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Lori A. Shibinette
Commissioner

Katja S. Fox
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
*DIVISION FOR BEHAVIORAL HEALTH*

129 PLEASANT STREET, CONCORD, NH 03301
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February 28, 2020

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

**REQUESTED ACTION**

1. Authorize the Department of Health and Human Services, Division for Behavioral Health, to enter into **Sole Source** contracts with the vendors listed below in an amount not to exceed $3,519,330 for the provision of Doorway services for access to substance use disorder treatment and recovery support services, with the option to renew for up to two (2) additional years, effective upon Governor and Council approval through September 29, 2020. 100% Federal.

| Vendor Name | Vendor Code | Area Served | Contract Amount |
|---|---|---|---|
| Catholic Medical Center | VC# 177240 | Greater Manchester | $1,948,342 |
| Southern New Hampshire Health System, Inc. | TBD | Greater Nashua | $1,570,988 |
| | | ***Total*** | ***$3,519,330*** |

2. Further, authorize an advance payment in an amount not to exceed $568,370 in the aggregate for both vendors for startup costs, hiring staff, and readiness activities effective upon Governor and Council approval.

Funds are available in the following account(s) for State Fiscal Years 2020 and 2021, with authority to adjust amounts within the price limitation and adjust encumbrances between state fiscal years through the Budget Office, if needed and justified.

**05-95-92-920510-7040 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: BEHAVIORAL HEALTH DIV OF, BUREAU OF DRUG & ALCOHOL SERVICES, STATE OPIOID RESPONSE GRANT**

| Catholic Medical Center | | | |
|---|---|---|---|
| State Fiscal Year | Class Title | Class Amount | Current Budget |
| 2020 | Contracts for Prog Svs | 102-500731 | $1,223,728 |
| 2021 | Contracts for Prog Svs | 102-500731 | $724,614 |
| | | ***Subtotal*** | ***$1,948,342*** |

| Southern New Hampshire Health System, Inc. | | | |
|---|---|---|---|
| **State Fiscal Year** | **Class Title** | **Class Amount** | **Current Budget** |
| 2020 | Contracts for Prog Svs | 102-500731 | $1,048,716 |
| 2021 | Contracts for Prog Svs | 102-500731 | $522,272 |
| | | ***Subtotal*** | ***$1,570,988*** |
| | | ***Grand Total*** | ***$3,519,330*** |

## EXPLANATION

This request is **Sole Source** because the Department has implemented the Doorway system for substance use services across the State with hospital systems to provide services to individuals struggling with substance use disorders. Based on a review of the non-hospital based Vendor currently operating the Doorways in the Greater Manchester and Greater Nashua regions, the Department has determined that these two (2) Vendors have the capability and are well poised and positioned to take over the programs in the Greater Manchester and Greater Nashua regions from the current Vendor. These new Vendors will work with the current Vendor for a period of 90 days to transition the program while maintaining services in the two cities. The new Vendors will begin offering services within 60 days of contract approval. The current Vendor will serve the two regions during that time period and have 30 days thereafter to complete the full transition.

Approximately 1,500 individuals in the Greater Manchester and Greater Nashua regions are expected to be served May 10, 2020 through September 29, 2020.

The Doorway program was launched in January 2019 as part of the federal State Opioid Response (SOR) grant, which also funds services including but not limited to Medication Assisted Treatment, recovery housing, peer recovery support, mobile crisis and employment. The SOR funding also serves specialty populations, including caregivers with opioid use disorder, pregnant women and individuals transitioning from correctional facilities to community based settings. These contracts will allow the Doorways to continue ensuring that every resident in New Hampshire has access to in-person substance use disorder treatment and recovery services. Services include assessments and evaluations for substance use disorder care coordination, and referrals to community partners for needed services and supports. The Doorways also distribute naloxone to individuals and service providers in their regions.

In 2019, the Doorway program served close to 8,400 individuals and in January 2020 alone, over 1,000 individuals were served. The Doorways continue to increase and standardize services for individuals with opioid use disorder; strengthen existing prevention, treatment, and recovery programs; ensure access to critical services to decrease the number of opioid-related deaths in New Hampshire; and promote engagement in the recovery process. With these contracts, all nine regional Doorways will be aligned with hospital systems.

The Department will work closely with these Contractors as they prepare to assume the delivery of Doorway services in the Greater Manchester and Greater Nashua regions, as well as provide for the transition of current clients from Granite Pathways to Catholic Medical Center and Southern New Hampshire Health Systems, Inc. This will include a kick-off meeting, weekly check-ins and monthly onsite visits.

The Department will monitor the effectiveness and the delivery of services required under these agreements using the following performance measures:

- Monthly de-identified, aggregate data reports;
- Weekly and biweekly Doorway program calls;
- Monthly Community of Practice meetings; and
- Regular review and monitoring of Government Performance and Results Act interviews and follow-ups through the Web Information Technology System database.

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

Should the Governor and Executive Council not authorize this request, individuals seeking help for opioid use disorder in the Greater Nashua and Greater Manchester regions may experience difficulty navigating a complex system; may not receive the supports and clinical services they need; and may experience delays in receiving care.

Area served: Statewide

Source of Funds: 100% Federal Funds from the Substance Abuse and Mental Health Services Administration. CFDA # 93.788, FAIN #H79TI081685 and FAIN #TI080246.

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

Respectfully submitted,

Lori A. Shibinette
Commissioner

Subject: Access and Delivery Hub for Opioid Use Disorder Services (SS-2019-BDAS-05-ACCESS-09)

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<br>NH Department of Health and Human Services | | 1.2 State Agency Address<br>129 Pleasant Street<br>Concord, NH 03301-3857 | |
| 1.3 Contractor Name<br>Catholic Medical Center | | 1.4 Contractor Address<br>100 McGregor Street<br>Manchester, NH 03102 | |
| 1.5 Contractor Phone Number<br>603-663-8709 | 1.6 Account Number<br>05-095-092-920510-70400000-102-500731 | 1.7 Completion Date<br>09/29/2020 | 1.8 Price Limitation<br>$1,948,342 |
| 1.9 Contracting Officer for State Agency<br>Nathan D. White, Director | | 1.10 State Agency Telephone Number<br>603-271-9631 | |
| 1.11 Contractor Signature<br>Date: 2/28/2020 | | 1.12 Name and Title of Contractor Signatory<br>Joseph Pepe, MD<br>President/CEO Catholic Medical Center | |
| 1.13 State Agency Signature<br>Lori Shibinette<br>Date: 2/28/20 | | 1.14 Name and Title of State Agency Signatory<br>Lori Shibinette - Commissioner | |
| 1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*<br>By: | | Director, On: | |
| 1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)*<br>By: J.D. Laraller | | On: 3/2/2020 | |
| 1.17 Approval by the Governor and Executive Council *(if applicable)*<br>G&C Item number: | | G&C Meeting Date: | |



Contractor Initials JH
Date 2/28/20

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

**3. EFFECTIVE DATE/COMPLETION OF SERVICES.**

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

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

**4. CONDITIONAL NATURE OF AGREEMENT.**

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

**5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.**

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

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

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

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

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

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

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

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

**7. PERSONNEL.**

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

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

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



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**8. EVENT OF DEFAULT/REMEDIES.**

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

8.1.1 failure to perform the Services satisfactorily or on schedule;

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

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

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

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

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

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

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

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

**9. TERMINATION.**

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

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

**10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.**

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

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

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

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

**12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.**

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

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

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



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

**14. INSURANCE.**

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

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

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

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

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

**15. WORKERS' COMPENSATION.**

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

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

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

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

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

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

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

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

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

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

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



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Date 2/22/2020

## REVISIONS TO STANDARD CONTRACT PROVISIONS

### Section 1 – Revisions to Form P-37, General Provisions

1. 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 year(s) from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

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

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

Scope of Services

## 1. Provisions Applicable to All Services

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

1.2. The Contractor agrees that, to the extent future 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.

1.3. All Exhibits D through K are attached hereto and incorporated by reference herein.

## 2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder treatment and recovery support service access.

2.2. The Contractor shall provide residents in the Greater Manchester Region with access to referrals to substance use disorder treatment and recovery support services and other health and social services.

2.3. The Contractor shall participate in technical assistance, guidance, and oversight activities directed by the Department for implementation of Doorway services.

2.4. The Contractor shall have the Doorway operational no later than 60 calendar days from the contract effective date.

2.5. The Contractor shall work with the Department's current Doorway Contractor for the region identified in Section 2.2 above and the Department to transfer operations as soon as possible, but no later than the operational date identified in Section 2.4 above.

2.6. For the transfer of operations, the Contractor shall:

2.6.1. Cooperate fully, during the transfer period in Section 2.5, with the Department and Department's current Doorway Contractor in the transition of services including, but not limited to, obtaining authorization from clients and transferring treatment records as authorized and/or required by law, including obtaining appropriate patient consent.

2.6.2. Work directly with the Department's current Doorway Contractor to ensure no lapse in services occur.

2.6.3. Use the Department's current Doorway Contractor as a resource to ensure an adequate transition of services.

2.6.4. Provide a transition plan to the Department within fifteen (15) business days of the contract effective date that includes but is not limited to:

2.6.4.1. Identifying the present and future needs of clients currently receiving services under the Department's current Doorway Contractor and establishes a process to meet those needs.

2.6.4.2. Providing ongoing communication and revisions of the Transition Plan to the Department as requested.

2.6.4.3. Providing a process for uninterrupted delivery of services, which shall include warm hand off of clients from the current Doorway to this Contractor.

2.6.4.4. Establishing a method of notifying clients and other affected individuals about the transition and provide the Department with a copy of the communications to notify the clients.

2.6.4.5. Receiving from the current Department's Doorway Contractor undistributed naloxone kits under the guidance of the Department.

2.7. The Contractor shall collaborate with the Department to assess the Contractor's level of readiness, capacity and resource needs required to operate Doorway services in-house to include, but not be limited to:

2.7.1. Medication assisted treatment induction at emergency rooms and facilitated coordination with ongoing Doorway care coordination inclusive of the core principles of the Medication First Model.

2.7.2. Outpatient and inpatient substance use disorder services, in accordance with ASAM.

2.7.3. Coordinating overnight placement for Doorway clients engaged in Doorway services outside of regular Doorway operating hours identified in Section 3.1.1, in need of a safe location while awaiting treatment placement the following business day.

2.7.4. Expanding populations for Doorway core services.

2.8. The Contractor shall collaborate with the Department to identify gaps in financial and staffing resources required in Section 5 Staffing below, throughout the contract period.

2.9. The Contractor shall ensure formalized coordination with 2-1-1 NH and the Department's after hours Doorway Contractor. This coordination shall include:

2.9.1. Establishing an MOU with 2-1-1 NH which defines the workflows to coordinate 2-1-1 NH calls and Doorway activities including the following workflow:

2.9.1.1. Individuals seeking substance use disorder treatment services will call 2-1-1 NH;

2.9.1.2. If an individual is seeking information only, 2-1-1 NH staff will provide that information;

2.9.1.3. If an individual is in an SUD related crisis and wants to speak with a licensed counselor and/or is seeking assistance with accessing treatment services outside of regular Doorway operating hours identified in Section 3.1.1, 2-1-1 NH staff will transfer the caller to the Departments' after hours Contractor for on-call services.

2.9.2. The Contractor shall establish an MOU with the Department's after hours Contractor for after hour services which shall include but not limited to:

2.9.2.1. A process for ensuring that the client's preferred Doorway receives information on the outcomes and events of the call for continued follow-up

2.9.2.2. A process for obtaining appropriate consent forms in order to enable the sharing of information about each client, in accordance with all applicable state and federal requirements.

2.9.3. The MOU with 2-1-1 NH shall include a process for bi-directional information sharing of updated referral resource databases to ensure that each entity has recently updated referral information.

2.10. The Contractor shall establish formalized agreements for coordination of services and case management services provided by Integrated Delivery Networks (IDNs) to reduce duplication of services and leverage existing integrated care projects in their region.

2.11. The Contractor, with the assistance of the Department, shall establish formalized agreements with:

2.11.1. Medicaid Managed Care Organizations to coordinate case management efforts on behalf of the client.

2.11.2. Private insurance carriers to coordinate case management efforts on behalf of the client.

2.12. The Contractor shall be required to create policies for obtaining patient consent to disclose protected health information as required by state administrative rules and federal and state laws for agreements reached with Managed Care Organizations and private insurance carriers as outlined in Section 2.11.

2.13. The Contractor shall develop a Department approved conflict of interest policy related to Doorway services and self-referrals to Doorway organization substance use disorder treatment and recovery support service programs funded outside of this contract that

maintains the integrity of the referral process and client choice in determining placement in care.

2.14. The Contractor shall participate in community collaboration that includes but is not limited to attending:

2.14.1. Monthly Community of Practice Meetings

2.14.2. Monthly meetings led by the Department and attended by the other Department's Doorway Contractors

2.14.3. Community and regional-based partner meetings that address substance use, mental health and housing matters.

2.15. The Contractor shall convene or participate in regional community partner meetings to provide information regarding the Doorway services. The Contractor shall:

2.15.1. Ensure partners include, but are not limited to:

2.15.1.1. City leaders.

2.15.1.2. Providers.

2.15.1.3. Other stakeholders affected by SUD.

2.15.2. Ensure meeting agendas include, but are not limited to:

2.15.2.1. Receiving input on successes, challenges and ways within which to improve transitions and process flows.

2.15.3. Provide meeting minutes to partners and the Department no later than 10 days following each community partner meetings.

## 3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one location, at a minimum:

3.1.1. Operating hours at a minimum of 8 am to 11 pm Monday through Friday, and 11 am to 11 pm Saturday and Sunday, from the operational date in Section 2.4 above.

3.1.2. Reserved.

3.1.3. A physical location for clients to receive face-to-face services.

3.1.3.1. The Contractor shall submit a request for Department approval to move to another physical location, at least thirty (30) days prior to the move.

3.1.4. Telephonic services for calls referred to the Doorway by 2-1-1 NH.

3.1.5. Initial intake and screening to assess an individual's potential need for Doorway services.

3.1.6. Crisis intervention and stabilization that ensures any individual in an acute OUD related crisis who requires immediate, non-emergency intervention receives crisis intervention counseling services by a licensed clinician. If the individual is calling rather than physically presenting at the Doorway, this includes, but is not limited to:

3.1.6.1. Directing callers to 911 if a client is in imminent danger or there is an emergency.

3.1.6.2. If the client is unable or unwilling to call 911, the Doorway shall contact emergency or mobile crisis services.

3.1.7. Clinical evaluation including:

3.1.7.1. Evaluation of all American Society of Addiction Medicine Criteria (ASAM, October 2013), domains.

3.1.7.2. A level of care recommendation based on ASAM Criteria (October 2013).

3.1.7.3. Identification of client strengths and resources that can be used to support treatment and recovery.

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Section 3.1.7. The service plan shall include, but not be limited to:

3.1.8.1. Determination of an initial ASAM level of care.

3.1.8.2. Identification of any needs the client may have relative to supportive services including, but not limited to:

3.1.8.2.1. Physical health needs

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Need for peer recovery support services.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Needs regarding criminal justice that includes Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. Plan for addressing all areas of need identified in Section 3.1.8.2 by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. When the level of care identified in Section 3.1.7 is not available to the client within 48 hours of service plan development, the service

plan shall include plans for referrals to external providers to offer interim services, which are defined as:

3.1.8.4.1. At least one sixty (60) minute individual or group outpatient session per week and/or;
3.1.8.4.2. Recovery support services, as needed by the client; and/or
3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs.
3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be the licensed clinician, CRSW outlined in the Staffing section, or other non-clinical support staff, capable of aiding specialty populations in accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and/or service members.
3.1.9.2. Pregnant, postpartum, and parenting women.
3.1.9.3. DCYF involved families.
3.1.9.4. Individuals at-risk of or with HIV/AIDS.
3.1.9.5. Adolescents.

3.1.10. Facilitated referrals to substance use disorder treatment and recovery support and other health and social services which shall include, but not be limited to:

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.
3.1.10.2. Determining referrals based on the service plan developed in Section 3.1.8.
3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.
3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

3.1.10.5. Assisting clients with meeting the financial requirements for accessing services including, but not limited to:

3.1.10.5.1. Identifying sources of financial assistance for accessing services and supports, and;

3.1.10.5.2. Providing assistance in accessing such financial assistance including, but not limited to:

3.1.10.5.2.1. Assisting the client with making contact with the assistance agency, as appropriate.

3.1.10.5.2.2. Contacting the assistance agency on behalf of the client, as appropriate.

3.1.10.5.2.3. Supporting the client in meeting the admission, entrance, and intake requirements of the assistance agency.

3.1.10.5.3. When no other payer is available, assisting clients with accessing services by maintaining a flexible needs fund specific to the Doorway region that supports clients who meet the eligibility criteria for assistance under the NH DHHS SOR Flexible Needs Fund Policy with their financial needs including, but not limited to:

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations as identified and recommended by Doorway professional staff to assist the eligible client with recovery;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments as identified and recommended by Doorway professional staff to assist the eligible client with recovery;

3.1.10.5.3.3. Payment of short-term housing costs or other costs necessary to remove financial barriers to obtaining or retaining safe housing, such as payment of security deposits or unpaid utility bills;

3.1.10.5.3.4. Provision of light snacks not to exceed $3.00 per eligible client;

3.1.10.5.3.5. Provision of phone minutes or a basic prepaid phone to permit the eligible client to contact treatment providers and recovery services, and to permit contact with the eligible client for continuous recovery support;

3.1.10.5.3.6. Provision of clothing appropriate for cold weather, job interviews, or work; and

3.1.10.5.3.7. Other uses preapproved in writing by the Department.

3.1.10.5.4. Providing a Respite Shelter Voucher program to assist individuals in need of respite shelter while awaiting treatment and recovery services. The Contractor shall:

3.1.10.5.4.1. Collaborate with the Department on a respite shelter voucher policy and related procedures to determine eligibility for respite shelter vouchers based on criteria that include but are not limited to confirming an individual is:

3.1.10.5.4.1.1. A Doorway client;

3.1.10.5.4.1.2. In need of respite shelter while awaiting treatment and recovery services; and

3.1.10.5.4.1.3. In need of obtaining financial assistance to access short-term, temporary shelter.

3.1.11. Continuous case management services which include, but are not limited to:

3.1.11.1. Ongoing assessment of the clinical evaluation in Section 3.1.7 above for individuals until they are receiving the level of care services and supports identified as appropriate for them. The level of care services needed may be revised based on how the individual responds while receiving interim services and supports.

3.1.11.2. Ongoing assessment in collaboration or consultation with the client's external service provider(s) of necessary support services to address needs identified in the evaluation or by the client's service provider that may create barriers to the client entering and/or maintaining treatment and/or recovery.

3.1.11.3. Supporting clients in meeting the admission, entrance, and intake requirements of the provider agency.

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service provider(s) until such time that the discharge Government Performance and Results Act (GPRA) interview in 3.1.11.7.3 is completed including, but not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until such time that the discharge GPRA interview in Section 3.1.11.7.3 has been completed, according to the following guidelines:

3.1.11.4.1.1. Attempt the first contact by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available.

3.1.11.4.1.2. If the attempt in Section 3.1.11.4.1.1 is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Section 3.1.11.4.1.2 is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later

than three (3) business days after the second attempt.

3.1.11.5. When the follow-up in Section 3.1.11.4 results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

3.1.11.6. When possible, client contact and outreach shall be conducted in coordination and consultation with the client's external service provider to ensure continuous communication and collaboration between the Doorway and service provider.

