavita Babu, M.D. and Mark Neavyn, M.D. (Co-PI)	University of Massachusetts Memorial Medical Center Risk Management		$25,000	Co-Principal Investigator
2019-2020	Medical Toxicology Consultant Service	Mark Neavyn, M.D.	National Highway Traffic Safety Administration, U.S. Department of	GS10F0211M, NHTSA Task Order No: 693JJ918F000240	$178,722.75	Project Manager

2019-2020	Crash Risk Associated with Drug and Alcohol Use by Drivers in Fatal and Serious Injury Crashes	Mark Neavyn, M.D.	Transportation National Highway Traffic Safety Administration, U.S. Department of Transportation	DTNH2211D00225L, NHTSA Task Order No: 6	$454,771	Site Director
2020-2025	Medical Toxicology Consultant Service	Dereece Smither, Ph.D.	National Highway Traffic Safety Administration	Contract Numbers: GS10F0211M 693JJ920F000159	$1,030,562	Consultant

EDITORIAL BOARDS

Dates	*Role*	*Board/Publication Name*
2013-2014	Editorial Board member	Journal of Medical Toxicology

AD HOC JOURNAL REVIEWER

Publication Name

American Journal of Emergency Medicine
Drug and Alcohol Dependence
European Journal of Pediatrics

PATENTS

Year Awarded	*Patent Number*	*Description*
N/A		

BIBLIOGRAPHY

a) *Refereed Publications:*

1. Felix A, Campbell D, Neavyn M, Hackett P. Rescue Veno-arterial extracorporeal membrane oxygenation in venlafaxine overdose: a case report. Journal of Emergency and Critical Care Medicine. 2022 April 30. Doi: 10.21037/jeccm-22-2
2. Kaczor EE, Greene K, Zacharia J, Tormoehlen L, **Neavyn M**, Carreiro S. The Potential Proconvulsant Effects of Cannabis: a Scoping Review. J Med Toxicol. 2022 Mar 29. doi: 10.1007/s13181-022-00886-3. Epub ahead of print. Erratum in: J Med Toxicol. 2022 Apr 21;: PMID: 35352276.
3. Cameron-Burr KT, Conicella A, **Neavyn MJ**. Opioid Use and Driving Performance. J Med Toxicol. 2021 Jul;17(3):289-308. doi: 10.1007/s13181-020-00819-y. Epub 2021 Jan 5. PMID: 33403571; PMCID: PMC8206443.

4. Bradley E, **Neavyn M**. A case of hemorrhagic pneumonitis resulting from heavy use of cannabis vaporizer products, Toxicology Communications, 3:1, 85-87, DOI: 10.1080/24734306.2019.1688495
5. Blohm E, Sell P, **Neavyn M**. Cannabinoid Toxicity in Pediatrics. Current Opinion in Pediatrics. 2019 Apr;31(2):256-261. doi: 10.1097/MOP.0000000000000739
6. Goldfine C, **Neavyn M**. Articles You Might Have Missed. J Med Toxicol. 2018 Dec 3. doi: 10.1007/s13181-018-0692-2. [Epub ahead of print] PubMed PMID: 30511215.
7. Kao L, Pizon A; ACMT Fellowship Directors Committee.. Medical Toxicology Fellowship Training Is Available to Applicants from Many Specialties. J Med Toxicol. 2018 Sep;14(3):177-178. doi: 10.1007/s13181-018-0664-6. Epub 2018 May 21. PubMed PMID: 29785474; PubMed Central PMCID: PMC6097972.
8. Cancelliere A, Blohm E, **Neavyn M**. A dangerous chase: severe neurocognitive impairment and death following smoked heroin. Clin Toxicol (Phila). 2018 May;56(5):386-388. doi: 10.1080/15563650.2017.1392559. Epub 2017 Oct 25. PubMed PMID: 29065717.
9. Blohm E, Lai J, **Neavyn M**, Drug-induced hyperlactatemia. Clinical Toxicology, Published online: 27 Apr 2017. http://dx.doi.org/10.1080/15563650.2017.1317348
10. **Neavyn MJ**, Murphy C. "Coming to a Consensus on Informed Consent for Case Reports". Journal of Medical Toxicology, 10(4): 337-9
11. **Neavyn MJ**, Blohm E, Babu KM, Bird SB. "Medical Marijuana and Driving: A Review". Journal of Medical Toxicology, *10(3): 269-79*
12. **Neavyn MJ**, Boyer EW, Bird SB, Babu KM. "Sodium Acetate as a Replacement for Sodium Bicarbonate in Medical Toxicology- A Review." Journal of Medical Toxicology, 9(3): 250-254, September 2013.
13. McGuire KP, Ngoubilly N, **Neavyn M**, Lanza-Jacoby S. "3,3'-diindolylmethane and Paclitaxel act synergistically to promote apoptosis in HER2/NEU Human Breast Cancer Cells." J Surg Res. 132(2):208-13, 2006 May 15.
14. Sethi RK, **Neavyn MJ**, Rubash HE, Shanbhag AS. "Macrophage Response to Cross-Linked and Conventional UHMWPE." Biomaterials. 24(15): 2561-73, 2003 July.