3.1.11.6.1. Each successful contact shall include, but not be limited to:

3.1.11.6.1.1. Inquiry on the status of each client's recovery and experience with their external service provider.

3.1.11.6.1.2. Identification of client needs.

3.1.11.6.1.3. Assisting the client with addressing needs, as identified in Section 3.1.11.6.1.2.

3.1.11.6.1.4. Providing early intervention to clients who have relapsed or whose recovery is at risk.

3.1.11.7. Collecting and documenting attempts to collect client-level data at multiple intervals including, but not limited to ensuring the GPRA Interview tool is completed and entered into the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Performance Accountability and Reporting System (SPARS), at a minimum:

3.1.11.7.1. At intake or within three (3) calendar days following initial client contact.

3.1.11.7.2. Six (6) months post intake into Doorway services.

3.1.11.7.3. Upon discharge from the initially referred service.

3.1.11.7.3.1. If the client is discharged from services before the time intervals in Section 3.1.11.7.2 or Section 3.1.11.7.3 the Doorway must make every reasonable effort to conduct a follow-up GPRA for that client.

3.1.11.7.3.2. If a client is re-admitted into services after discharge or being lost to care, the Doorway is not required to re-administer the intake GPRA but must complete a follow-up GPRA for the time interval in Section 3.1.11.7.2 or 3.1.11.7.3 closest to the intake GPRA.

3.1.11.8. Documenting any loss of contact in the SPARS system using the appropriate process and protocols as defined by SAMHSA through technical assistance provided under the State Opioid Response grant.

3.1.11.9. Ensuring that contingency management strategies are utilized to increase client engagement in follow-up GPRA interviews, which may include, but are not limited to gift cards provided to clients for follow-up participation at each follow-up interview, which shall not exceed thirty dollars ($30) in value.

3.1.11.9.1. Payments to incentivize participation in treatment are not allowable.

3.1.11.10. Assistance to individuals who are unable to secure financial resources, in enrolling in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare, and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.11. Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the NH DHHS Naloxone Distribution Policy regarding the use of naloxone.

3.2. The Contractor shall obtain treatment consent forms from all clients served, either in-person or through electronic means, to ensure compliance with all applicable state and federal confidentiality laws.

3.3. The Contractor shall provide services in accordance with:

3.3.1. The twelve (12) Core Functions of the Alcohol and Other Drug Counselor.

3.3.2. The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice

3.3.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium

3.3.4. TIP 27: Comprehensive Case Management for Substance Abuse Treatment

3.4. The Contractor shall utilize recent and inform any future developments of a comprehensive needs assessment of their region. The needs assessment shall be coordinated with existing regional partners including, but not limited to:

3.4.1. Regional Public Health Networks.
3.4.2. Integrated Delivery Networks.
3.4.3. Continuum of Care Facilitators.

3.5. The Contractor shall inform the inclusion of regional goals into the future development of needs assessments in Section 3.4 that the Contractor and its partners in the region have over the contract period including, but not limited to reductions in:

3.5.1. Naloxone use.
3.5.2. Emergency Room use.
3.5.3. Overdose related fatalities.

3.6. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers.

3.7. The Contractor shall provide information to all individuals seeking services on how to file a grievance in the event of dissatisfaction with services provided. The Contractor shall ensure each individual seeking services receives information on:

3.7.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.
3.7.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.8. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date that includes but not limited to:

3.8.1. Policies such as, but not be limited to client consent forms, conflict of interest, consent and privacy, financial assistance, shelter vouchers, referrals and evaluation form other providers, complaints, and grievances.
3.8.2. Formalized agreements such as, but not be limited to relationship with 2-1-1 and after hours on-call clinical services.
3.8.3. Formalized agreements with Integrated Delivery Networks (IDNs), Medicaid Managed Care Organizations (MCOs), and private insurers, within sixty (60) business days of the contract effective date. The Contractor may submit for an extension beyond the sixty (60) days upon approval of the Department.

**4. Subcontracting for the Doorways**

4.1. The Doorway shall submit all subcontracts they propose to enter into for services provided through this contract to the Department for approval prior to execution.

4.2. The Doorway may subcontract with prior approval of the Department for support and assistance in providing core Doorway services; except that such core services shall not be subcontracted providers whose principal operations are to serve individuals with a specific diagnosis of substance use disorders.

4.2.1. Core Doorway services are defined, for purposes of this contract, as screening, assessment, evaluation, referral, continuous case management, GPRA data completion, and naloxone distribution.

4.2.2. The Doorway shall at all times be responsible for continuous oversight of, and compliance with, all Core Doorway services and shall be the single point of contact with the Department for those Core services.

4.2.3. Any subcontract for support and assistance in providing Core Doorway services shall ensure that the patient experience is consistent across the continuum of Core Doorway services and that the subcontracted entities and personnel are at all times acting, in name and in fact, as agents of the Doorway. The Doorway shall consolidate Core Doorway services, to the greatest extent practicable, in a single location.

**5. Staffing**

5.1. The Contractor shall meet the following minimum staffing requirements:

5.1.1. Between the hours and days of the week identified in Section 3.1.1 as follows:

5.1.1.1. A minimum of one (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically;

5.1.1.2. A minimum of one (1) Recovery support worker (CRSW) with the ability to fulfill recovery support and care coordination functions;

5.1.1.3. A minimum of one (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Section 3.1.9.

5.1.2. Sufficient staffing levels that are appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making such change to the staffing.

5.1.3. All unlicensed staff providing treatment, education and/or recovery support services shall be under the direct supervision of a licensed supervisor.

5.1.4. No licensed supervisor shall supervise more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.1.5. Peer clinical supervision is provided for all clinicians including, but not limited to:

5.1.5.1. Weekly discussion of cases with suggestions for resources or alternative approaches.

5.1.5.2. Group supervision to help optimize the learning experience, when enough candidates are under supervision.

5.2. The Contractor must meet the training requirements for staff which include, but are not limited to:

5.2.1. For all clinical staff:

5.2.1.1. Suicide prevention and early warning signs.

5.2.1.2. The 12 Core Functions of the Alcohol and Other Drug Counselor.

5.2.1.3. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics.

5.2.1.4. An approved course on the twelve (12) core functions and The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within twelve (12) months of hire.

5.2.1.5. A Department approved ethics course within twelve (12) months of hire.

5.2.2. For recovery support staff and other non-clinical staff working directly with clients:

5.2.2.1. Knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee.

5.2.2.2. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics, and confidentiality safeguards in accordance with HIPAA and 42 CFR Part 2, and state rules and laws.

5.2.2.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium

5.2.2.4. An approved ethics course within twelve (12) months of hire.

5.2.3. Required trainings in Section 5.2 may be satisfied through existing licensure requirements and/or through Department approved alternative training curriculums and/or certifications.

5.2.4. Ensuring all recovery support staff and clinical staff receive continuous education regarding substance use disorders, at a minimum annually.

5.2.5. Providing in-service training to all staff involved in client care within fifteen (15) business days of the contract effective date or the staff person's start date on the following:

5.2.5.1. The contract requirements.

5.2.5.2. All other relevant policies and procedures provided by the Department.

5.3. The Contractor shall provide its staff, subcontractors, or end users as defined in Exhibit K, with periodic training in practices and procedures to ensure compliance with information security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.4. The Contractor shall notify the Department in writing:

5.4.1. When a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program, within one (1) month of hire.

5.4.2. When there is not sufficient staffing to perform all required services for more than one (1) month, within fourteen (14) calendar days.

5.5. The Contractor shall have policies and procedures related to student interns to address minimum coursework, experience, and core competencies for those interns having direct contact with individuals served by this contract.

5.6. The Contractor shall ensure that student interns complete an approved ethics course and an approved course on the twelve (12) core functions as described in Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within six (6) months of beginning their internship.

**6. Records.**

6.1. The Contractor must maintain the following records:

6.1.1. 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.

6.1.2. 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.

6.1.3. 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.

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

**7. Health Insurance Portability and Accountability Act and Confidentiality:**

7.1.1. The Contractor is a covered entity as defined under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 160, 162 and 164, and shall comply with all confidentiality requirements and safeguards set forth in state and federal law and rules. The Contractor is also a substance use disorder provider as defined under 42 CFR Part 2 and shall safeguard confidential information as required. The Contractor shall ensure compliance with all consent and notice requirements prohibiting the redisclosure of confidential information in accordance with 42 CFR Part 2.

7.1.2. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the disclosure of any protected health information shall be in accordance with the regulatory provisions of HIPAA, 42 CFR Part 2, and applicable state and federal laws and rules. Further, the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, their attorney or guardian. Notwithstanding anything to the contrary contained herein, the covenants and conditions contained in this Section 7 of Exhibit B shall survive the termination of the Contract for any reason whatsoever.

**8. Reporting Requirements.**

8.1. The Contractor shall comply with all aspects of the DHHS Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003, effective April 24, 2019, and any subsequent versions and/or amendments.

8.1.1. The Contractor shall report to DHHS Bureau of Drug and Alcohol Services within twenty-four (24) hours and follow up with written documentation submitted to the Bureau of Quality Assurance and Improvement within 72 hours, as specified in PO.1003, any sentinel event that occurs with any individual who is receiving services under this contract. This does not replace the responsibility of the Contractor's responsibility to notify the appropriate authority if the Contractor suspects a crime has occurred.

8.1.2. The Contractor shall comply with all statutorily mandated reporting requirements, including but not limited to, NH RSA 161-F:42-54 and RSA 169-C:29.

8.1.3. The Contractor shall cooperate with providing any information requested by DHHS as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

8.2. The Contractor shall submit monthly activity reports on templates provided by the Department with data elements that include, but may not be limited to:

8.2.1. call counts,
8.2.2. counts of clients seen,
8.2.3. reason types,
8.2.4. count of clinical evaluations,
8.2.5. count of referrals made and type,
8.2.6. naloxone distribution,
8.2.7. referral statuses,
8.2.8. recovery monitoring contacts,
8.2.9. service wait times, flex fund utilization, and
8.2.10. respite shelter utilization

8.3. The Contractor shall ensure the GPRAs are completed and entered into the WITS system on a timely basis so that the Department can create quarterly de-identified, aggregate client report on each client served, as required by SAMHSA. The GPRA data should include but not be limited to:

8.3.1. Diagnoses.
8.3.2. Demographic characteristics.
8.3.3. Substance use.
8.3.4. Services received and referrals made, by provider organization name.
8.3.5. Types of MAT received.
8.3.6. Length of stay in treatment.
8.3.7. Employment status.
8.3.8. Criminal justice involvement.
8.3.9. Housing.

8.4. The Contractor shall submit monthly reports on naloxone kits distributed, utilizing a template provided by the Department.

8.5. The Contractor shall report quarterly on federally required data points specific to this funding opportunity as identified by SAMHSA over the grant period.

8.6. The Contractor shall be required to prepare and submit ad hoc data reports as deemed necessary by the Department.

**9. Performance Measures**

9.1. The Department shall measure the effectiveness of the Contractor's performance in accordance with the provisions of this Agreement as follows:

9.1.1. The Contractor shall attempt to complete a GPRA interview for 100% of Doorway clients at intake or within three (3) calendar days following initial client contact and at six (6) months post intake, and upon discharge from Doorway referred services.

9.1.2. In accordance with SAMHSA State Opioid Response grant requirements, the Contractor shall attempt to ensure that the GPRA interview follow-up rate at six (6) months post intake for Doorway clients is no less than 80%.

**10. Doorway Implementation and Contract Management**

10.1. The Contractor shall participate in a kick-off meeting with the Department within ten (10) calendar days of the contract effective date to review contract timelines, scope, and deliverables.

10.2. The Contractor shall participate in weekly status telephone calls with the Department to review the status of the development and implementation for the Doorway, for the first three (3) months of the contract. The Contractor shall:

10.2.1. Provide a written weekly progress report in advance of the telephone call that would summarize:

10.2.1.1. Key work performed,

10.2.1.2. Encountered and foreseeable key issues and problems and provide a solution or mitigation strategy for each

10.2.1.3. Scheduled work for the upcoming week

10.2.2. Provide a report summarizing the results of the weekly status telephone call.

10.3. The Contractor shall participate in implementation and operational site visits on a schedule provided by the Department. All contract deliverables, programs, and activities shall be subject to review during this time. The Contractor shall:

10.3.1. Ensure the Department has access sufficient for monitoring of contract compliance requirements.

10.3.2. Ensure the Department is provided with access that includes but is not limited to:
10.3.2.1. Data.
10.3.2.2. Financial records.
10.3.2.3. Scheduled access to Contractor work sites/locations/work spaces and associated facilities.
10.3.2.4. Unannounced access to Contractor work sites/locations/work spaces and associated facilities.
10.3.2.5. Scheduled phone access to Contractor principals and staff.

10.4. The Contractor shall provide a work plan to develop, implement, and operationalize the Doorway for Department for review, within fifteen days of the contract effective date. The work plan shall include but not limited to:

10.4.1. A Staffing plan to provide the hours of operation as identified in Section 3.1.1 above.
10.4.2. Identification and description of the tasks to be performed
10.4.3. Identification of the staff responsible for performing the tasks
10.4.4. Milestones.
10.4.5. Start and end dates.
10.4.6. Contingency planning as it relates to identified risks.
10.4.7. Issue tracking and resolution.

**11. State Opioid Response (SOR) Grant Standards**

11.1. The Contractor and/or referred providers shall ensure that only FDA-approved MAT for Opioid Use Disorder (OUD) is utilized. FDA-approved MAT for OUD includes:

11.1.1. Methadone.
11.1.2. Buprenorphine products, including:
11.1.2.1. Single-entity buprenorphine products.
11.1.2.2. Buprenorphine/naloxone tablets,
11.1.2.3. Buprenorphine/naloxone films.
11.1.2.4. Buprenorphine/naloxone buccal preparations.
11.1.2.5. Long-acting injectable buprenorphine products.
11.1.2.6. Buprenorphine implants.
11.1.2.7. Injectable extended-release naltrexone.

11.2. The Contractor and/or referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.3. The Contractor and/or referred providers shall ensure that clients receiving financial aid for recovery housing utilizing SOR funds shall only be in a recovery housing facility that is aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.4. The Contractor and/or referred providers shall assist clients with enrolling in public or private health insurance, if the client is determined eligible for such coverage.

11.5. The Contractor and/or referred providers shall accept clients on MAT and facilitate access to MAT on-site or through referral for all clients supported with SOR Grant funds, as clinically appropriate.

11.6. The Contractor and/or referred providers shall coordinate with the NH Ryan White HIV/AIDs program for clients identified as at risk of or with HIV/AIDS.

11.7. The Contractor and/or referred providers shall ensure that all clients are regularly screened for tobacco use, treatment needs and referral to the QuitLine as part of treatment planning.

**12. Data Management Requirements**

12.1. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements, which is attached hereto and incorporated by reference herein.

**13. Termination Report/Transition Plan**

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

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

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

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

13.5. During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

**14. Credits and Copyright Ownership**

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

14.2. All materials produced or purchased under the contract shall have prior approval from the Department before printing, production, distribution or use. The Department will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. The Contractor shall not reproduce any materials produced under the contract without prior written approval from the Department.

**15. Operation of Facilities: Compliance with Laws and Regulations**

15.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose

an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

**16. Equal Employment Opportunity Plan (EEOP)**

16.1. The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non- profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

**17. Equipment Purchases**

17.1. The Contractor shall submit to the Department's Contract Unit a list of the purchased office equipment (with funding from this Contract). The list shall include office equipment such as, but not limited to, laptop computers, printers/scanners, and phones with the make, model, and serial number of each piece of office equipment.

17.2. The Contractor shall return said office equipment in Section 17.1 to the Department's Contract Unit within 30 days from the completion date of the Contract.

**18. Compliance with Federal and State Laws**

18.1. If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

18.2. Time and Manner of Determination

18.2.1. Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

18.3. Documentation

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

18.4. Fair Hearings

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

## Payment Terms

1. This contract is funded with funds from the Substance Abuse and Mental Health Services Administration CFDA #93.788, Federal Award Identification Number (FAIN) H79TI081685 and TI080246.

2. 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.

3. The Contractor may invoice the Department in an amount not to exceed $200,000 upon Governor and Executive Council approval of this Agreement. The Contractor shall ensure:

   3.1. The invoice clearly states a request for advance payment for the total advance payment amount.

   3.2. The invoice includes how funds will be utilized toward start up costs, hiring staff and staff readiness activities and furnishings, in accordance with with the implementaton plan in Exhibit B, Scope of Services, Section 10 Doorway Implementaion and Contract Management.

   3.3. Monthly reports detailing the actual costs incurred for items in Section 3.2 above, shall be submitted to the Department prior to submitting invoices for services provided after the period of implementation is completed. The invoices for services after implementation will be paid on a cost reimbursement basis as stated in Section 2 above. Reimbursement for services after implementation will not occur until the advanced funds in Section 3 above have been fully expended,unless otherwise approved by the Department.

4. During the period of implementation as outlined in Exhibit B, Scope of Services, Section 10 Doorway Implementation and Contract Management, the Contractor may invoice the Department for costs associated with implementation only.

5. The Contractor shall seek reimbursement as follows:

   5.1. First, bill the clients other insurance or payor sources.

   5.2. Medicare

   5.3. For Medicaid enrolled individuals:

      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

5.3.2. Medicaid Fee for Service: The Contractor shall bill Medicaid for services on the Fee for Service (FFS) schedule.

5.4. Sliding Fee Scale Program

5.5. Lastly, the contractor shall bill this Agreement.

6. The Contractor shall submit an invoice in a form satisfactory to the State by the fifteenth (15th) working day of the following month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment. Invoices shall be net any other revenue received towards the services billed in fulfillment of this agreement.

6.1. Backup documentation shall include, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract

6.1.2. Timesheets and/or time cards that support the hours employees worked for wages reported under this contract.

6.1.2.1. Per 45 CFR Part 75.430(i)(1) Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed.

6.2. The following backup documentation may also be requested as needed:

6.2.1. Invoices supporting expenses reported.

6.2.1.1. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed $3.00 per person for clients.

6.2.2. Cost center reports

6.2.3. Profit and loss report

6.2.4. Remittance Advices from the insurances billed. Remittance Advices do not need to be supplied with the invoice, but should be retained to be available upon request.

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

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

8. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available, subject to Paragraph 4 of the General Provisions (Form Number P-37) of this Agreement.
9. The final invoice shall be due to the State no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.
10. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.
11. Grant Funds shall not be used to:
    - 11.1. Pay for the purchase or construction of any building or structure to house any part of the program.
    - 11.2. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.
12. 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.
13. Notwithstanding paragraph 18 of the General Provisions 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.
14. Audits
    - 14.1. The Contractor is required to submit an annual audit to the Department if any of the following conditions exist:
        - 14.1.1. 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.
        - 14.1.2. 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.
        - 14.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.
    - 14.2. 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.

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

14.4. Any Contractor that receives an amount equal to or greater than $250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA if the Department's risk assessment determination indicates the Contractor is high-risk.

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

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

Contractor name: Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region

Budget Period: March 2020 - June 2020

| 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 | $ 264,000.00 | $ - | $ 264,000.00 | $ - | $ - | $ - | $ 264,000.00 | $ - | $ 264,000.00 |
| 2. Employee Benefits | $ 79,000.00 | $ - | $ 79,000.00 | $ - | $ - | $ - | $ 79,000.00 | $ - | $ 79,000.00 |
| 3. Consultants | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 4. Equipment: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Rental | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Repair and Maintenance | $ 1,800.00 | $ - | $ 1,800.00 | $ - | $ - | $ - | $ 1,800.00 | $ - | $ 1,800.00 |
| Purchase/Depreciation | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 5. Supplies: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Educational | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Lab | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Pharmacy | $ 150,000.00 | $ - | $ 150,000.00 | $ - | $ - | $ - | $ 150,000.00 | $ - | $ 150,000.00 |
| Medical | $ 400.00 | $ - | $ 400.00 | $ - | $ - | $ - | $ 400.00 | $ - | $ 400.00 |
| Office | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Furniture / Technology | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 6. Travel | $ 5,600.00 | $ - | $ 5,600.00 | $ - | $ - | $ - | $ 5,600.00 | $ - | $ 5,600.00 |
| 7. Occupancy | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 8. Current Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Telephone | $ 7,320.00 | $ - | $ 7,320.00 | $ - | $ - | $ - | $ 7,320.00 | $ - | $ 7,320.00 |
| Postage | $ 200.00 | $ - | $ 200.00 | $ - | $ - | $ - | $ 200.00 | $ - | $ 200.00 |
| Subscriptions | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Audit and Legal | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Insurance | $ 2,700.00 | $ - | $ 2,700.00 | $ - | $ - | $ - | $ 2,700.00 | $ - | $ 2,700.00 |
| Board Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 9. Software | $ 68,160.00 | $ - | $ 68,160.00 | $ - | $ - | $ - | $ 68,160.00 | $ - | $ 68,160.00 |
| 10. Marketing/Communications | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 11. Staff Education and Training | $ 3,500.00 | $ - | $ 3,500.00 | $ - | $ - | $ - | $ 3,500.00 | $ - | $ 3,500.00 |
| 12. Subcontracts/Agreements | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 13. Other (specific details mandatory): | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Flex funding | $ 104,000.00 | $ - | $ 104,000.00 | $ - | $ - | $ - | $ 104,000.00 | $ - | $ 104,000.00 |
| video conferencing | $ 2,400.00 | $ - | $ 2,400.00 | $ - | $ - | $ - | $ 2,400.00 | $ - | $ 2,400.00 |
| Internet | $ 2,400.00 | $ - | $ 2,400.00 | $ - | $ - | $ - | $ 2,400.00 | $ - | $ 2,400.00 |
| Respite Housing Vouchers | $ 221,000.00 | $ - | $ 221,000.00 | $ - | $ - | $ - | $ 221,000.00 | $ - | $ 221,000.00 |
| Start-Up Expenses (Advance Payment) | $ 200,000.00 | $ - | $ 200,000.00 | | | | $ 200,000.00 | $ - | $ 200,000.00 |
| TOTAL | $ 1,112,480.00 | $ 111,248.00 | $ 1,223,728.00 | $ - | $ - | $ - | $ 1,112,480.00 | $ 111,248.00 | $ 1,223,728.00 |
| Indirect As A Percent of Direct | | 10.0% | | | | | | | |



Contractor Initials: [signature]
Date: 2/22/2020

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

Contractor name Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region

Budget Period: July 2020 - Sept 2020

| 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 | $ 197,500.00 | $ - | $ 197,500.00 | $ - | $ - | $ - | $ 197,500.00 | $ - | $ 197,500.00 |
| 2. Employee Benefits | $ 59,250.00 | $ - | $ 59,250.00 | $ - | $ - | $ - | $ 59,250.00 | $ - | $ 59,250.00 |
| 3. Consultants | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 4. Equipment: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Rental | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Repair and Maintenance | $ 1,350.00 | $ - | $ 1,350.00 | $ - | $ - | $ - | $ 1,350.00 | $ - | $ 1,350.00 |
| Purchase/Depreciation | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 5. Supplies: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Educational | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Lab | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Pharmacy | $ 112,500.00 | $ - | $ 112,500.00 | $ - | $ - | $ - | $ 112,500.00 | $ - | $ 112,500.00 |
| Medical | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Office | $ 3,000.00 | $ - | $ 3,000.00 | $ - | $ - | $ - | $ 3,000.00 | $ - | $ 3,000.00 |
| Furniture / Technology | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 6. Travel | $ 4,200.00 | $ - | $ 4,200.00 | $ - | $ - | $ - | $ 4,200.00 | $ - | $ 4,200.00 |
| 7. Occupancy | $ 22,500.00 | $ - | $ 22,500.00 | $ - | $ - | $ - | $ 22,500.00 | $ - | $ 22,500.00 |
| 8. Current Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Telephone | $ 5,490.00 | $ - | $ 5,490.00 | $ - | $ - | $ - | $ 5,490.00 | $ - | $ 5,490.00 |
| Postage | $ 150.00 | $ - | $ 150.00 | $ - | $ - | $ - | $ 150.00 | $ - | $ 150.00 |
| Subscriptions | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Audit and Legal | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Insurance | $ 2,700.00 | $ - | $ 2,700.00 | $ - | $ - | $ - | $ 2,700.00 | $ - | $ 2,700.00 |
| Board Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 9. Software | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 10. Marketing/Communications | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 11. Staff Education and Training | $ 2,500.00 | $ - | $ 2,500.00 | $ - | $ - | $ - | $ 2,500.00 | $ - | $ 2,500.00 |
| 12. Subcontracts/Agreements | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 13. Other (specific details mandatory): | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Flex funding | $ 78,000.00 | $ - | $ 78,000.00 | $ - | $ - | $ - | $ 78,000.00 | $ - | $ 78,000.00 |
| video conferencing | $ 1,800.00 | $ - | $ 1,800.00 | $ - | $ - | $ - | $ 1,800.00 | $ - | $ 1,800.00 |
| Internet | $ 1,800.00 | $ - | $ 1,800.00 | $ - | $ - | $ - | $ 1,800.00 | $ - | $ 1,800.00 |
| Respite Housing Vouchers | $ 166,000.00 | $ - | $ 166,000.00 | $ - | $ - | $ - | $ 166,000.00 | $ - | $ 166,000.00 |
| TOTAL | $ 658,740.00 | $ 65,874.00 | $ 724,614.00 | $ - | $ - | $ - | $ 658,740.00 | $ 65,874.00 | $ 724,614.00 |
| Indirect As A Percent of Direct | | 10.0% | | | | | | | |



Contractor Initials

Date 3/28/2020

## CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

**ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS**

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

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

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

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

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

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

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

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

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

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

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

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

Vendor Name: Joseph Pepe, MD Catholic Medical Center

2/28/2020
Date

Name: Joseph Pepe, MD
Title: President + CEO
Catholic Medical Center

## 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: Joseph Pepe, MD Catholic Medical Center

2/28/2020
Date

Name:
Title: President/CEO
Catholic Medical Center

## CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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



Vendor Initials _____

Date 5/22/2020

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

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

Vendor Name: Joseph Pepe, my Catholic Medical Center

2/27/2020
Date

Name:
Title: President / CEO
Catholic Medical Center

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vendor Name: Joseph Pepe, MD Catholic Medical Center

2/28/2020
Date

Name:
Title: President/CEO
Catholic Medical Center

## CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Vendor Name: Joseph Pepe, MD Catholic Medical Center

2/28/2020
Date

Name:
Title: President/CEO
Catholic Medical Center

## HEALTH INSURANCE PORTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

Exhibit I is not applicable.

Remainder of page intentionally left blank.

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

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name: Joseph Pepe, MD Catholic Medical Center

2/28/2020
Date

Name:
Title: President/CEO
Catholic Medical Center

## FORM A

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

1. The DUNS number for your entity is: 827021382

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

   ✓ NO _____ YES

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

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

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

   _____ NO _____ YES

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

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

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

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

A. Definitions

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

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

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

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

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

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

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

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

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

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

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

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

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

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

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

## I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

## II. METHODS OF SECURE TRANSMISSION OF DATA

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

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

## III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

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

whole, must have aggressive intrusion-detection and firewall protection.

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

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

## IV. PROCEDURES FOR SECURITY

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

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

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

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

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

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

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

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

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

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

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

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

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

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

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

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

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

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

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

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

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

## V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

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

## VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

# State of New Hampshire

# Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that CATHOLIC MEDICAL CENTER is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on November 07, 1974. 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: **62116**

Certificate Number: **0004623259**


IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 2nd day of December A.D. 2019.

William M. Gardner

Secretary of State

CERTIFICATE OF VOTE

I, Matthew Kfoury, hereby certify that:

1. I am the duly elected Secretary of the Board of Trustees of Catholic Medical Center, a New Hampshire voluntary corporation ("CMC");

2. Joseph Pepe, MD is the duly elected President and CEO of CMC;

3. The following are true copies of resolutions duly adopted at a meeting of the Board of Trustees of CMC, duly held on February 20, 2020 at which a quorum of the Trustees were present and voting:

   RESOLVED: That entering into an agreement with the State of New Hampshire through the New Hampshire Department of Health and Human Services to develop, implement and operationalize a Greater Manchester access and delivery hub for substance use disorder treatment and recovery support services ("Doorway") is consistent with Catholic Medical Center's ("CMC") mission of carrying out Christ's healing ministry by offering health, healing and hope to every individual who seeks care, that it is in the best interests of CMC and the community it services, and that CMC is hereby authorized to enter into such an agreement, conditioned upon the State's approval of all necessary funding.

   RESOLVED: That Joseph Pepe, MD, as the President & CEO of CMC is hereby authorized on behalf of CMC to negotiate, execute and deliver any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he may deem necessary, desirable, or appropriate related to Doorway and CMC's participation in Doorway.

4. It is understood that the State of New Hampshire will rely on this Certificate of Vote as evidence that Dr. Pepe is currently the President & CEO of CMC and has the full authority to bind CMC.

5. The foregoing resolutions have not been amended, repealed or revoked and remain in full force and effect as of 2/28, 2020.

IN WITNESS WHEREOF, I have hereunto set my hand as Secretary of CMC this 2/28, 2020.

Matthew Kfoury, duly authorized
Secretary

STATE OF NEW HAMPSHIRE
COUNTY OF HILLSBOROUGH

This instrument was acknowledged before me this 2/28, 2020 by Matthew Kfoury as Secretary of CMC.

Lee F. Moriarty, Notary Public
My Commission Expires:

LEE F. MORIARTY
NOTARY PUBLIC - NEW HAMPSHIRE
My Commission Expires July 11, 2023

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 02/13/2020

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

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

| | |
|---|---|
| **PRODUCER**<br>MARSH USA, INC.<br>99 HIGH STREET<br>BOSTON, MA 02110<br>Attn: Boston.certrequest@Marsh.com Fax: 212-948-4377<br><br>CN109021768-ALL-GAWXP-19-20 | **CONTACT NAME:**<br>**PHONE (A/C, No, Ext):** **FAX (A/C, No):**<br>**E-MAIL ADDRESS:** |
| **INSURED**<br>Catholic Medical Center<br>100 McGregor Street<br>Manchester, NH 03102 | **INSURER(S) AFFORDING COVERAGE** — **NAIC #**<br>INSURER A : Pro Select Insurance Company<br>INSURER B : Safety National Casualty Corp. — 15105<br>INSURER C : N/A — N/A<br>INSURER D :<br>INSURER E :<br>INSURER F : |

**COVERAGES** **CERTIFICATE NUMBER:** NYC-010828730-01 **REVISION NUMBER:** 6

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<br>[ ] CLAIMS-MADE [X] OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br>[X] POLICY [ ] PRO-JECT [ ] LOC<br>[ ] OTHER: | | | 002NH000016052 | 10/01/2019 | 10/01/2020 | EACH OCCURRENCE<br>DAMAGE TO RENTED PREMISES (Ea occurrence)<br>MED EXP (Any one person)<br>PERSONAL & ADV INJURY<br>GENERAL AGGREGATE<br>PRODUCTS - COMP/OP AGG | $ 1,000,000<br>$ 50,000<br>$ 5,000<br>$ 1,000,000<br>$ 3,000,000<br>$ 3,000,000 |
| | AUTOMOBILE LIABILITY<br>[ ] ANY AUTO<br>[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS<br>[ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY | | | | | | COMBINED SINGLE LIMIT (Ea accident)<br>BODILY INJURY (Per person)<br>BODILY INJURY (Per accident)<br>PROPERTY DAMAGE (Per accident) | $<br>$<br>$<br>$ |
| | [ ] UMBRELLA LIAB [ ] OCCUR<br>[ ] EXCESS LIAB [ ] CLAIMS-MADE<br>[ ] DED [ ] RETENTION $ | | | | | | EACH OCCURRENCE<br>AGGREGATE | $<br>$ |
| B | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N [N]<br>If yes, describe under DESCRIPTION OF OPERATIONS below | N / A | | SP 4061346<br>*SIR $750,000 | 10/01/2019 | 10/01/2020 | [X] PER STATUTE [ ] OTH-ER<br>E.L. EACH ACCIDENT<br>E.L. DISEASE - EA EMPLOYEE<br>E.L. DISEASE - POLICY LIMIT | <br>$ 1,000,000<br>$ 1,000,000<br>$ 1,000,000 |

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

**CERTIFICATE HOLDER**

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

**CANCELLATION**

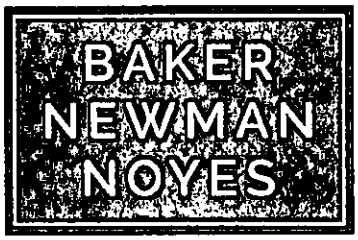
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

# Mission Statement

The heart of Catholic Medical Center is to carry out Christ's healing ministry by offering **health, healing and hope** to every individual who seeks our care.




# Catholic Medical Center

## Audited Financial Statements

*Years Ended September 30, 2019 and 2018*
*With Independent Auditors' Report*

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

# CATHOLIC MEDICAL CENTER

AUDITED FINANCIAL STATEMENTS

Years Ended September 30, 2019 and 2018

TABLE OF CONTENTS

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

# INDEPENDENT AUDITORS' REPORT

Board of Trustees
Catholic Medical Center

We have audited the accompanying financial statements of Catholic Medical Center, which comprise the balance sheets as of September 30, 2019 and 2018, and the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

*Management's Responsibility for the Financial Statements*

Management is responsible for the preparation and fair presentation of these 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 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 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 financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the 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 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 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 Trustees
Catholic Medical Center

*Opinion*

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Catholic Medical Center as of September 30, 2019 and 2018, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

*Emphasis of Matter*

As discussed in Note 2 to the financial statements, in 2019, Catholic Medical Center adopted the provisions of Financial Accounting Standards Board Accounting Standards Update No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities* and applied the guidance retrospectively for all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

**CATHOLIC MEDICAL CENTER**

BALANCE SHEETS

September 30, 2019 and 2018

ASSETS

| | 2019 | 2018 |
|---|---|---|
| Current assets: | | |
| Cash and cash equivalents | $ 47,897,010 | $ 57,668,500 |
| Short-term investments | 4,021,270 | 29,009,260 |
| Accounts receivable, less allowance for doubtful accounts of $19,786,141 in 2019 and $19,525,261 in 2018 | 78,067,491 | 54,074,988 |
| Inventories | 4,600,802 | 3,583,228 |
| Other current assets | 12,780,425 | 9,150,610 |
| Total current assets | 147,366,998 | 153,486,586 |
| Property, plant and equipment, net | 118,690,076 | 109,898,233 |
| Other assets: | | |
| Intangible assets and other | 11,869,524 | 10,875,302 |
| Assets whose use is limited: | | |
| Pension and insurance obligations | 18,832,810 | 17,859,458 |
| Board designated and donor restricted investments and restricted grants | 122,116,666 | 119,411,378 |
| Held by trustee under revenue bond agreements | 18,845,355 | 36,660,053 |
| | 159,794,831 | 173,930,889 |
| Total assets | $437,721,429 | $448,191,010 |

## LIABILITIES AND NET ASSETS

| | 2019 | 2018 |
|---|---|---|
| Current liabilities: | | |
| Accounts payable and accrued expenses | $ 36,870,043 | $ 28,743,870 |
| Accrued salaries, wages and related accounts | 18,604,407 | 18,755,583 |
| Amounts payable to third-party payors | 11,456,467 | 14,643,104 |
| Amounts due to affiliates | 991,062 | 1,477,267 |
| Current portion of long-term debt | 3,924,079 | 4,131,199 |
| Total current liabilities | 71,846,058 | 67,751,023 |
| Accrued pension and other liabilities, less current portion | 160,696,816 | 115,111,279 |
| Long-term debt, less current portion | 114,421,351 | 115,229,329 |
| Total liabilities | 346,964,225 | 298,091,631 |
| Net assets: | | |
| Without donor restrictions | 79,512,313 | 139,672,561 |
| With donor restrictions | 11,244,891 | 10,426,818 |
| Total net assets | 90,757,204 | 150,099,379 |
| Total liabilities and net assets | $437,721,429 | $448,191,010 |

See accompanying notes.

## CATHOLIC MEDICAL CENTER

STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018

| | 2019 | 2018 |
|---|---|---|
| Net patient service revenues, net of contractual allowances and discounts | $449,484,087 | $436,357,697 |
| Provision for doubtful accounts | (20,972,163) | (19,593,714) |
| Net patient service revenues less provision for doubtful accounts | 428,511,924 | 416,763,983 |
| Other revenue | 14,687,063 | 12,515,169 |
| Disproportionate share funding | 22,566,094 | 17,993,289 |
| Total revenues | 465,765,081 | 447,272,441 |
| Expenses: | | |
| Salaries, wages and fringe benefits | 227,559,475 | 217,868,046 |
| Supplies and other | 161,282,151 | 153,527,155 |
| New Hampshire Medicaid enhancement tax | 21,382,132 | 19,968,497 |
| Depreciation and amortization | 15,741,819 | 14,972,724 |
| Interest | 3,913,935 | 3,933,617 |
| Total expenses | 429,879,512 | 410,270,039 |
| Income from operations | 35,885,569 | 37,002,402 |
| Nonoperating gains (losses): | | |
| Investment income, net | 3,875,387 | 5,699,700 |
| Net periodic pension cost, other than service cost | (595,606) | (1,023,371) |
| Contributions without donor restrictions | 834,004 | 629,198 |
| Development costs | (739,596) | (635,408) |
| Other nonoperating loss | (3,153,699) | (511,679) |
| Total nonoperating gains, net | 220,490 | 4,158,440 |
| Excess of revenues and gains over expenses | 36,106,059 | 41,160,842 |
| Unrealized appreciation on investments | 1,026,222 | 2,184,604 |
| Change in fair value of interest rate swap agreement | (482,735) | 302,826 |
| Assets released from restriction used for capital | 434,010 | 128,600 |
| Pension-related changes other than net periodic pension cost | (51,110,160) | 18,843,760 |
| Net assets transferred to affiliates | (46,133,644) | (35,782,824) |
| Change in net assets without donor restrictions | (60,160,248) | 26,837,808 |
| Net assets without donor restrictions at beginning of year | 139,672,561 | 112,834,753 |
| Net assets without donor restrictions at end of year | $ 79,512,313 | $139,672,561 |

See accompanying notes.

## CATHOLIC MEDICAL CENTER

### STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2019 and 2018

| | Net Assets Without Donor Restrictions | Net Assets With Donor Restrictions | Total Net Assets |
|---|---|---|---|
| Balances at September 30, 2017 | $ 112,834,753 | $ 9,726,007 | $122,560,760 |
| Excess of revenues and gains over expenses | 41,160,842 | – | 41,160,842 |
| Restricted investment income | – | 27,373 | 27,373 |
| Changes in interest in perpetual trust | – | 341,439 | 341,439 |
| Donor-restricted contributions | – | 646,924 | 646,924 |
| Unrealized appreciation on investments | 2,184,604 | 61,431 | 2,246,035 |
| Change in fair value of interest rate swap agreement | 302,826 | – | 302,826 |
| Assets released from restriction used for operations | – | (247,756) | (247,756) |
| Assets released from restriction used for capital | 128,600 | (128,600) | – |
| Pension-related changes other than net periodic pension cost | 18,843,760 | – | 18,843,760 |
| Net assets transferred to affiliates | (35,782,824) | – | (35,782,824) |
| | 26,837,808 | 700,811 | 27,538,619 |
| Balances at September 30, 2018 | 139,672,561 | 10,426,818 | 150,099,379 |
| Excess of revenues and gains over expenses | 36,106,059 | – | 36,106,059 |
| Restricted investment income | – | 31,596 | 31,596 |
| Changes in interest in perpetual trust | – | (110,168) | (110,168) |
| Donor-restricted contributions | – | 1,536,316 | 1,536,316 |
| Unrealized appreciation on investments | 1,026,222 | 15,219 | 1,041,441 |
| Change in fair value of interest rate swap agreement | (482,735) | – | (482,735) |
| Assets released from restriction used for operations | – | (220,880) | (220,880) |
| Assets released from restriction used for capital | 434,010 | (434,010) | – |
| Pension-related changes other than net periodic pension cost | (51,110,160) | – | (51,110,160) |
| Net assets transferred to affiliates | (46,133,644) | – | (46,133,644) |
| | (60,160,248) | 818,073 | (59,342,175) |
| Balances at September 30, 2019 | $ 79,512,313 | $11,244,891 | $ 90,757,204 |

See accompanying notes.