b) *Books Authored/Books Edited:*

1. Irwin and Rippe's Textbook of Intensive Care Medicine, 9th Edition, *Under Revision*
Section 10: Pharmacology, Overdoses and Poisonings
Co-Section Editors: **Mark J. Neavyn** & Luke Yip
Chapters 97-126

c) *Book Chapters/Invited Reviewers:*

1. Curtis A, **Neavyn MJ** Chapter 319: Antidysrhythmics, in Harwood-Nuss Clinical Practice of Emergency Medicine, 7th Edition, 2020 Pending publication
2. Carey JL, **Neavyn MJ** Chapter 79: Hallucinogens, in Goldfrank's Toxicologic Emergencies, 11th Edition, *2019.*
3. **Neavyn, M.**; Pena, M.; Irvin, C. Chapter 27: Autotransfusion, in Roberts & Hedges: Clinical Procedures in Emergency Medicine, 6th Edition, 2013, *7th Edition, 2018*

d) *Monographs, Proceedings, and White Papers:*

1. Ngo TB, Karkanitsa M, Adusei KM, Graham LA, Ricotta EE, Darrah JR, Blomberg RD, Spathies J, Pauly KJ, Klumpp-Thomas C, Travers J, Mehalko J, Drew M, Hall MD, Memoli MJ, Esposito D, Kozar RA, Griggs C, Cunningham KW, Schulman CI, Crandall M, **Neavyn M**, Dorfman JD, Lai JT, Whitehill JM, Babu KM, Mohr NM, Van Heukelom J, Fell JC, Rooke W, Kalish H, Thomas FD, Sadtler K. SARS-CoV-2 Seroprevalence and Drug Use in Trauma Patients from Six Sites in the United States. medRxiv [Preprint]. 2021 Aug 11:2021.08.10.21261849. doi: 10.1101/2021.08.10.21261849. PMID: 34401892; PMCID: PMC8366813.
2. Ngo TB, Karkanitsa M, Adusei KM, Graham LA, Ricotta EE, Darrah JR, Blomberg RD, Spathies J, Pauly KJ, Klumpp-Thomas C, Travers J, Mehalko J, Drew M, Hall MD, Memoli MJ, Esposito D, Kozar RA, Griggs C, Cunningham KW, Schulman CI, Crandall M, **Neavyn M,** Dorfman JD, Lai JT, Whitehill JM, Babu KM, Mohr NM, Van Heukelom J, Fell JC, Rooke W, Kalish H, Thomas FD, Sadtler K. SARS-CoV-2 Seroprevalence and Drug Use in Trauma Patients from Six Sites in the United States. medRxiv [Preprint]. 2021 Aug 11:2021.08.10.21261849. doi: 10.1101/2021.08.10.21261849. PMID: 34401892; PMCID: PMC8366813.
3. **Neavyn MJ**, Sethi RK, Rubash HE, Shanbhag AS: "Macrophage Response to Cross-Linked High Molecular Weight Polyethylene." Orthopedic Journal of Harvard Medical School. (3): 97-99, 2001

e) *Editorials:*

1. **Neavyn MJ**, Ethics in Action: Dopesick Decision-Making. Society of Academic Emergency Medicine Newsletter, September-October 2015.
2. **Neavyn MJ**, JMT Update: Plagiarism. American College of Medical Toxicology Newsletter, August 2013.
3. **Neavyn MJ**, JMT Update: Chelation. American College of Medical Toxicology. Newsletter, October 2013.
4. **Neavyn MJ**, *Suicide and the Surrogate*. Journal of Medical Toxicology, 2013 Oct, 10:3–6 DOI 10.1007/s13181-013-0335-6.

f) *Letters to the Editor:*
N/A

g) *Case Reports:*
N/A

h) *Theses/Dissertation:*
N/A

i) *Published Abstracts*:

1. Kaczor E, Greene K, Zacharia J, **Neavyn M**, Carreiro S. *Cannabis as a cause of seizures: a scoping review.* October 2020, Abstracts of the 2021 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT) Oct 2021. Clinical Toxicology. https://doi.org/10.1080/15563650.2021.1960683
2. Wilkosz C, Bonney C, **Neavyn MJ**, Simone K. *All set without Chemet®: the challenge of treating a pediatric exposure to lead paint during a shortage of succimer.* October 2021, Abstracts of the 2021 Annual Meeting of the North

American Congress of Clinical Toxicology (NACCT) Oct 2021. Clinical Toxicology. https://doi.org/10.1080/15563650.2021.1960683