## CATHOLIC MEDICAL CENTER

### STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018

| | 2019 | 2018 |
|---|---|---|
| Operating activities: | | |
| Change in net assets | $ (59,342,175) | $ 27,538,619 |
| Adjustments to reconcile change in net assets to net cash provided by operating activities: | | |
| Depreciation and amortization | 15,741,819 | 14,972,724 |
| Pension-related changes other than net periodic pension cost | 51,110,160 | (18,843,760) |
| Net assets transferred to affiliates | 46,133,644 | 35,782,824 |
| Restricted gifts and investment income | (1,567,912) | (674,297) |
| Net realized and unrealized gains on investments | (969,582) | (5,099,360) |
| Change in interest in perpetual trust | 110,168 | (341,439) |
| Change in fair value of interest rate swap agreement | 482,735 | (302,826) |
| Bond discount/premium and issuance cost amortization | (301,980) | (324,032) |
| Changes in operating assets and liabilities: | | |
| Accounts receivable, net | (23,992,503) | (5,692,536) |
| Inventories | (1,017,574) | (176,408) |
| Other current assets | (3,629,815) | 1,660,997 |
| Amounts due to affiliates | (486,205) | 71,377 |
| Other assets | (1,024,839) | (343,421) |
| Accounts payable and accrued expenses | 6,874,483 | (5,518,601) |
| Accrued salaries, wages and related accounts | (151,176) | 1,948,851 |
| Amounts payable to third-party payors | (3,186,637) | 291,782 |
| Accrued pension and other liabilities | (6,018,750) | 6,250,950 |
| Net cash provided by operating activities | 18,763,861 | 51,201,444 |
| Investing activities: | | |
| Purchases of property, plant and equipment | (23,239,963) | (35,831,031) |
| Net change in assets held by trustee under revenue bond agreements | 17,814,698 | 14,819,012 |
| Proceeds from sales of investments | 52,750,600 | 23,284,364 |
| Purchases of investments | (29,781,836) | (31,034,584) |
| Net cash provided (used) by investing activities | 17,543,499 | (28,762,239) |
| Financing activities: | | |
| Payments on long-term debt | (3,455,000) | (3,330,000) |
| Proceeds from long-term debt | 3,513,632 | – |
| Payments on capital leases | (676,199) | (707,299) |
| Bond issuance costs | (95,551) | – |
| Restricted gifts and investment income | 767,912 | 674,297 |
| Net assets transferred to affiliates | (46,133,644) | (35,782,824) |
| Net cash used by financing activities | (46,078,850) | (39,145,826) |
| Decrease in cash and cash equivalents | (9,771,490) | (16,706,621) |
| Cash and cash equivalents at beginning of year | 57,668,500 | 74,375,121 |
| Cash and cash equivalents at end of year | $ 47,897,010 | $ 57,668,500 |

Supplemental disclosure:
At September 30, 2019, amounts totaling $1,251,690 related to the purchase of property, plant and equipment were included in accounts payable and accrued expenses.

See accompanying notes.

## 1. Organization

Catholic Medical Center (the Medical Center) is a voluntary not-for-profit acute care hospital based in Manchester, New Hampshire. The Medical Center, which primarily serves residents of New Hampshire and northern Massachusetts, was controlled by CMC Healthcare System, Inc. (the System), a not-for-profit corporation which functioned as the parent company and sole member of the Medical Center until December 31, 2016, as discussed below.

On December 30, 2016, the System became affiliated with Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, and Monadnock Community Hospital (MCH), a 25-bed critical access hospital in Peterborough, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of HH and MCH and co-member of the Medical Center, along with the System. GraniteOne is governed by a thirteen member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying financial statements for the years ended September 30, 2019 and 2018 do not include the accounts and activity of GraniteOne, HH and MCH.

On September 30, 2019, GraniteOne, the Medical Center, the System, certain subsidiaries of the System, HH and MCH entered into a Combination Agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. Pursuant to the terms of the Agreement, the parties intend to revise D-HH's corporate name to Dartmouth-Hitchcock Health GraniteOne (D-HH GO), which will continue to serve as the sole corporate member of the existing D-HH System Members (Mary Hitchcock Memorial Health and Dartmouth-Hitchcock Clinic, New London Hospital (NLH), Cheshire Medical Center (Cheshire), Mt. Ascutney Hospital and Health Center (MAHHC), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)), and which will be substituted for GraniteOne as the sole corporate member of HH and MCH and as co-member, of the Medical Center and certain subsidiaries of the System (the Combination). The overarching goal of the Combination is to create a New Hampshire-based, integrated and regionally distributed health care delivery system that better serves its patients and communities. While the System will not be a component of the D-HH GO System, it will continue to serve as the corporate vehicle through which the Bishop of the Diocese of Manchester (the Bishop) ensures the Medical Center's adherence to the Ethical and Religious Directives for Catholic Health Care Services. Neither the System nor the Bishop will have authority over any other D-HH GO System Member, including HH and MCH. Subject to certain rights reserved to the Bishop and the System with respect to the Medical Center and the System's subsidiaries, D-HH GO will reserve to itself certain approval and initiation powers over the governance, financial, programmatic, administrative, and strategic decisions of D-HH GO System Members.

## 1. Organization (Continued)

On December 30, 2019, GraniteOne, the Medical Center, HH and MCH submitted a Joint Notice of Change of Control to the New Hampshire Attorney General, Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the Combination. If all necessary approvals are obtained and closing conditions satisfied, D-HH GO will consist of a major academic medical center offering tertiary and quaternary services, an acute care community hospital in an urban setting (the Medical Center), an acute care community hospital in a rural setting (Cheshire), five rural critical access hospitals (NLH, MAHHC, APD, HH and MCH), a post-acute home health and hospice provider (VNH), and nearly 1,800 employed and affiliated primary and specialty care physicians. D-HH GO System Members will combine their resources to offer a broader array of inpatient, outpatient and ambulatory services.

## 2. Significant Accounting Policies

*Basis of Presentation*

The accompanying financial statements have been prepared using the accrual basis of accounting.

*Use of Estimates*

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The primary estimates relate to collectibility of receivables from patients and third-party payors, amounts payable to third-party payors, accrued compensation and benefits, conditional asset retirement obligations, and self-insurance reserves.

*Income Taxes*

The Medical Center is a not-for-profit corporation as described in Section 501(c)(3) of the Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Management evaluated the Medical Center's tax positions and concluded the Medical Center has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to the financial statements.

*Performance Indicator*

Excess of revenues and gains over expenses is comprised of operating revenues and expenses and nonoperating gains and losses. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenue and expenses. Peripheral or incidental transactions are reported as nonoperating gains or losses, which include contributions without donor restrictions, development costs, net investment income (including realized gains and losses on sales of investments), net periodic pension costs (other than service cost), other nonoperating losses and contributions to community agencies.

## 2. Significant Accounting Policies (Continued)

*Charity Care and Community Benefits*

The Medical Center has a formal charity care policy under which patient care is provided to patients who meet certain criteria without charge or at amounts less than its established rates. The Medical Center does not pursue collection of amounts determined to qualify as charity care; therefore, they are not reported as revenues. The Medical Center rendered charity care in accordance with this policy, which, at established charges, amounted to $22,371,381 and $21,393,063 for the years ended September 30, 2019 and 2018, respectively.

Of the Medical Center's $429,879,512 total expenses reported for the year ended September 30, 2019, an estimated $6,900,000 arose from providing services to charity patients. Of the Medical Center's $410,270,039 total expenses reported for the year ended September 30, 2018, an estimated $6,700,000 arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the Medical Center's total expenses divided by gross patient service revenue.

The Medical Center provides community service programs, without charge, such as the Medication Assistance Program, Community Education and Wellness, Patient Transport, and the Parish Nurse Program. The costs of providing these programs amounted to $977,697 and $983,861 for the years ended September 30, 2019 and 2018, respectively.

*Concentration of Credit Risk*

Financial instruments which subject the Medical Center to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Medical Center's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The Medical Center's accounts receivable are primarily due from third-party payors and amounts are presented net of expected contractual allowances and uncollectible amounts. The Medical Center's investment portfolio consists of diversified investments, which are subject to market risk. Investments that exceeded 10% of investments include the SSGA S&P 500 Tobacco Free Fund and the Dreyfus Treasury Securities Cash Management Fund as of September 30, 2019 and 2018.

*Cash and Cash Equivalents*

Cash and cash equivalents include certificates of deposit with maturities of three months or less when purchased and investments in overnight deposits at various banks. Cash and cash equivalents exclude amounts whose use is limited by board designation and amounts held by trustees under revenue bond and other agreements. The Medical Center maintains approximately $44,000,000 and $56,000,000 at September 30, 2019 and 2018, respectively, of its cash and cash equivalent accounts with a single institution. The Medical Center has not experienced any losses associated with deposits at this institution.

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

*Net Patient Service Revenues and Accounts Receivable*

The Medical Center has agreements with third-party payors that provide for payments at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, per diem payments and fee schedules. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the year the related services are rendered and adjusted in future years as final settlements are determined. Changes in these estimates are reflected in the financial statements in the year in which they occur.

The Medical Center recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients, the Medical Center provides a discount approximately equal to that of its largest private insurance payors.

The provision for doubtful accounts is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. The Medical Center records a provision for doubtful accounts in the year services are provided related to self-pay patients, including both uninsured patients and patients with deductible and copayment balances due for which third-party coverage exists for a portion of their balance.

Periodically, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. Accounts receivable are written off after collection efforts have been followed in accordance with internal policies.

*Inventories*

Inventories of supplies are stated at the lower of cost (determined by the first-in, first-out method) or net realizable value.

*Property, Plant and Equipment*

Property, plant and equipment is stated at cost at time of purchase or fair value at the time of donation, less accumulated depreciation. The Medical Center's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. The provisions for depreciation and amortization have been determined using the straight-line method at rates intended to amortize the cost of assets over their estimated useful lives, which range from 2 to 40 years. Assets which have been purchased but not yet placed in service are included in construction in progress and no depreciation expense is recorded.

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

*Conditional Asset Retirement Obligations*

The Medical Center recognizes the fair value of a liability for legal obligations associated with asset retirements in the year in which the obligation is incurred, in accordance with the Accounting Standards for *Accounting for Asset Retirement Obligations* (ASC 410-20). When the liability is initially recorded, the cost of the asset retirement obligation is capitalized by increasing the carrying amount of the related long lived asset. The liability is accreted to its present value each year, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statements of operations.

As of September 30, 2019 and 2018, $958,666 and $1,001,165, respectively, of conditional asset retirement obligations are included within accrued pension and other liabilities in the accompanying balance sheets.

*Goodwill*

The Medical Center reviews its goodwill and other long-lived assets annually to determine whether the carrying amount of such assets is impaired. Upon determination that an impairment has occurred, these assets are reduced to fair value. There were no impairments recorded for the years ended September 30, 2019 or 2018.

*Retirement Benefits*

The Catholic Medical Center Pension Plan (the Plan) provides retirement benefits for certain employees of the Medical Center and certain employees of an affiliated organization who have attained age twenty-one and work at least 1,000 hours per year. The Plan consists of a benefit accrued to July 1, 1985, plus 2% of plan year earnings (to legislative maximums) per year. The Medical Center's funding policy is to contribute amounts to the Plan sufficient to meet minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, plus such additional amounts as may be determined to be appropriate from time to time. The Plan is intended to constitute a plan described in Section 414(k) of the Code, under which benefits derived from employer contributions are based on the separate account balances of participants in addition to the defined benefits under the Plan.

Effective January 1, 2008 the Medical Center decided to close participation in the Plan to new participants. As of January 1, 2008, current participants continued to participate in the Plan while new employees receive a higher matching contribution to the tax-sheltered annuity benefit program discussed below.

During 2011, the Board of Trustees voted to freeze the accrual of benefits under the Plan effective December 31, 2011.

The Plan was amended effective as of May 1, 2016 to provide a limited opportunity for certain terminated vested participants to elect an immediate lump sum or annuity distribution option.

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

The Medical Center also maintains tax-sheltered annuity benefit programs in which it matches one half of employee contributions up to 3% of their annual salary, depending on date of hire, plus an additional 3% - 5% based on tenure. The Medical Center made matching contributions under the program of $6,532,030 and $5,942,550 for the years ended September 30, 2019 and 2018, respectively.

During 2007, the Medical Center created a nonqualified deferred compensation plan covering certain employees under Section 457(b) of the Code. Under the plan, a participant may elect to defer a portion of their compensation to be held until payment in the future to the participant or his or her beneficiary. Consistent with the requirements of the Code, all amounts of deferred compensation, including but not limited to any investments held and all income attributable to such amounts, property, and rights will remain subject to the claims of the Medical Center's creditors, without being restricted to the payment of deferred compensation, until payment is made to the participant or their beneficiary. No contributions were made by the Medical Center for the years ended September 30, 2019 or 2018.

The Medical Center also provides a noncontributory supplemental executive retirement plan covering certain former executives of the Medical Center, as defined. The Medical Center's policy is to accrue costs under this plan using the "Projected Unit Credit Actuarial Cost Method" and to amortize past service costs over a fifteen year period. Benefits under this plan are based on the participant's final average salary, social security benefit, retirement income plan benefit, and total years of service. Certain investments have been designated for payment of benefits under this plan and are included in assets whose use is limited–pension and insurance obligations.

During 2007, the Medical Center created a supplemental executive retirement plan covering certain executives of the Medical Center under Section 457(f) of the Code. The Medical Center recorded compensation expense of $661,215 and $682,820 for the years ended September 30, 2019 and 2018, respectively related to this plan.

*Employee Fringe Benefits*

The Medical Center has an "earned time" plan. Under this plan, each qualifying employee "earns" hours of paid leave for each pay period worked. These hours of paid leave may be used for vacations, holidays, or illness. Hours earned but not used are vested with the employee and are paid to the employee upon termination. The Medical Center expenses the cost of these benefits as they are earned by the employees.

*Debt Issuance Costs/Original Issue Discount or Premium*

The debt issuance costs incurred to obtain financing for the Medical Center's construction and renovation programs and refinancing of prior bonds and the original issue discount or premium are amortized to interest expense using the effective interest method over the repayment period of the bonds. The original issue discount or premium and debt issuance costs are presented as a component of long-term debt.

*Assets Whose Use is Limited or Restricted*

Assets whose use is limited or restricted include assets held by trustees under indenture agreements, pension and insurance obligations, designated assets set aside by the Board of Trustees, over which the Board retains control and may, at its discretion, subsequently use for other purposes, and donor-restricted investments.

## 2. Significant Accounting Policies (Continued)

*Net Assets With Donor Restrictions*

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of the receipt of the promise. When a donor restriction expires (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 statements of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions used for capital purchases (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the Medical Center in perpetuity.

Except for contributions related to capital purchases, donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions within net assets without donor restrictions in the accompanying financial statements.

*Pledges Receivable*

Pledges receivable are recognized as revenue when the unconditional promise to give is made. Pledges expected to be collected within one year are recorded at their net realizable value. Pledges that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The present value of estimated future cash flows is measured utilizing risk-free rates of return adjusted for market and credit risk established at the time a contribution is received.

*Investments and Investment Income*

Investments are carried at fair value in the accompanying balance sheets. See Note 8 for further discussion regarding fair value measurements. Investment income (including realized gains and losses on investments and interest and dividends) is included in the excess of revenues and gains over expenses unless the income is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions. Realized gains or losses on the sale of investment securities are determined by the specific identification method and are recorded on the settlement date. Unrealized gains and losses on investments are excluded from the excess of revenues and gains over expenses unless the investments are classified as trading securities or losses are considered other-than-temporary.

*Derivative Instruments*

Derivatives are recognized as either assets or liabilities in the balance sheets at fair value regardless of the purpose or intent for holding the instrument. Changes in the fair value of derivatives are recognized either in the excess of revenues and gains over expenses or net assets, depending on whether the derivative is speculative or being used to hedge changes in fair value or cash flows. See also Note 6.

## 2. Significant Accounting Policies (Continued)

*Beneficial Interest in Perpetual Trust*

The Medical Center is the beneficiary of trust funds administered by trustees or other third parties. Trusts wherein the Medical Center has the irrevocable right to receive the income earned on the trust assets in perpetuity are recorded as net assets with donor restrictions at the fair value of the trust at the date of receipt. Income distributions from the trusts are reported as investment income that increase net assets without donor restrictions, unless restricted by the donor. Annual changes in the fair value of the trusts are recorded as increases or decreases to net assets with donor restrictions.

*Endowment, Investment and Spending Policies*

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the Medical Center considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

Spending policies may be adopted by the Medical Center, from time to time, to provide a stream of funding for the support of key programs. The spending policies are structured in a manner to ensure that the purchasing power of the assets is maintained while providing the desired level of annual funding to the programs. The Medical Center currently has a policy allowing interest and dividend income earned on investments to be used for operations with the goal of keeping principal, including its appreciation, intact.

The Medical Center's investment policies provide guidance for the prudent and skillful management of invested assets with the objective of preserving capital and maximizing returns. The invested assets include endowment, specific purpose and board designated funds.

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events.

Specific purpose funds are temporary in nature, restricted as to time or purpose as identified by the donor or grantor. These funds have various intermediate/long-term time horizons associated with specific identified spending objectives.

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees.

Management of these assets is designed to maximize total return while preserving the capital values of the funds, protecting the funds from inflation and providing liquidity as needed. The objective is to provide a real rate of return that meets inflation, plus 4% to 5%, over a long-term time horizon.

The Medical Center targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

## 2. Significant Accounting Policies (Continued)

*Federal Grant Revenue and Expenditures*

Revenues and expenses under federal grant programs are recognized as the related expenditure is incurred.

*Malpractice Loss Contingencies*

The Medical Center has a claims-made basis policy for its malpractice insurance coverage. A claims-made basis policy provides specific coverage for claims reported during the policy term. The Medical Center has established a reserve to cover professional liability exposure, which may not be covered by insurance. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the Medical Center. In the event a loss contingency should occur, the Medical Center would give it appropriate recognition in its financial statements in conformity with accounting standards. The Medical Center expects to be able to obtain renewal or other coverage in future years.

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2019 and 2018, the Medical Center recorded a liability of $13,252,269 and $12,520,618, respectively, related to estimated professional liability losses covered under this policy. At September 30, 2019 and 2018, the Medical Center also recorded a receivable of $9,584,019 and $8,829,118, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other liabilities, and intangible assets and other, respectively, on the balance sheets.

*Workers' Compensation*

The Medical Center maintains workers' compensation insurance under a self-insured plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the Medical Center against excessive losses. The Medical Center has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $3,069,898 and $3,061,261 at September 30, 2019 and 2018, respectively, have been discounted at 1.25% and, in management's opinion, provide an adequate reserve for loss contingencies. At September 30, 2019, $1,397,510 and $1,672,388 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying balance sheets. The Medical Center has also recorded $258,107 and $408,034 within other current assets and intangible assets and other, respectively, in the accompanying balance sheets to limit the accrued losses to the retention amount at September 30, 2019. At September 30, 2018, $1,359,646 and $1,701,615 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying balance sheets. The Medical Center has also recorded $248,403 and $408,513 within other current assets and intangible assets and other, respectively, in the accompanying balance sheets to limit the accrued losses to the retention amount at September 30, 2018.

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

*Health Insurance*

The Medical Center has a self-funded health insurance plan. The plan is administered by an insurance company and the Medical Center has employed independent actuaries to estimate unpaid claims, and those claims incurred but not reported at fiscal year end. The Medical Center was insured above a stop-loss amount of $570,000 and $375,000 at September 30, 2019 and 2018, respectively, on individual claims. Estimated unpaid claims, and those claims incurred but not reported, at September 30, 2019 and 2018 of $2,334,000 and $2,849,427, respectively, are reflected in the accompanying balance sheets within accounts payable and accrued expenses.

*Functional Expense Allocation*

The costs of providing program services and other activities have been summarized on a functional basis in Note 11. Accordingly, costs have been allocated among program services and supporting services benefitted.

*Advertising Costs*

The Medical Center expenses advertising costs as incurred, and such costs totaled approximately $1,298,000 and $1,716,000 for the years ended September 30, 2019 and 2018, respectively.

*Recent Accounting Pronouncements*

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the Medical Center for the year ended September 30, 2019. The Medical Center has adjusted the presentation of these financial statements and related disclosures accordingly. ASU 2016-14 has been applied retrospectively to all periods presented. The adoption of ASU 2016-14 had no impact to changes in net assets or total net assets in 2019 or 2018.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the Medical Center expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the Medical Center on October 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The Medical Center is evaluating the impact that ASU 2014-09 will have on its revenue recognition policies, but does not expect the new pronouncement will have a material impact on its financial statements.

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

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). The amendments in ASU 2016-01 address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. ASU 2016-01 is effective for the Medical Center for the year ended September 30, 2020, with early adoption permitted. The Medical Center is currently evaluating the impact that ASU 2016-01 will have on its financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the Medical Center on October 1, 2021, with early adoption permitted. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The Medical Center is currently evaluating the impact of the pending adoption of ASU 2016-02 on the Medical Center's financial statements.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash (a consensus of the FASB Emerging Issues Task Force)* (ASU 2016-18), which provides guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. ASU 2016-18 will be effective for the Medical Center's fiscal year ended September 30, 2020, and early adoption is permitted. ASU 2016-18 must be applied using a retrospective transition method. The Medical Center is currently evaluating the impact of the adoption of this guidance on its financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for the Medical Center on October 1, 2019, with early adoption permitted. The Medical Center is currently evaluating the impact that ASU 2018-08 will have on its financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement* (ASU 2018-13). The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the Medical Center on October 1, 2020, with early adoption permitted. The Medical Center is currently evaluating the impact that ASU 2018-13 will have on its financial statements.

*Subsequent Events*

Management of the Medical Center evaluated events occurring between the end of the Medical Center's fiscal year and February 4, 2020, the date the financial statements were available to be issued.

## 3. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs consisted of the following at September 30, 2019:

| | |
|---|---|
| Cash and cash equivalents | $ 47,897,010 |
| Short-term investments | 4,021,270 |
| Accounts receivable | 78,067,491 |
| | $129,985,771 |

To manage liquidity, the Medical Center maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the Medical Center. In addition, the Medical Center has board-designated assets that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2019, the balance in board-designated assets was approximately $103 million.

## 4. Net Patient Service Revenue

The following summarizes net patient service revenue for the years ended September 30:

| | 2019 | 2018 |
|---|---|---|
| Gross patient service revenue | $1,401,201,814 | $1,309,372,108 |
| Less contractual allowances | (951,717,727) | (873,014,411) |
| Less provision for doubtful accounts | (20,972,163) | (19,593,714) |
| Net patient service revenue | $ 428,511,924 | $ 416,763,983 |

The Medical Center maintains contracts with the Social Security Administration ("Medicare") and the State of New Hampshire Department of Health and Human Services ("Medicaid"). The Medical Center is paid a prospectively determined fixed price for each Medicare and Medicaid inpatient acute care service depending on the type of illness or the patient's diagnosis related group classification. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed price. The Medical Center receives payment for other Medicaid outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports.

Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known. The percentage of net patient service revenues earned from the Medicare and Medicaid programs was 38% and 5%, respectively, for the year ended September 30, 2019 and 39% and 5%, respectively, for the year ended September 30, 2018.

## 4. Net Patient Service Revenue (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Medical Center believes that it is in compliance with all applicable laws and regulations; compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs (Note 15).

The Medical Center also maintains contracts with certain commercial carriers, health maintenance organizations, preferred provider organizations and state and federal agencies. The basis for payment under these agreements includes prospectively determined rates per discharge and per day, discounts from established charges and fee screens. The Medical Center does not currently hold reimbursement contracts which contain financial risk components.

The approximate percentages of patient service revenues, net of contractual allowances and discounts and provision for doubtful accounts from third-party payors and uninsured patients, are as follows for the years ended September 30:

| | Third-Party Payors | Uninsured Patients | Total All Payors |
|---|---|---|---|
| **2019** | | | |
| Net patient service revenues, net of contractual allowance and discounts | 99.5% | 0.5% | 100.0% |
| **2018** | | | |
| Net patient service revenues, net of contractual allowance and discounts | 99.6% | 0.4% | 100.0% |

An estimated breakdown of patient service revenues, net of contractual allowances, discounts and provision for doubtful accounts recognized, is as follows for the years ended September 30 from major payor sources:

| | Gross Patient Service Revenues | Contractual Allowances and Discounts | Provision for Doubtful Accounts | Net Patient Service Revenues Less Provision for Doubtful Accounts |
|---|---|---|---|---|
| **2019** | | | | |
| Private payors (includes coinsurance and deductibles) | $ 507,590,533 | $(255,769,398) | $ (7,335,140) | $ 244,485,995 |
| Medicaid | 147,565,016 | (126,294,392) | (258,587) | 21,012,037 |
| Medicare | 712,776,609 | (548,836,484) | (3,196,353) | 160,743,772 |
| Self-pay | 33,269,656 | (20,817,453) | (10,182,083) | 2,270,120 |
| | $1,401,201,814 | $(951,717,727) | $(20,972,163) | $428,511,924 |

## 4. Net Patient Service Revenue (Continued)

| | Gross Patient Service Revenues | Contractual Allowances and Discounts | Provision for Doubtful Accounts | Net Patient Service Revenues Less Provision for Doubtful Accounts |
|---|---|---|---|---|
| **2018** | | | | |
| Private payors (includes coinsurance and deductibles) | $ 460,815,614 | $(221,115,162) | $ (8,909,152) | $ 230,791,300 |
| Medicaid | 134,155,231 | (111,760,430) | (579,838) | 21,814,963 |
| Medicare | 684,086,037 | (518,673,771) | (2,876,172) | 162,536,094 |
| Self-pay | 30,315,226 | (21,465,048) | (7,228,552) | 1,621,626 |
| | $1,309,372,108 | $(873,014,411) | $(19,593,714) | $416,763,983 |

The Medical Center recognizes changes in accounting estimates for net patient service revenues and third-party payor settlements as new events occur or as additional information is obtained. For the year ended September 30, 2019, there were no significant adjustments recorded for changes to prior year estimates. For the year ended September 30, 2018, favorable adjustments recorded for changes to prior year estimates were approximately $1,000,000.

*Medicaid Enhancement Tax and Disproportionate Share Payment*

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of the Medical Center's net patient service revenues, with certain exclusions. The amount of tax incurred by the Medical Center for the years ended September 30, 2019 and 2018 was $21,382,132 and $19,968,497, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded in operating revenues and amounted to $22,566,094 and $17,993,289 for the years ended September 30, 2019 and 2018, respectively, net of reserves referenced below.

The Centers for Medicare and Medicaid Services (CMS) has completed audits of the State's program and the disproportionate share payments made by the State from 2011 through 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The Medical Center has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions. During 2019, the Medical Center reduced the recorded reserves by approximately $4,300,000.

## 5. Property, Plant and Equipment

The major categories of property, plant and equipment are as follows at September 30:

| | Useful Lives | 2019 | 2018 |
|---|---|---|---|
| Land and land improvements | 2-40 years | $ 1,472,137 | $ 855,991 |
| Buildings and improvements | 2-40 years | 106,435,085 | 97,791,941 |
| Fixed equipment | 3-25 years | 45,218,504 | 44,759,299 |
| Movable equipment | 3-25 years | 153,057,048 | 137,026,708 |
| Construction in progress | | 8,002,406 | 9,259,588 |
| | | 314,185,180 | 289,693,527 |
| Less accumulated depreciation and amortization | | (195,495,104) | (179,795,294) |
| Net property, plant and equipment | | $ 118,690,076 | $ 109,898,233 |

Depreciation expense amounted to $15,699,810 and $14,928,402 for the years ended September 30, 2019 and 2018, respectively.

The cost of equipment under capital leases was $7,844,527 at September 30, 2019 and 2018. Accumulated amortization of the leased equipment at September 30, 2019 and 2018 was $7,691,462 and $7,059,231, respectively. Amortization of assets under capital leases is included in depreciation and amortization expense.

## 6. Long-Term Debt and Note Payable

Long-term debt consists of the following at September 30:

| | 2019 | 2018 |
|---|---|---|
| New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds: | | |
| Series 2012 Bonds with interest ranging from 4.00% to 5.00% per year and principal payable in annual installments ranging from $1,125,000 to $2,755,000 through July 2032 | $ 19,800,000 | $ 22,450,000 |
| Series 2015A Bonds with interest at a fixed rate of 2.27% per year and principal payable in annual installments ranging from $185,000 to $1,655,000 through July 2040 | 21,650,000 | 22,255,000 |
| Series 2015B with variable interest subject to interest rate swap described below and principal payable in annual installments ranging from $195,000 to $665,000 through July 2036 | 8,060,000 | 8,260,000 |
| Series 2017 Bonds with interest ranging from 3.38% to 5.00% per year and principal payable in annual installments ranging from $2,900,000 to $7,545,000 beginning in July 2033 through July 2044 | 61,115,000 | 61,115,000 |
| | 110,625,000 | 114,080,000 |

## 6. Long-Term Debt and Note Payable (Continued)

| | 2019 | 2018 |
|---|---|---|
| Construction loan – see below | $ 3,513,632 | $ – |
| Capitalized lease obligations | 344,079 | 1,020,278 |
| Unamortized original issue premiums/discounts | 5,057,437 | 5,450,325 |
| Unamortized debt issuance costs | (1,194,718) | (1,190,075) |
| | 118,345,430 | 119,360,528 |
| Less current portion | (3,924,079) | (4,131,199) |
| | $114,421,351 | $115,229,329 |

*The Authority Revenue Bonds*

In December 2012, the Medical Center, in connection with the Authority, issued $35,275,000 of tax-exempt fixed rate revenue bonds (Series 2012). Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. The proceeds of the Series 2012 bond issue were used to advance refund the remaining 2002A Bonds, advance refund certain 2002B Bonds, pay off a short term CAN note and fund certain capital purchases.

On September 3, 2015, the Authority issued $32,720,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2015, consisting of the $24,070,000 aggregate principal amount Series 2015A Bonds and the $8,650,000 aggregate principal amount Series 2015B Bonds sold via direct placement to a financial institution. Although the Series 2015B Bonds were issued, they were not drawn on until July 1, 2016, as discussed below. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Series 2015A Bonds were issued to provide funds for the purpose of (i) advance refunding a portion of the outstanding 2006 Bonds in an amount of $20,655,000 to the first call date of July 1, 2016, (ii) funding certain construction projects and equipment purchases in an amount of approximately $3,824,000, and (iii) paying the costs of issuance related to the Series 2015 Bonds.

The Series 2015B Bonds were structured as drawdown bonds. On July 1, 2016, the full amount available under the Series 2015B Bonds totaling $8,650,000 was drawn upon and the proceeds in combination with cash contributed by the Medical Center totaling $555,000 were used to currently refund the remaining balance of the Series 2006 Bonds totaling $9,205,000.

## 6. Long-Term Debt and Note Payable (Continued)

On September 1, 2017, the Authority issued $61,115,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2017. The Series 2017 Bonds were issued to fund various construction projects and equipment purchases, as well as pay certain costs of issuance related to the Series 2017 Bonds. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Medical Center has an agreement with the Authority, which provides for the establishment of various funds, the use of which is generally restricted to the payment of debt, as well as a construction fund related to the Series 2017 Bonds. These funds are administered by a trustee, and income earned on certain of these funds is similarly restricted.

*Construction Loan*

On July 1, 2019, the Medical Center established a nonrevolving line of credit up to $10,000,000 with a bank in order to fund the expansion of the Medical Center as discussed in Note 15. The line of credit bears interest at the LIBOR lending rate plus 0.75% (2.84% at September 30, 2019). Advances from the line of credit are available through July 1, 2021, at which time the then outstanding line of credit balance will automatically convert to a term loan. Upon conversion, the Medical Center shall make monthly payments of principal and interest, assuming a 30-year level monthly principal and interest payment schedule, with a final maturity of July 1, 2029. The bank shall compute the schedule of principal payments based on the interest rate applicable on the conversion date. Payments of interest only are due on a monthly basis until the conversion date. The Medical Center has pledged gross receipts as collateral and is also required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. As of September 30, 2019, the Medical Center has drawn $3,513,632 on this line of credit.

The aggregate principal payments due on the revenue bonds, capital lease obligations and other debt obligations for each of the five years ending September 30 and thereafter are as follows:

| | |
|---|---|
| 2020 | $ 3,924,079 |
| 2021 | 2,416,886 |
| 2022 | 2,545,704 |
| 2023 | 2,767,881 |
| 2024 | 2,860,120 |
| Thereafter | 99,968,041 |
| | $114,482,711 |

Interest paid by the Medical Center totaled $4,390,413 (including capitalized interest of $158,155) for the year ended September 30, 2019 and totaled $3,926,297 (including capitalized interest of $251,490) for the year ended September 30, 2018.

## 6. Long-Term Debt and Note Payable (Continued)

The fair value of the Medical Center's long-term debt is estimated using discounted cash flow analysis, based on the Medical Center's current incremental borrowing rate for similar types of borrowing arrangements. The fair value of the Medical Center's long-term debt, excluding capitalized lease obligations, was approximately $120,300,000 and $114,080,000 at September 30, 2019 and 2018, respectively.

On March 27, 2018, the MOB LLC (a subsidiary of Alliance Enterprises, Inc., which is a subsidiary of the System) refinanced an existing note payable to a term loan totaling $8,130,000. Interest is fixed at 3.71% and is payable monthly. Principal payments of $19,500 are due in monthly installments beginning May 1, 2018, continuing until March 27, 2028, at which time the remaining unpaid principal and interest shall be due in full. Under the terms of the loan agreement, the Medical Center and MOB LLC (the Obligated Group) has granted the bank a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center and the System also guarantee the note payable. The Obligated Group is required to maintain a minimum debt service coverage ratio of 1.20. The Obligated Group was in compliance with this covenant as of September 30, 2019.

*Derivatives*

The Medical Center uses derivative financial instruments principally to manage interest rate risk. In January 2016, the Medical Center entered into an interest rate swap agreement with an initial notional amount of $8,650,000 in connection with its Series 2015B Bond issuance. The swap agreement hedges the Medical Center's interest exposure by effectively converting interest payments from variable rates to a fixed rate. The swap agreement is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. Under this agreement, the Medical Center pays a fixed rate equal to 1.482%, and receives a variable rate of 69.75% of the one-month LIBOR rate (1.46% at September 30, 2019). Payments under the swap agreement began August 1, 2016 and the agreement will terminate August 1, 2025.

The fair value of the Medical Center's interest rate swap agreement amounted to a liability of $220,010 as of September 30, 2019, which amount has been recorded within accrued pension and other liabilities in the accompanying 2019 balance sheet. The fair value of the Medical Center's interest rate swap agreement amounted to an asset of $262,725 as of September 30, 2018, which amount has been recorded within intangible assets and other in the accompanying 2018 balance sheet. The (decrease) increase in the fair value of this derivative of $(482,735) and $302,826, respectively, has been included within the statements of changes in net assets as a change in net assets without donor restrictions for the years ended September 30, 2019 and 2018.

## 7. Operating Leases

The Medical Center has various noncancelable agreements to lease various pieces of medical equipment. The Medical Center also has noncancelable leases for office space and its physician practices. Certain real estate leases are with related parties. Total rent expense paid to related parties for the years ended September 30, 2019 and 2018 was $2,470,557 and $2,396,723, respectively. Rental expense under all leases for the years ended September 30, 2019 and 2018 was $5,459,713 and $5,371,336, respectively.

Estimated future minimum lease payments under noncancelable operating leases are as follows:

| | |
|---|---|
| 2020 | $ 4,341,378 |
| 2021 | 4,392,246 |
| 2022 | 4,452,544 |
| 2023 | 2,447,919 |
| 2024 | 2,428,338 |
| Thereafter | 4,534,987 |
| | $22,597,412 |

## 8. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited are comprised of the following at September 30:

| | 2019 | | 2018 | |
|---|---|---|---|---|
| | Fair Value | Cost | Fair Value | Cost |
| Cash and cash equivalents | $ 16,779,157 | $ 16,779,157 | $ 16,330,473 | $ 16,330,473 |
| U.S. federal treasury obligations | 19,045,894 | 19,043,708 | 36,950,913 | 36,957,748 |
| Marketable equity securities | 39,052,447 | 35,856,117 | 38,360,061 | 34,394,784 |
| Fixed income securities | 36,384,136 | 36,288,215 | 55,768,356 | 56,864,630 |
| Private investment funds | 51,796,283 | 21,653,351 | 55,530,346 | 25,886,418 |
| Pledges receivable | 758,184 | 758,184 | – | – |
| | $163,816,101 | $130,378,732 | $202,940,149 | $170,434,053 |

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. In determining fair value, the use of various valuation approaches, including market, income and cost approaches, is permitted.

A fair value hierarchy has been established based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entity's own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The standard describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

## 8. Investments and Assets Whose Use is Limited (Continued)

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Medical Center for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

Level 1 — Observable inputs such as quoted prices in active markets;

Level 2 — Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and

Level 3 — Unobservable inputs in which there is little or no market data.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques).

In determining the appropriate levels, the Medical Center performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2019 and 2018.

The following is a description of the valuation methodologies used:

*U.S. Federal Treasury Obligations and Fixed Income Securities*

The fair value is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The Medical Center holds fixed income mutual funds and exchange traded funds, governmental and federal agency debt instruments, municipal bonds, corporate bonds, and foreign bonds which are primarily classified as Level 1 within the fair value hierarchy.

*Marketable Equity Securities*

Marketable equity securities are valued based on stated market prices and at the net asset value of shares held by the Medical Center at year end, which generally results in classification as Level 1 within the fair value hierarchy.

## 8. Investments and Assets Whose Use is Limited (Continued)

*Private Investment Funds*

The Medical Center invests in private investment funds that consist primarily of limited partnership interests in investment funds, which, in turn, invest in diversified portfolios predominantly comprised of equity and fixed income securities, as well as options, futures contracts, and some other less liquid investments. Management has approved procedures pursuant to the methods in which the Medical Center values these investments, which ordinarily will be the amount equal to the pro-rata interest in the net assets of the limited partnership, as such value is supplied by, or on behalf of, each investment manager from time to time, usually monthly and/or quarterly.