3. Temple C, Lai J, Carreiro S, **Neavyn M**. 265. *Traffic Fatalities Before and After Legalization of Adult-Use Cannabis*. October 2020, Abstracts of the 2020 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT) Oct 2020. Clinical Toxicology. Vol 58. No.11 https://doi.org/10.1080/15563650.2020.1804238
4. Higgins A, Klaucke C, Stephens P, Barima A, Patel V, **Neavyn M**, Broach J, Gaspari R. 391- *Paralysis Following Acute Organophosphate Poisoning Improves Survival and Decreases Pulmonary Secretion Production in a Rat Model*. September 2018, Annals of Emergency Medicine 72(4):S153. DOI: 10.1016/j.annemergmed.2018.08.396
5. Krist Tase, Katharine Devin-Holcombe, Kavita Babu, Jeffrey Lai, **Mark Neavyn**, Julie Flahive. *Determining the Range of Naloxone Dosing Required for Reversal After Suspected Heroin Overdose.* ACMT 2018 Annual Scientific Meeting Abstracts—Washington, DC J. Med. Toxicol. (2018) 14: 3. https://doi.org/10.1007/s13181-018-0655-7
6. Salinger L, Brass R, Bayer M, **Neavyn M**. *Not "Just Another Day in the Lab": A Dimethyl Mercury Exposure,* Abstracts of the 2015 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT) - October 10-12, 2015
7. Salinger L, McKay C, Laskey D, **Neavyn M**, Sangalli B, Bayer M. *Lessons Learned from a Brodifacoum Case Exhibiting Prolonged Morbidity,* Abstracts of the 2015 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT) - October 10-12, 2015
8. Laskey D, **Neavyn M**. *APAPxAT as a Hepatotoxicity Predictor in Patients with Acetaminophen Ingestions of Chronic, Subacute, or Unknown Time,* Abstracts of the 2015 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT)- October 10-12, 2015
9. Felton D, Carey JL, Boyer EW, **Neavyn MJ.** *Brain Death and Overdose*, Abstracts of the XXXIV International Congress of the European Association of Poisons Centres and Clinical Toxicologists, 27 to 30 May 2014, Brussels, Belgium
10. Yen M, **Neavyn M**, Felton D, Burns M. *Ethanol Metabolism in Infants Under 6 Months of Age*, Abstracts of the XXXIII International Congress of the European Association of Poisons Centres and Clinical Toxicologists, 28 to 31 May 2013, Copenhagen, Denmark ***(Platform Presentation)***
11. **Neavyn MJ**, Yen M, Williams M, Weibrecht KW. *A Case Report of Early Levothyroxine Toxicity in a Young Child*, Abstracts of the XXXIII International Congress of the European Association of Poisons Centres and Clinical Toxicologists, 28 to 31 May 2013, Copenhagen, Denmark
12. Carey JL, Yen MY, **Neavyn MJ**, Zuckerman MD, Berger RE, Jenner JL, Salhanick SD, Hernon CH. *Urine Ricinine Levels Following Potentially Fatal Castor Bean Ingestions Do Not Correlate with Clinical Outcomes*, Abstracts of the 2013 ACMT Annual Scientific Meeting - March 15–17, 2013 San Juan, Puerto Rico, US

13. **Neavyn MJ**, Carey JL, Rhyee SH, Ward JA. *Early Non-Detectable Acetaminophen Levels in Patients Requiring N -Acetylcysteine Therapy*, Abstracts of the 2013 ACMT Annual Scientific Meeting - March 15–17, 2013 San Juan, Puerto Rico, US
14. **Neavyn MJ**, Zuckerman MD, Carey J, Boyer EW and Babu KM. *Thrombotic thrombocytopenic purpura and Injection Use of Oxymorphone: Elucidating the Mechanisms*, Abstracts of the 2013 ACMT Annual Scientific Meeting - March 15–17, 2013 San Juan, Puerto Rico, US
15. Zuckerman MD, **Neavyn MJ**, Boyer EW, Babu KM.The *Fall of OxyContin® and the rise of Opana®: Use of Google Trends to Monitor Drug Diversion*, Abstracts of the 2013 ACMT Annual Scientific Meeting - March 15–17, 2013 San Juan, Puerto Rico, US
16. **Neavyn MJ**, Yen M, Williams M, Weibrecht K, Burns M. *Cases of Levothyroxine and Liothyronine Exposure Reported to a Regional Poison Control Center,* 2013 Annual Meeting of the North American Congress of Clinical Toxicology September 27 - October 2 Atlanta, GA

j) *Non-print Scholarship:*

1. Babu KM, **Neavyn MJ** Psychoactive Medications, in American Scientific Emergency Medicine, 1st Edition (online only), 2015 (now known as Deckerip.com) https://www.deckerip.com/products/emergency-medicine/table-of-contents/
2. Bird SB, **Neavyn MJ**, Alcohols, in American Scientific Emergency Medicine, 1st Edition (Online only), 2015 https://www.deckerip.com/products/emergency-medicine/table-of-contents/

CONTRACTOR NAME: MaineHealth d/b/a Northern New England Poison Center
FY23

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Karen Simone	Director NNEPC	$171,494	9.59%	$16,446.27
Mark Neavyn	Medical Director	$327,000	10.00%	$32,700.00

CONTRACTOR NAME: MaineHealth d/b/a Northern New England Poison Center
FY24

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Karen Simone	Director NNEPC	$176,639	10.4%	$18,370.43
Mark Neavyn	Medical Director	$336,810	10.00%	$33,681.00