Medical Center management is responsible for the fair value measurements of investments reported in the financial statements. Such amounts are generally determined using audited financial statements of the funds and/or recently settled transactions. Because of inherent uncertainty of valuation of certain private investment funds, the estimate of the fund manager or general partner may differ from actual values, and differences could be significant. Management believes that reported fair values of its private investment funds at the balance sheet dates are reasonable.

*Fair Value on a Recurring Basis*

The following table presents information about the Medical Center's assets and liabilities measured at fair value on a recurring basis based upon the lowest level of significant input to the valuations at September 30.

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| **2019** | | | | |
| Assets | | | | |
| Cash and cash equivalents | $ 16,779,157 | $ – | $ – | $ 16,779,157 |
| U.S. federal treasury obligations | 19,045,894 | – | – | 19,045,894 |
| Marketable equity securities | 39,052,447 | – | – | 39,052,447 |
| Fixed income securities | 36,384,136 | – | – | 36,384,136 |
| Pledges receivable | – | – | 758,184 | 758,184 |
| | $111,261,634 | $ – | $758,184 | 112,019,818 |
| Investments measured at net asset value: | | | | |
| Private investment funds | | | | 51,796,283 |
| Total assets at fair value | | | | $163,816,101 |
| Liabilities | | | | |
| Interest rate swap agreement | $ – | $ – | $220,010 | $ 220,010 |

8. **Investments and Assets Whose Use is Limited (Continued)**

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| **2018** | | | | |
| Assets | | | | |
| Cash and cash equivalents | $ 16,330,473 | $ – | $ – | $ 16,330,473 |
| U.S. federal treasury obligations | 36,950,913 | – | – | 36,950,913 |
| Marketable equity securities | 38,360,061 | – | – | 38,360,061 |
| Fixed income securities | 55,768,356 | – | – | 55,768,356 |
| Interest rate swap agreement | – | – | 262,725 | 262,725 |
| | $147,409,803 | $ – | $262,725 | 147,672,528 |
| Investments measured at net asset value: | | | | |
| Private investment funds | | | | 55,530,346 |
| Total assets at fair value | | | | $203,202,874 |

The following table presents the assets (liabilities) carried at fair value as of September 30, 2019 and 2018 that are classified within Level 3 of the fair value hierarchy.

| | Pledges Receivable |
|---|---|
| Balance at September 30, 2018 | $ – |
| Net activity | 758,184 |
| Balance at September 30, 2019 | $ 758,184 |

| | Interest Rate Swap Agreement |
|---|---|
| Balance at September 30, 2017 | $ (40,101) |
| Unrealized gains | 302,826 |
| Balance at September 30, 2018 | 262,725 |
| Unrealized losses | (482,735) |
| Balance at September 30, 2019 | $(220,010) |

There were no significant transfers between Levels 1, 2 or 3 for the years ended September 30, 2019 or 2018.

## 8. Investments and Assets Whose Use is Limited (Continued)

*Net Asset Value Per Share*

The following table discloses the fair value and redemption frequency of those assets whose fair value is estimated using the net asset value per share practical expedient at September 30:

| Category | Fair Value | Unfunded Commitments | Redemption Frequency | Notice Period |
|---|---|---|---|---|
| **2019** | | | | |
| Private investment funds | $48,155,175 | $ – | Daily/monthly | 2-30 day notice |
| Private investment funds | 3,641,108 | – | Quarterly | 30 day notice |
| **2018** | | | | |
| Private investment funds | $52,108,790 | $ – | Daily/monthly | 2-30 day notice |
| Private investment funds | 3,421,556 | – | Quarterly | 30 day notice |

*Investment Strategies*

U.S. Federal Treasury Obligations and Fixed Income Securities

The primary purpose of these investments is to provide a highly predictable and dependable source of income, preserve capital, reduce the volatility of the total portfolio, and hedge against the risk of deflation or protracted economic contraction.

Marketable Equity Securities

The primary purpose of equity investments is to provide appreciation of principal and growth of income with the recognition that this requires the assumption of greater market volatility and risk of loss. The total equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics, including style and capitalization. The Medical Center may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

Private Investment Funds

The primary purpose of private investment funds is to provide further portfolio diversification and to reduce overall portfolio volatility by investing in strategies that are less correlated with traditional equity and fixed income investments. Private investment funds may provide access to strategies otherwise not accessible through traditional equities and fixed income such as derivative instruments, real estate, distressed debt and private equity and debt.

## 8. Investments and Assets Whose Use is Limited (Continued)

*Fair Value of Other Financial Instruments*

Other financial instruments consist of accounts receivable, accounts payable and accrued expenses, amounts payable to third-party payors and long-term debt. The fair value of all financial instruments other than long-term debt approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value. See Note 6 for disclosure of the fair value of long-term debt.

## 9. Retirement Benefits

As previously discussed in Note 2, the Plan provides retirement benefits for certain employees of an affiliated organization. The disclosure below provides information for the Plan as a whole. A reconciliation of the changes in the Catholic Medical Center Pension Plan and the Medical Center's Supplemental Executive Retirement Plan projected benefit obligations and the fair value of assets for the years ended September 30, 2019 and 2018, and a statement of funded status of the plans for both years is as follows:

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Changes in benefit obligations: | | | | |
| Projected benefit obligations at beginning of year | $(270,114,507) | $(284,200,778) | $(4,140,755) | $(4,567,286) |
| Service cost | (1,500,000) | (1,500,000) | – | – |
| Interest cost | (11,301,910) | (10,628,197) | (154,744) | (140,414) |
| Benefits paid | 7,935,050 | 7,117,759 | 408,853 | 411,692 |
| Actuarial (loss) gain | (48,841,695) | 17,666,264 | (174,264) | 155,253 |
| Expenses paid | 1,468,125 | 1,430,445 | – | – |
| Projected benefit obligations at end of year | (322,354,937) | (270,114,507) | (4,060,910) | (4,140,755) |
| Changes in plan assets: | | | | |
| Fair value of plan assets at beginning of year | 185,414,590 | 181,485,201 | – | – |
| Actual return on plan assets | 5,194,931 | 12,074,468 | – | – |
| Employer contributions | 8,141,191 | 403,125 | 408,853 | 411,692 |
| Benefits paid | (7,935,050) | (7,117,759) | (408,853) | (411,692) |
| Expenses paid | (1,468,125) | (1,430,445) | – | – |
| Fair value of plan assets at end of year | 189,347,537 | 185,414,590 | – | – |
| Funded status of plan at September 30 | $(133,007,400) | $ (84,699,917) | $(4,060,910) | $(4,140,755) |

## 9. Retirement Benefits (Continued)

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Amounts recognized in the balance sheets consist of: | | | | |
| Current liability | $ – | $ – | $ (391,100) | $ (398,750) |
| Noncurrent liability | (133,007,400) | (84,699,917) | (3,669,810) | (3,742,005) |
| | $(133,007,400) | $ (84,699,917) | $(4,060,910) | $ (4,140,755) |

The net loss for the defined benefit pension plans that will be amortized from net assets without donor restrictions into net periodic benefit cost over the next fiscal year is $4,607,147.

The current portion of accrued pension costs included in the above amounts for the Medical Center amounted to $391,100 and $398,750 at September 30, 2019 and 2018, respectively, and has been included in accounts payable and accrued expenses in the accompanying balance sheets.

The amounts recognized in net assets without donor restrictions for the years ended September 30 consist of:

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Amounts recognized in the balance sheets – total plan: | | | | |
| Net assets without donor restrictions: | | | | |
| Net loss | $(160,478,700) | $(105,860,712) | $(2,141,585) | $ (2,102,034) |
| | $(160,478,700) | $(105,860,712) | $(2,141,585) | $ (2,102,034) |

Net periodic pension cost includes the following components for the years ended September 30:

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Service cost | $ 1,500,000 | $ 1,500,000 | $ – | $ – |
| Interest cost | 11,301,910 | 10,628,197 | 154,744 | 140,414 |
| Expected return on plan assets | (13,738,629) | (13,110,637) | – | – |
| Amortization of actuarial loss | 2,767,405 | 3,275,000 | 134,713 | 147,466 |
| Net periodic pension cost | $ 1,830,686 | $ 2,292,560 | $289,457 | $ 287,880 |

## 9. Retirement Benefits (Continued)

Other changes in plan assets and benefit obligations recognized in net assets without donor restrictions for the years ended September 30 consist of:

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Net loss (gain) | $57,388,232 | $(16,630,095) | $ 174,264 | $ (155,253) |
| Amortization of actuarial loss | (2,767,405) | (3,275,000) | (134,713) | (147,466) |
| Net amount recognized | $54,620,827 | $(19,905,095) | $ 39,551 | $ (302,719) |

The investments of the plans are comprised of the following at September 30:

| | Target Allocation | | Catholic Medical Center Pension Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Cash and cash equivalents | 5.0% | 0.0% | 3.5% | 1.1% |
| Equity securities | 65.0 | 70.0 | 68.5 | 66.2 |
| Fixed income securities | 20.0 | 20.0 | 24.6 | 23.7 |
| Other | 10.0 | 10.0 | 3.4 | 9.0 |
| | 100.0% | 100.0% | 100.0% | 100.0% |

The assumption for the long-term rate of return on plan assets has been determined by reflecting expectations regarding future rates of return for the investment portfolio, with consideration given to the distribution of investments by asset class and historical rates of return for each individual asset class.

The weighted-average assumptions used to determine the defined benefit pension plan obligations at September 30 are as follows:

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Discount rate | 3.12% | 4.23% | 2.70% | 3.93% |
| Rate of compensation increase | N/A | N/A | N/A | N/A |

## 9. Retirement Benefits (Continued)

The weighted-average assumptions used to determine the defined benefit pension plan net periodic benefit costs for the years ended September 30 are as follows:

| | Catholic Medical Center Pension Plan | | Pre-1987 Supplemental Executive Retirement Plan | |
|---|---|---|---|---|
| | 2019 | 2018 | 2019 | 2018 |
| Discount rate | 4.23% | 3.79% | 3.93% | 3.22% |
| Rate of compensation increase | N/A | N/A | N/A | N/A |
| Expected long-term return on plan assets | 7.30% | 7.30% | N/A | N/A |

The Medical Center expects to make employer contributions totaling $6,500,000 to the Catholic Medical Center Pension Plan for the fiscal year ending September 30, 2020. Expected employer contributions to the Pre-1987 Supplemental Executive Retirement Plan for the fiscal year ending September 30, 2020 are not expected to be significant.

The benefits, which reflect expected future service, as appropriate, expected to be paid for the years ending September 30 are as follows:

| | Catholic Medical Center Pension Plan | Pre-1987 Supplemental Executive Retirement Plan |
|---|---|---|
| 2020 | $ 9,243,136 | $ 396,345 |
| 2021 | 9,993,328 | 381,634 |
| 2022 | 10,827,746 | 366,382 |
| 2023 | 11,705,953 | 350,590 |
| 2024 | 12,473,696 | 334,272 |
| 2025 - 2029 | 72,831,683 | 1,409,626 |

The Medical Center contributed $8,141,191 and $408,853 to the Catholic Medical Center Pension Plan and the Pre-1987 Supplemental Executive Retirement Plan, respectively, for the year ended September 30, 2019. The Medical Center contributed $403,125 and $411,692 to the Catholic Medical Center Pension Plan and the Pre-1987 Supplemental Executive Retirement Plan, respectively, for the year ended September 30, 2018. The Medical Center plans to make any necessary contributions during the upcoming fiscal 2020 year to ensure the plans continue to be adequately funded given the current market conditions.

## 9. Retirement Benefits (Continued)

The following fair value hierarchy table presents information about the financial assets of the above plans measured at fair value on a recurring basis based upon the lowest level of significant input valuation as of September 30:

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| **2019** | | | | |
| Cash and cash equivalents | $ 6,533,857 | $ – | $ – | $ 6,533,857 |
| Marketable equity securities | 48,189,852 | – | – | 48,189,852 |
| Fixed income securities | 46,506,391 | – | – | 46,506,391 |
| | $101,230,100 | $ – | $ – | 101,230,100 |
| Investments measured at net asset value: | | | | |
| Private investment funds | | | | 88,117,437 |
| Total assets at fair value | | | | $189,347,537 |
| **2018** | | | | |
| Cash and cash equivalents | $ 2,135,972 | $ – | $ – | $ 2,135,972 |
| Marketable equity securities | 38,773,946 | – | – | 38,773,946 |
| Fixed income securities | 43,989,255 | – | – | 43,989,255 |
| | $ 84,899,173 | $ – | $ – | 84,899,173 |
| Investments measured at net asset value: | | | | |
| Private investment funds | | | | 100,515,417 |
| Total assets at fair value | | | | $185,414,590 |

## 10. Related Party Transactions

During 2019 and 2018, the Medical Center made and received transfers of net assets (to) from affiliated organizations as follows:

| | 2019 | 2018 |
|---|---|---|
| Alliance Health Services | $ (5,650,000) | $ (4,130,000) |
| Physician Practice Associates | (42,163,000) | (31,967,000) |
| Alliance Ambulatory Service | 2,500,000 | 1,650,000 |
| Alliance Resources | (700,000) | (1,092,878) |
| NH Medical Laboratory | (120,167) | (42,936) |
| Saint Peter's Home | (477) | (10) |
| MOB LLC | – | (200,000) |
| | $(46,133,644) | $(35,782,824) |

## 10. Related Party Transactions (Continued)

The Medical Center entered into various other transactions with the aforementioned related organizations. The net effect of these transactions was an amount due to affiliates of $991,062 and $1,477,267 at September 30, 2019 and 2018, respectively. See Note 7 for related party leasing activity.

The Medical Center has engaged in various transactions with GraniteOne, HH and MCH. The Medical Center recognized approximately $3.3 million and $3.4 million in revenue from these related parties for the years ended September 30, 2019 and 2018, respectively, which is reflected within other revenues in the accompanying statements of operations. The Medical Center also incurred expenses to these related parties of approximately $2.5 million and $399,000 for the years ended September 30, 2019 and 2018, respectively, of which $800,000 and $399,000, respectively, is reflected within operating expenses. Additionally, approximately $1.7 million as of September 30, 2019, is reflected within nonoperating gains (losses) in the accompanying statement of operations for the year ended September 30, 2019. As of September 30, 2019, the Medical Center had a net amount due from these related parties of approximately $2.6 million, of which $4.4 million is reflected within other current assets and $1.8 million is reflected within accounts payable and accrued expenses in the accompanying 2019 balance sheet. As of September 30, 2018, the Medical Center has a net amount due from these related parties of approximately $507,000, which is reflected within other current assets in the accompanying 2018 balance sheet.

## 11. Functional Expenses

The Medical Center provides general health care services to residents within its geographic location including inpatient, outpatient and emergency care. Expenses related to providing these services are as follows at September 30, 2019:

| | Healthcare Services | General and Administrative | Total |
|---|---|---|---|
| Salaries, wages and fringe benefits | $188,050,439 | $39,509,036 | $227,559,475 |
| Supplies and other | 129,874,004 | 31,408,147 | 161,282,151 |
| New Hampshire Medicaid enhancement tax | 21,382,132 | – | 21,382,132 |
| Depreciation and amortization | 10,590,236 | 5,151,583 | 15,741,819 |
| Interest | 3,178,047 | 735,888 | 3,913,935 |
| | $353,074,858 | $76,804,654 | $429,879,512 |

For the year ended September 30, 2018, the Medical Center provided $332,542,503 in health services expenses and $77,727,536 in general and administrative expenses.

The financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits are allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

## 12. Concentration of Credit Risk

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors is as follows at September 30:

| | 2019 | 2018 |
|---|---|---|
| Medicare | 45% | 44% |
| Medicaid | 12 | 13 |
| Commercial insurance and other | 25 | 23 |
| Patients (self pay) | 5 | 8 |
| Anthem Blue Cross | 13 | 12 |
| | 100% | 100% |

## 13. Endowments and Net Assets With Donor Restrictions

*Endowments*

In July 2008, the State of New Hampshire enacted a version of UPMIFA (the Act). The new law, which had an effective date of July 1, 2008, eliminates the historical dollar threshold and establishes prudent spending guidelines that consider both the duration and preservation of the fund. As a result of this enactment, subject to the donor's intent as expressed in a gift agreement or similar document, a New Hampshire charitable organization may now spend the principal and income of an endowment fund, even from an underwater fund, after considering the factors listed in the Act.

Endowment net assets consist of the following at September 30:

| | Without Donor Restrictions | With Donor Restrictions | Total |
|---|---|---|---|
| **2019** | | | |
| Board-designated endowment funds | $102,949,965 | $ – | $102,949,965 |
| Donor-restricted endowment funds: | | | |
| Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor | – | 7,342,731 | 7,342,731 |
| Accumulated investment gains | – | 2,902,160 | 2,902,160 |
| Total endowment net assets | $102,949,965 | $10,244,891 | $113,194,856 |

## 13. Endowments and Net Assets With Donor Restrictions (Continued)

| | Without Donor Restrictions | With Donor Restrictions | Total |
|---|---|---|---|
| **2018** | | | |
| Board-designated endowment funds | $ 99,976,116 | $ – | $ 99,976,116 |
| Donor-restricted endowment funds: | | | |
| Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor | – | 7,342,731 | 7,342,731 |
| Accumulated investment gains | – | 3,084,087 | 3,084,087 |
| Total endowment net assets | $ 99,976,116 | $10,426,818 | $110,402,934 |

Changes in endowment net assets consisted of the following for the years ended September 30:

| | Without Donor Restrictions | With Donor Restrictions | Total |
|---|---|---|---|
| Balance at September 30, 2017 | $ 94,579,515 | $ 9,726,007 | $104,305,522 |
| Investment return, net | 5,268,001 | 430,243 | 5,698,244 |
| Contributions | – | 646,924 | 646,924 |
| Appropriation for operations | – | (247,756) | (247,756) |
| Appropriation for capital | 128,600 | (128,600) | – |
| Balance at September 30, 2018 | 99,976,116 | 10,426,818 | 110,402,934 |
| Investment return, net | 2,539,839 | (63,353) | 2,476,486 |
| Contributions | – | 536,316 | 536,316 |
| Appropriation for operations | – | (220,880) | (220,880) |
| Appropriation for capital | 434,010 | (434,010) | – |
| Balance at September 30, 2019 | $102,949,965 | $10,244,891 | $113,194,856 |

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 Medical Center to retain as a fund of perpetual duration. There were no such deficiencies as of September 30, 2019 or 2018.

## 13. Endowments and Net Assets With Donor Restrictions (Continued)

*Net Assets With Donor Restrictions*

Net assets with donor restrictions are available for the following purposes at September 30:

| | 2019 | 2018 |
|---|---|---|
| Funds subject to use or time restrictions: | | |
| Capital acquisitions | $ 258,494 | $ 37,941 |
| Health education | 909,765 | 899,288 |
| Indigent care | 168,437 | 253,492 |
| Pledges receivable | 758,184 | – |
| | 2,094,880 | 1,190,721 |
| Funds of perpetual duration | 9,150,011 | 9,236,097 |
| | $11,244,891 | $10,426,818 |

## 14. Investments in Joint Venture

The Medical Center, along with four other participating hospitals and Tufts Health Plan, formed Tufts Health Freedom Plan (THFP), a joint venture. THFP is a health insurance company which began operations as of January 1, 2016. The Medical Center has an approximate 12% ownership interest in this joint venture. Selected financial information relating to this joint venture for the years ended September 30, 2019 and 2018 is not shown as such amounts are not significant to the financial statements.

## 15. Commitments and Contingencies

*Litigation*

Various legal claims, generally incidental to the conduct of normal business, are pending or have been threatened against the Medical Center. The Medical Center intends to defend vigorously against these claims. While ultimate liability, if any, arising from any such claim is presently indeterminable, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the financial condition of the Medical Center.

*Regulatory*

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Government activity continues with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Compliance with such laws and regulations are subject to government review and interpretations as well as regulatory actions unknown or unasserted at this time.

## 15. Commitments and Contingencies (Continued)

*Development Agreement*

During fiscal year 2019, the Medical Center entered into a development agreement with PJC Manchester Realty, LLC ("Rite Aid") in regards to the Medical Center's acquisition of certain property owned by Rite Aid. Under the development agreement, the Medical Center acquired the property from Rite Aid for approximately $6.9 million, inclusive of certain costs expected to be incurred to construct a new building that Rite Aid will own and occupy at a separate location. The purchase of the property from Rite Aid allows the Medical Center to expand its campus. As the Medical Center retains title to the project until such time of the second closing, as defined within the development agreement, amounts paid under the development agreement are recorded by the Medical Center as land acquisition costs, and totaled approximately $4.6 million as of September 30, 2019.

The Medical Center has outstanding construction commitments related to this project totaling approximately $8.1 million at September 30, 2019.

Catholic Medical Center Board of Trustees 2020

John G. Cronin, Esq., Chair
REDACTED
REDACTED
REDACTED
REDACTED

Neil Levesque, Vice Chair
REDACTED
REDACTED
REDACTED
REDACTED

Matthew Kfoury, Secretary
REDACTED
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REDACTED
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Pamela Diamantis, Treasurer
REDACTED
REDACTED
REDACTED
REDACTED

Joseph Pepe, MD., President and CEO
REDACTED
REDACTED
REDACTED
REDACTED

Robert A. Catania, MD
REDACTED
REDACTED
REDACTED
REDACTED

Carolyn Claussen, MD., President of Medical Staff
REDACTED
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Louis I. Fink, MD
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REDACTED
REDACTED
REDACTED

Susan M. Kinney, MD
REDACTED
REDACTED
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REDACTED

John J. Munoz, MD
REDACTED
REDACTED
REDACTED
REDACTED

Catherine Provencher
REDACTED
REDACTED
REDACTED
REDACTED

Derek McDonald, Bishop's Delegate for Health Care
REDACTED
REDACTED
REDACTED
REDACTED

Timothy Riley
REDACTED
REDACTED
REDACTED
REDACTED

Marie McKay
REDACTED
REDACTED
REDACTED
REDACTED

# TIMOTHY M. SOUCY, MPH

## SUMMARY OF QUALIFICATIONS

- 28-Year Manchester Health Department Employee, 12-Years as Public Health Director
- Recognized Public Health Leader in the City of Manchester and State of New Hampshire
- Experienced in Managing Employees, Budgets and Community Collaborations
- Lifelong Manchester, New Hampshire Resident

## EDUCATION

| | | |
|---|---|---|
| ▪ Master of Public Health Degree<br>Boston, Massachusetts | May 1998 | Boston University School of Public Health<br>Concentration: Environmental Health |
| ▪ Bachelor of Science Degree<br>Burlington, Vermont | May 1989 | University of Vermont<br>Major: Biology |

## PROFESSIONAL EXPERIENCE

**9/18 – Present: Executive Director Community Health & Mission, Catholic Medical Center**

Catholic Medical Center (CMC) is a nonprofit 330-bed acute-care hospital and regional health system based in Manchester, New Hampshire. The Executive Director of Community Health & Mission is responsible assessing, evaluating and prioritizing community needs and identifying CMC's role in meeting these needs. In addition, the Executive Director manages the delivery of CMC's Community Health Services including Healthcare for the Homeless, Poisson Dental Facility, Medication Assistance Program, Breast and Cervical Cancer Screening Program, Veteran's Care Coordination, 1115 Waiver - Integrated Delivery Network, and the Office of Catholic Identity. The Executive Director rotates as the Administrator on Call for the hospital, serves on multiple hospital committees and acts as a liaison between the hospital and the Community.

**12/06 – 8/18: Public Health Director, City of Manchester**

The Public Health Director serves as the Chief Administrative Officer for the Manchester Health Department providing administrative oversight to all operations and activities including exclusive personnel responsibility, supervisory authority and budgetary authority. The Public Health Director oversees the routine assessment of the health of the community and recommends appropriate policies, ordinances and programs to improve the health of the community. The Public Health Director oversees investigations, communicable disease control, environmental inspections and investigations necessary to protect the public health and is also responsible for the provision of school health services in Manchester. The Public Health Director serves as the CEO of the Manchester Health Care for the Homeless Program (330-h) and has overseen the AmeriCorps VISTA Program and Weed & Seed Strategy.

**11/02 – 12/06: Public Health Preparedness Administrator, City of Manchester**

In addition to carrying out all of the functions as the Chief of Environmental Health, the Public Health Preparedness Administrator planned, directed and supervised all activities to assure local readiness, interagency collaboration, and preparedness for bioterrorism, outbreaks of infectious disease, and other

public health emergencies. The Public Health Preparedness Administrator routinely participated in City Emergency Operations Center activations, sheltering operations and hospital preparedness activities.

**08/94 – 11/02: Chief, Division of Environmental Health, City of Manchester**

The Chief of Environmental Health planned, directed and supervised all environmental health activities carried out within the City. Evaluated and recommended public health standards, ordinances and legislation. Advised governmental leaders, community representatives, and the general public on environmental health issues. Planned and conducted professional public health training programs. Coordinated epidemiological investigations for specific disease outbreaks. Supervised division staff and evaluated personnel performance.

**02/90 - 08/94: Environmental Health Specialist / Sanitarian, City of Manchester**

The Environmental Health Specialist / Sanitarian performed duties related to a comprehensive environmental health program, including, but not limited to inspection of food service facilities, investigation of foodborne illnesses, inspection of institutional facilities, swimming pool inspections, indoor air quality investigations, inspections of septic systems, investigation of public health nuisances, and investigation of childhood lead poisoning cases.

## HONORS, RECOGNITIONS, APPOINTMENTS AND PRESENTATIONS

- Timothy M. Soucy Day in the City of Manchester, August 31, 2018
- Fellow, Kresge Foundation, Emerging Leader in Public Health, 2017-2018
- Robert Wood Johnson Foundation, Culture of Health Prize Award – City of Manchester, 2016
- Appointee, Network4Health Steering Committee, 2016 –Present
- Appointee, Governor's Advisory Board, State Innovation Model, 2015 –2017
- Graduate, Leadership Greater Manchester, Greater Manchester Chamber of Commerce, 2016
- Friend of Public Health Award, New Hampshire Public Health Association, 2015
- Presenter, NACCHO Survive and Thrive Leadership Graduation, 2013
- Appointee, New Hampshire Health Exchange Advisory Board, 2012 - 2016
- Poster Session, NACCHO Annual Conference, 2010
- Presenter, NALBOH Annual Conference, 2009
- Presented with Key to the City, Honorable Mayor Frank C. Guinta, 2009
- Vice-Chair, Survive & Thrive Workgroup, NACCHO, 2009 – 2013
- Fellow, Survive & Thrive, National Association of County & City Health Officials, 2008 – 2009
- Guest Lecturer, University of New Hampshire, MPH Program, Law School and Undergraduate Programs, 2006- Present
- Associate, Leadership New Hampshire, Class of 2005
- 40 Under Forty, The Union Leader & Business and Industry Association of NH, Class of 2004
- Appointee, Legislative Study Committee for Public Health and the Environment, 2000-2003
- Inductee, Delta Omega Honor Society, Boston University School of Public Health 1998

# TIMOTHY M. SOUCY, MPH

## COMMUNITY and VOLUNTEER ACTIVITIES

- New Hampshire Charitable Foundation, Manchester Regional Advisory Board , 2019 – Present
- City of Manchester Homeless Task Force, 2019
- Decade Knight, West High School Blue Knight Foundation, 2016 – Present
- Member, Manchester Historic Association, 2016 – Present
- Member, Board of Directors, Families in Transition, Housing Benefits, Inc., 2010 – 2019
- Leadership Greater Manchester Steering Committee, Greater Manchester Chamber of Commerce, 2008 – Present
- Member, 100 Club of New Hampshire, 2008- Present
- Volunteer, Dance Visions Network, 2007 - Present
- Health Department Campaign Coordinator & Leadership Donor, Granite United Way, 2008 – 18
- Member, Greater Manchester Mental Health Center CEO Search Committee, 2015
- Member, Manchester Community Health Center CEO Search Committee, 2013
- Member, Management Team, Manchester Homeless Day Center, 2012 - 2015
- Member, Board of Directors, Mental Health Center of Greater Manchester, 2008 – 2015 (Board Chair 2012-2014)
- Member, Seniors Count Collaborating Council, Easter Seals of New Hampshire, 2006 - 2014
- Member, Board of Directors, New Horizons for New Hampshire, 2004 – 2010 (Board President 2007-2009)
- Coach, Parker Varney Girls Basketball Team, 2004-2005
- Assistant Coach, Rising Stars Recreation Soccer League, 2002
- Assistant Coach, Manchester Angels Recreation Soccer League, 2001-2003
- Member, Advisory Council, Endowment for Health, Inc. 2000-2003
- Assistant Coach, Manchester West Junior Soccer League, 2000-2003
- Assistant Coach, Manchester West Junior Deb Softball League, 2000
- Member, Allocations Committee, United Way of Greater Manchester, 1998-2003

## CITY OF MANCHESTER ACTIVITIES

- Acting Director, City of Manchester Welfare Department, 2018
- Co-Chair, Mayor's Opioid Task Force, 2018
- Mentor, City of Manchester Leadership Academy, 2016 - 2018
- Appointee, City of Manchester 911 Ambulance Review Committee, 2013 - 2018
- Appointee, City of Manchester Enterprise Resource Planning Committee, 2012 – 2018
- Appointee, City of Manchester Labor / Management Committee, 2011 – 2018
- Appointee, City of Manchester Local Emergency Planning Committee, 2011 – 2018
- Appointee, City of Manchester Refugee and Immigrant Integration Task Force, 2010 - 2018
- Appointee, City of Manchester 10-Year Plan to End Homelessness, 2010 - 2018
- Appointee, City of Manchester Quality Council, 2008 – 2018
- Appointee, City of Manchester AFSCME Sick Leave Bank, 2006 - 2018

# TIMOTHY M. SOUCY, MPH

## CATHOLIC MEDICAL CENTER ACTIVITIES

- CMC Expansion, Emergency Department Workgroup, 2020 - Present
- Millworks Condominium Association Board Member, 2019 – Present
- Human Trafficking Committee, 2019 - Present
- Behavioral Health Clinical Learning Collaborative, 2019 – Present
- CMC / DH Behavioral Health Integration Committee, 2019 – Present
- CMC Board of Directors, Ethics & Mission Committee, 2018 – Present
- Environment of Care Committee, 2018 – Present
- Cancer Committee, 2018 – Present
- Emergency Management Committee, 2018- Present
- Substance Use Disorder Strategy Group, 2018 – Present
- Wilson Street Condominium Association Board Member, 2018 – Present
- Lung Cancer Steering Committee, 2018 – Present
- POLST Advisory Committee, 2018 – Present
- Preventative Food Pantry Advisory Committee, 2018 – Present
- Ethics Consultative Committee, 2018- Present
- Gift of Heart Campaign 2018 - Present
- Holiday Turkey Distribution 2018 - Present

## CONTINUING EDUCATION

- National League of Cities - Mayor's Institute on Opioids, Boston, MA 2018
- CMC's Annual Summit on the Treatment of Opioid-dependent Patients and Pain, 2017 - 2019
- 500 Cities: Local Data for Better Health, CDC Foundation, RWJ Foundation, 2016
- Culture of Health Prize Award Learning Event, Robert Wood Johnson Foundation, 2016
- Government Leaders Development Program, Tuck Executive Education at Dartmouth, 2016
- Roadmaps to Health Action Awards Convening, Robert Wood Johnson Foundation, 2016
- New Hampshire Department of Environmental Services, Educational Seminars, 2010 - 2016
- Avoid, Deny, Defend Training, City of Manchester Police Department, 2016
- Culture and Cultural Effectiveness, Southern New Hampshire AHEC, 2015
- American Public Health Association Annual Meeting, Boston, MA, 2013
- Reasonable Suspicion Supervisory Training, City of Manchester Human Resources, 2010
- ICS 300, MGT 313, Incident Management/Unified Command, Texas A&M, 2008
- MGT -100 WMD Incident Management/Unified Command Concept, Texas A&M, 2008
- ICS 100, ICS 200, US Department of Homeland Security, 2008
- Bi-State Primary Care Association, Primary Care Conference, 2007
- Public Health Preparedness Summit, National Association of City & County Health Officials, 2006
- National Incident Management Systems (NIMS), US Department of Homeland Security, 2005
- Healthcare Leadership & Administrative Decision-Making in Response to Weapons of Mass Destruction (WMD) Incidents, US Federal Emergency Management Agency, 2004
- Forensic Epidemiology, US Department of Justice & US Centers for Disease Control, 2003
- BioDefense Mobilization Conference, University of Washington, School of Public Health, 2002

# TIMOTHY M. SOUCY, MPH

- Emergency Response to Domestic Biological Incidents, US Department of Justice & LSU, 2001
- Financial Skills for Non-Financial Managers, University of New Hampshire, 2001
- National Environmental Health Association Annual Education Conference, NEHA, 2000
- Management Perspectives for Public Health Practitioners, US Centers for Disease Control, 2000
- Investigating Foodborne Illnesses, US Food & Drug Administration, 1999
- Environmental Health Risks to Children, US Environmental Protection Agency, 1998
- Food Microbiological Control, US Food & Drug Administration, 1998
- Computer Assisted Modeling for Emergency Operations, Harvard School of Public Health, 1997
- Local Radon Coordinators Network Training, NACCHO, 1996
- Introduction to Indoor Air Quality, US EPA & Harvard University, 1995
- Hazard Analysis & Critical Control Point (HACCP), US Food & Drug Administration, 1995
- Safety Measurement, Bloodborne Pathogens, Confined Space Entry, UNH, 1994
- Environmental Health Sciences, US Centers for Disease Control & Prevention, 1992
- Field Description of Soils, University of New Hampshire, 1992
- Kentucky Lead Training Workshop, Jefferson County Health Department, 1991
- Foodborne Disease Control, US Centers for Disease Control & Prevention, 1991
- Lead Paint Inspectors Course, PCG PRO-Tech Services, Massachusetts, 1990

# CHRISTINE WEBER

[redacted]

Process Analysis
Compliance
Program Development

Operational Oversight
Cross-Functional Team Lead
Public Speaking

**Education:** AS, Human Services, New Hampshire Technical Institute 2008
BA, Psychology, University of New Hampshire 2013
MS, Management, in progress with Granite State College 2020

**Technologies:** Office, Electronic Medical Records

## WORK EXPERIENCE

**Consultant** Dec 2019- Present

- Strategy and operational process development
- Contract review and implementation
- Delivering results in healthcare business

**Farnum Center, Manchester and Franklin NH**

VP of Operations, formerly Program Director 2014- Oct 2019

- Oversee project management tied to strategic plan. Includes growth and revenue exceeding targets month over month, budget >16 million.
- Established metrics for project cycles and program benchmarks.
- Successful management of organization accreditations and licenses related to health and safety, administration, and quality care measures.
- Personnel development; rapid departmental growth and cross-functional team management.
- Established subject matter expertise in the implementation of insurance contract deliverables.
- Drove employee satisfaction and retention rates.
- Executed strategies to ensure financial margins that met or exceeded expectations. Pivoted operations which increased revenue that consistently exceeded projections.

Practice Manager 2013 - 2014

- Developed behavioral health billing department expertise for the first time within the agency.
- Created policy and procedure, training 50 staff to gain competence in interfacing with insurance carriers with successful outcomes for clientele.
- Mentor individuals within the organization and in their professional development pursuits

Clinician and Program Coordinator 2008 - 2013

- Facilitated a broad scope of individual and group counseling sessions and lecture.
- Caseload averaged 70 cases of adults with primary concern of substance abuse disorders.
- Client evaluations, including evaluations for the New Hampshire court system. Strong understanding of diagnostics and able to use various severity indexes/ assessment tools.
- Regular usage of electronic medical records.

**R.E.A.P Program, Manchester NH**

Program Facilitator 2005-2008

- Conduct and interpret risk testing and recidivism factors.
- Teach and evaluate understanding of class participants.
- Administrative functions

**CONTRACTOR NAME**

Key Personnel

| | | | | |
|---|---|---|---|---|
| Name | Job Title | Salary | % Paid from this Contract | Amount Paid from this Contract |
| Timothy Soucy | Executive Director-Community Health & Mission | 149,000 | 0 | 0 |
| Christine Weber | Director of HUB Services | 90,000 | 100 | 90,000 |
| | | | | |
| | | | | |
| | | | | |

Subject: Access and Delivery Hub for Opioid Use Disorder Services (SS-2019-BDAS-05-ACCES-10)

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<br>NH Department of Health and Human Services | | 1.2 State Agency Address<br>129 Pleasant Street<br>Concord, NH 03301-3857 | |
| 1.3 Contractor Name<br>Southern New Hampshire Health System, Inc. | | 1.4 Contractor Address<br>8 Prospect Street<br>PO Box 2014<br>Nashua, NH 03060 | |
| 1.5 Contractor Phone Number<br>603.281.9809 | 1.6 Account Number<br>05-095-092-920510-70400000-102-500731 | 1.7 Completion Date<br>9/29/2020 | 1.8 Price Limitation<br>$1,570,988 |
| 1.9 Contracting Officer for State Agency<br>Nathan D. White, Director | | 1.10 State Agency Telephone Number<br>603-271-9631 | |
| 1.11 Contractor Signature<br>Date: 3/2/2020 | | 1.12 Name and Title of Contractor Signatory<br>Paul L. Tramor, CFO | |
| 1.13 State Agency Signature<br>Date: 3/2/20 | | 1.14 Name and Title of State Agency Signatory<br>Katja S. Fox, Director | |
| 1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*<br>By: | | Director, On: | |
| 1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)*<br>By: J.D. Laralle | | On: 3/2/2020 | |
| 1.17 Approval by the Governor and Executive Council *(if applicable)*<br>G&C Item number: | | G&C Meeting Date: | |



Contractor Initials PLT
Date 3/2/2020

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

**3. EFFECTIVE DATE/COMPLETION OF SERVICES.**

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

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

**4. CONDITIONAL NATURE OF AGREEMENT.**

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

**5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.**

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

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

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

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

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

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

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

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

**7. PERSONNEL.**

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

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

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



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**8. EVENT OF DEFAULT/REMEDIES.**

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

8.1.1 failure to perform the Services satisfactorily or on schedule;

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

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

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

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

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

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

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

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

**9. TERMINATION.**

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

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

**10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.**

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

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

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

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

**12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.**

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

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

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



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

**14. INSURANCE.**

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

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

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

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

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

**15. WORKERS' COMPENSATION.**

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

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

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

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

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

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

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

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

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

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

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



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## REVISIONS TO STANDARD CONTRACT PROVISIONS

### Section 1 – Revisions to Form P-37, General Provisions

1. 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 year(s) from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

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

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

Scope of Services

## 1. Provisions Applicable to All Services

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

1.2. The Contractor agrees that, to the extent future 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.

1.3. All Exhibits D through K are attached hereto and incorporated by reference herein.

## 2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder treatment and recovery support service access.

2.2. The Contractor shall provide individuals in the Greater Nashua Region with access to referrals to substance use disorder treatment and recovery support services and other health and social services.

2.3. The Contractor shall participate in technical assistance, guidance, and oversight activities directed by the Department for implementation of Doorway services.

2.4. The Contractor shall have the Doorway operational no later than 60 calendar days from the contract effective date.

2.5. The Contractor shall work with the Department's current Doorway Contractor for the region identified in Section 2.2 above and the Department to transfer operations as soon as possible, but no later than the operational date identified in Section 2.4 above.

2.6. For the transfer of operations, the Contractor shall:

2.6.1. Cooperate fully, during the transfer period in Section 2.5, with the Department and Department's current Doorway Contractor in the transition of services including, but not limited to, assisting with obtaining authorization and appropriate consent from clients and transferring treatment records as authorized and/or required by law.

2.6.2. Work directly with the Department's current Doorway Contractor to ensure no lapse in services occur.

2.6.3. Use the Department's current Doorway Contractor as a resource to ensure an adequate transition of services.

2.6.4. Provide a transition plan to the Department within fifteen (15) business days of the contract effective date that includes but is not limited to:

2.6.4.1. Identify the present and future needs of clients currently receiving services under the Department's current Doorway Contractor and establishes a process to meet those needs.

2.6.4.2. Providing ongoing communication and revisions of the Transition Plan to the Department as requested.

2.6.4.3. Providing a process for uninterrupted delivery of services, which shall include warm hand off of the clients from the current Doorway to this Contractor

2.6.4.4. Establishing a method of notifying clients and other affected individuals about the transition and provide the Department with a copy of the communications to notify the clients.

2.6.4.5. Receiving from the current Department's Doorway Contractor undistributed naloxone kits under the guidance of the Department.

2.7. The Contractor shall collaborate with the Department to assess the Contractor's level of readiness, capacity and resource needs required to provide and expand Doorway services in-house to include, but not be limited to:

2.7.1. Medication assisted treatment induction at emergency rooms, in collaboration with community partners, and facilitated coordination with ongoing Doorway care coordination inclusive of the core principles of the Medication First Model.

2.7.2. Outpatient and inpatient substance use disorder services, in accordance with ASAM.

2.7.3. Coordinating overnight placement for Doorway clients engaged in Doorway services, outside of regular Doorway operating hours identified in Section 3.1.1 and 3.1.2.1, in need of a safe location while awaiting treatment placement the following business day.

2.7.4. Expanding populations for Doorway core services.

2.8. The Contractor shall collaborate with the Department to identify gaps in financial and staffing resources required in Section 5 Staffing below, throughout the contract period.

2.9. The Contractor shall ensure formalized coordination with 2-1-1 NH and the Department's after hours Doorway Contractor This coordination shall include:

2.9.1. Establishing an MOU with 2-1-1 NH which defines the workflows to coordinate 2-1-1 NH calls and Doorway activities including the following workflow:

2.9.1.1. Individuals seeking substance use disorder treatment services will call 2-1-1 NH;

2.9.1.2. If an individual is seeking information only, 2-1-1 NH staff will provide that information;

2.9.1.3. If an individual is in an SUD related crisis and wants to speak with a licensed counselor and/or is seeking assistance with accessing treatment services outside of regular Doorway operating hours identified in Section 3.1.1 and 3.1.2.1, 2-1-1 NH staff will transfer the caller to the Departments' after hours Contractor for on-call services

2.9.2. The Contractor shall establish an MOU with the Department's after hours Contractor for after hour services which shall include but not limited to:

2.9.2.1. A process for ensuring that the client's preferred Doorway receives information on the outcomes and events of the call for continued follow-up

2.9.2.2. A process for obtaining appropriate consent forms in order to enable the sharing of information about each client, in accordance with all applicable state and federal requirements.

2.9.3. The MOU with 2-1-1 NH shall include a process for bi-directional information sharing of updated referral resource databases to ensure that each entity has recently updated referral information.

2.10. The Contractor shall establish formalized agreements for coordination of services and case management services provided by Integrated Delivery Networks (IDNs) to reduce duplication of services and leverage existing integrated care projects in their region.

2.11. The Contractor, with the assistance of the Department, shall establish formalized agreements with:

2.11.1. Medicaid Managed Care Organizations to coordinate case management efforts on behalf of the client.

2.11.2. Private insurance carriers to coordinate case management efforts on behalf of the client.

2.12. The Contractor shall be required to create policies for obtaining patient consent to disclose protected health information as required by state administrative rules and

federal and state laws for agreements reached with Managed Care Organizations and private insurance carriers as outlined in Section 2.11.

2.13. The Contractor shall develop a Department approved conflict of interest policy related to Doorway services and self-referrals to Doorway organization substance use disorder treatment and recovery support service programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.14. The Contractor shall participate in community collaboration that includes but is not limited to attending:

2.14.1. Monthly Community of Practice Meetings

2.14.2. Monthly meetings led by the Department and attended by the other Department's Doorway Contractors

2.14.3. Community and regional-based partner meetings that address substance use, mental health and housing matters.

2.15. The Contractor shall convene regional community partner meetings to provide information regarding the Doorway services. The Contractor shall:

2.15.1. Ensure partners include, but are not limited to:

2.15.1.1. City leaders.
2.15.1.2. Providers.
2.15.1.3. Other stakeholders affected by SUD.

2.15.2. Ensure meeting agendas include, but are not limited to:

2.15.2.1. Receiving input on successes, challenges and ways within which to improve transitions and process flows.

2.15.3. Provide meeting minutes to partners and the Department no later than 10 days following each community partner meetings.

**3. Scope of Work for Doorway Activities**

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one location, at a minimum:

3.1.1. Operating hours of 8 am to 5 pm Monday through Friday for thirty (30) days from the operational date in Section 2.4 above.

3.1.2. Operating hours of 8 am to 5 pm Monday through Sunday, after the thirty (30) days in Section 3.1.1 above.

3.1.2.1. Operating hours of 8 am to 11 pm Monday through Friday, and 8 am to 5 pm Saturday and Sunday, after the thirty (30) days in Section 3.1.2 above.

3.1.3. A physical location for clients to receive face-to-face services.

3.1.3.1. The Contractor shall submit a request for Department approval to move to another physical location, at least thirty (30) days prior to the move.

3.1.4. Telephonic services for calls referred to the Doorway by 2-1-1 NH.

3.1.5. Initial intake and screening to assess an individual's potential need for Doorway services.

3.1.6. Crisis intervention and stabilization that ensures any individual in an acute OUD related crisis who requires immediate, non-emergency intervention receives crisis intervention counseling services by a licensed clinician. If the individual is calling rather than physically presenting at the Doorway, this includes, but is not limited to:

3.1.6.1. Directing callers to 911 if a client is in imminent danger or there is an emergency.

3.1.6.2. If the client is unable or unwilling to call 911, the Doorway shall contact emergency or mobile crisis services.

3.1.7. Clinical evaluation including:

3.1.7.1. Evaluation of all American Society of Addiction Medicine Criteria (ASAM, October 2013), domains.

3.1.7.2. A level of care recommendation based on ASAM Criteria (October 2013).

3.1.7.3. Identification of client strengths and resources that can be used to support treatment and recovery.

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Section 3.1.7. The service plan shall include, but not be limited to:

3.1.8.1. Determination of an initial ASAM level of care.

3.1.8.2. Identification of any needs the client may have relative to supportive services including, but not limited to:

3.1.8.2.1. Physical health needs

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Need for peer recovery support services.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Needs regarding criminal justice that includes Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. Plan for addressing all areas of need identified in Section 3.1.8.2 by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. When the level of care identified in Section 3.1.7. is not available to the client within 48 hours of service plan development, the service plan shall include plans for referrals to external providers to offer interim services, which are defined as:

3.1.8.4.1. At least one sixty (60) minute individual or group outpatient session per week and/or;

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs.

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be the licensed clinician, CRSW outlined in the Staffing section, or other non-clinical support staff, capable of aiding specialty populations in accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and/or service members.
3.1.9.2. Pregnant, postpartum, and parenting women.
3.1.9.3. DCYF involved families.
3.1.9.4. Individuals at-risk of or with HIV/AIDS.
3.1.9.5. Adolescents.

3.1.10. Facilitated referrals to substance use disorder treatment and recovery support and other health and social services which shall include, but not be limited to:

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Section 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

3.1.10.5. Assisting clients with meeting the financial requirements for accessing services including, but not limited to:

3.1.10.5.1. Identifying sources of financial assistance for accessing services and supports, and;

3.1.10.5.2. Providing assistance in accessing such financial assistance including, but not limited to:

3.1.10.5.2.1. Assisting the client with making contact with the assistance agency, as appropriate.

3.1.10.5.2.2. Contacting the assistance agency on behalf of the client, as appropriate.

3.1.10.5.2.3. Supporting the client in meeting the admission, entrance, and intake requirements of the assistance agency.

3.1.10.5.3. When no other payer is available, assisting clients with accessing services by maintaining a flexible needs fund specific to the Doorway region that supports clients who meet the eligibility criteria for assistance under the NH DHHS SOR Flexible Needs Fund Policy with their financial needs including, but not limited to:

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations as identified and recommended by Doorway professional staff to assist the eligible client with recovery;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments as

identified and recommended by Doorway professional staff to assist the eligible client with recovery;

3.1.10.5.3.3. Payment of short-term housing costs or other costs necessary to remove financial barriers to obtaining or retaining safe housing, such as payment of security deposits or unpaid utility bills;

3.1.10.5.3.4. Provision of light snacks not to exceed $3.00 per eligible client;

3.1.10.5.3.5. Provision of phone minutes or a basic prepaid phone to permit the eligible client to contact treatment providers and recovery services, and to permit contact with the eligible client for continuous recovery support;

3.1.10.5.3.6. Provision of clothing appropriate for cold weather, job interviews, or work; and

3.1.10.5.3.7. Other uses preapproved in writing by the Department.

3.1.10.5.4. Providing a Respite Shelter Voucher program to assist individuals in need of respite shelter while awaiting treatment and recovery services. The Contractor shall:

3.1.10.5.4.1. Collaborate with the Department on a respite shelter voucher policy and related procedures to determine eligibility for respite shelter vouchers based on criteria that include but are not limited to confirming an individual is:

3.1.10.5.4.1.1. A Doorway client;

3.1.10.5.4.1.2. In need of respite shelter while awaiting treatment and recovery services; and

3.1.10.5.4.1.3. In need of obtaining financial assistance to access short-term, temporary shelter.

3.1.11. Continuous case management services which include, but are not limited to:

3.1.11.1. Ongoing assessment of the clinical evaluation in Section 3.1.7 above for individuals until they are receiving the level of care services and supports identified as appropriate for them. The level of care services needed may be revised based on how the individual responds while receiving interim services and supports.

3.1.11.2. Ongoing assessment in collaboration or consultation with the client's external service provider(s) of necessary support services to address needs identified in the evaluation or by the client's service provider that may create barriers to the client entering and/or maintaining treatment and/or recovery.

3.1.11.3. Supporting clients in meeting the admission, entrance, and intake requirements of the provider agency.

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service provider(s) until such time that the discharge Government Performance and Results Act (GPRA) interview in Section 3.1.11.7.3 is completed including, but not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until such time that the discharge GPRA interview in Section 3.1.11.7.3 has been completed, according to the following guidelines:

3.1.11.4.1.1. Attempt the first contact by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available.

3.1.11.4.1.2. If the attempt in Section 3.1.11.4.1.1 is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Section 3.1.11.4.1.2 is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.5. When the follow-up in Section 3.1.11.4 results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

3.1.11.6. When possible, client contact and outreach shall be conducted in coordination and consultation with the client's external service provider to ensure continuous communication and collaboration between the Doorway and service provider.

3.1.11.6.1. Each successful contact shall include, but not be limited to:

3.1.11.6.1.1. Inquiry on the status of each client's recovery and experience with their external service provider.

3.1.11.6.1.2. Identification of client needs.

3.1.11.6.1.3. Assisting the client with addressing needs, as identified in Section 3.1.11.6.1.2.

3.1.11.6.1.4. Providing early intervention to clients who have relapsed or whose recovery is at risk.

3.1.11.7. Collecting and documenting attempts to collect client-level data at multiple intervals including, but not limited to ensuring the GPRA Interview tool is completed and entered into the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Performance Accountability and Reporting System (SPARS), at a minimum:

3.1.11.7.1. At intake or within three (3) calendar days following initial client contact.

3.1.11.7.2. Six (6) months post intake into Doorway services.

3.1.11.7.3. Upon discharge from the initially referred service.

3.1.11.7.3.1. If the client is discharged from services before the time intervals in Section 3.1.11.7.2 or Section 3.1.11.7.3 the Doorway must make every reasonable effort to conduct a follow-up GPRA for that client.

3.1.11.7.3.2. If a client is re-admitted into services after discharge or being lost to care, the Doorway is not required to re-administer the intake GPRA but must complete a follow-up GPRA for the time interval in Section 3.1.11.7.2 or 3.1.11.7.3 closest to the intake GPRA.

3.1.11.8. Documenting any loss of contact in the SPARS system using the appropriate process and protocols as defined by SAMHSA through technical assistance provided under the State Opioid Response grant.

3.1.11.9. Ensuring that contingency management strategies are utilized to increase client engagement in follow-up GPRA interviews, which may include, but are not limited to gift cards provided to clients for follow-up participation at each follow-up interview, which shall not exceed thirty dollars ($30) in value.

3.1.11.9.1. Payments to incentivize participation in treatment are not allowable.

3.1.11.10. Assistance to individuals who are unable to secure financial resources, in enrolling in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare, and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.11. Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the NH DHHS Naloxone Distribution Policy regarding the use of naloxone.

3.2. The Contractor shall obtain treatment consent forms from all clients served, either in-person or through electronic means, to ensure compliance with all applicable state and federal confidentiality laws.

3.3. The Contractor shall provide services for both day and overnight shifts in accordance with:

3.3.1. The twelve (12) Core Functions of the Alcohol and Other Drug Counselor.

3.3.2. The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice

3.3.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium

3.3.4. TIP 27: Comprehensive Case Management for Substance Abuse Treatment

3.4. The Contractor shall utilize recent and inform any future developments of a comprehensive needs assessment of their region. The needs assessment shall be coordinated with existing regional partners including, but not limited to:

3.4.1. Regional Public Health Networks.

3.4.2. Integrated Delivery Networks.

3.4.3. Continuum of Care Facilitators.

3.5. The Contractor shall inform the inclusion of regional goals into the future development of needs assessments in Section 3.4 that the Contractor and its partners in the region have over the contract period including, but not limited to reductions in:

3.5.1. Naloxone use.

3.5.2. Emergency Room use.

3.5.3. Overdose related fatalities.

3.6. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers.

3.7. The Contractor shall provide information to all individuals seeking services on how to file a grievance in the event of dissatisfaction with services provided. The Contractor shall ensure each individual seeking services receives information on:

3.7.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.7.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.8. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date that includes but not limited to:

3.8.1. Policies such as, but not be limited to client consent forms, conflict of interest, consent and privacy, financial assistance, shelter vouchers, referrals and evaluation form other providers, complaints, and grievances.

3.8.2. Formalized agreements such as, but not be limited to relationship with 2-1-1 NH and after hours on-call clinical services.

3.8.3. Formalized agreements with Integrated Delivery Networks (IDNs), Medicaid Managed Care Organizations (MCOs), and private insurers within sixty (60) business days of the contract effective date. The Contractor may submit for an extension beyond the sixty (60) days upon approval of the Department.

**4. Subcontracting for the Doorways**

4.1. The Doorway shall submit all subcontracts they propose to enter into for services provided through this contract to the Department for approval prior to execution.

4.2. The Doorway may subcontract with prior approval of the Department for support and assistance in providing core Doorway services; except that such core services shall not be subcontracted providers whose principal operations are to serve individuals with a specific diagnosis of substance use disorders.

4.2.1. Core Doorway services are defined, for purposes of this contract, as screening, assessment, evaluation, referral, continuous case management, GPRA data completion, and naloxone distribution.

4.2.2. The Doorway shall at all times be responsible for continuous oversight of, and compliance with, all Core Doorway services and shall be the single point of contact with the Department for those Core services.

4.2.3. Any subcontract for support and assistance in providing Core Doorway services shall ensure that the patient experience is consistent across the continuum of Core Doorway services and that the subcontracted entities and personnel are at all times acting, in name and in fact, as agents of the Doorway. The Doorway shall consolidate Core Doorway services, to the greatest extent practicable, in a single location.

**5. Staffing**

5.1. The Contractor shall meet the following minimum staffing requirements:

5.1.1. Between and hours and days of the week identified in Sections 3.1.1 and 3.1.2.1 above as follows:

5.1.1.1. A minimum of one (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically;

5.1.1.2. A minimum of one (1) Recovery support worker (CRSW) with the ability to fulfill recovery support and care coordination functions;

5.1.1.3. A minimum of one (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Section 3.1.9.

5.1.2. Sufficient staffing levels that are appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making such change to the staffing.

5.1.3. All unlicensed staff providing treatment, education and/or recovery support services shall be under the direct supervision of a licensed supervisor.

5.1.4. No licensed supervisor shall supervise more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.1.5. Peer clinical supervision is provided for all clinicians including, but not limited to:

5.1.5.1. Weekly discussion of cases with suggestions for resources or alternative approaches.

5.1.5.2. Group supervision to help optimize the learning experience, when enough candidates are under supervision.

5.2. The Contractor must meet the training requirements for staff which include, but are not limited to:

5.2.1. For all clinical staff:

5.2.1.1. Suicide prevention and early warning signs.

5.2.1.2. The 12 Core Functions of the Alcohol and Other Drug Counselor.

5.2.1.3. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics.

5.2.1.4. An approved course on the twelve (12) core functions and The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within twelve (12) months of hire.

5.2.1.5. A Department approved ethics course within twelve (12) months of hire.

5.2.2. For recovery support staff and other non-clinical staff working directly with clients:

5.2.2.1. Knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee.

5.2.2.2. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics, and confidentiality safeguards in accordance with HIPAA and 42 CFR Part 2, and state rules and laws.

5.2.2.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium

5.2.2.4. An approved ethics course within twelve (12) months of hire.

5.2.3. Required trainings in Section 5.2 may be satisfied through existing licensure requirements and/or through Department approved alternative training curriculums and/or certifications.

5.2.4. Ensuring all recovery support staff and clinical staff receive continuous education regarding substance use disorders, at a minimum annually.

5.2.5. Providing in-service training to all staff involved in client care within fifteen (15) business days of the contract effective date or the staff person's start date on the following:

5.2.5.1. The contract requirements.

5.2.5.2. All other relevant policies and procedures provided by the Department.

5.3. The Contractor shall provide its staff, subcontractors, or end users as defined in Exhibit K, with periodic training in practices and procedures to ensure compliance with information security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.4. The Contractor shall notify the Department in writing:

5.4.1. When a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program, within one (1) month of hire.

5.4.2. When there is not sufficient staffing to perform all required services for more than one (1) month, within fourteen (14) calendar days.

5.5. The Contractor shall have policies and procedures related to student interns to address minimum coursework, experience, and core competencies for those interns having direct contact with individuals served by this contract.

5.6. The Contractor shall ensure that student interns complete an approved ethics course and an approved course on the twelve (12) core functions as described in Addiction

Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within six (6) months of beginning their internship.

**6. Records.**

6.1. The Contractor must maintain the following records:

6.1.1. 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.

6.1.2. 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.

6.1.3. 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.

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

**7. Health Insurance Portability and Accountability Act and Confidentiality:**

7.1.1. The Contractor is a covered entity as defined under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 160, 162 and 164, and shall comply with all confidentiality requirements and safeguards set forth in state and federal law and rules. The Contractor is also a substance use disorder provider as defined under 42 CFR Part 2 and shall safeguard confidential information as required. The Contractor shall ensure compliance with all consent and notice requirements prohibiting the redisclosure of confidential information in accordance with 42 CFR Part 2.

7.1.2. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and

for purposes directly connected to the administration of the services and the Contract; and provided further, that the disclosure of any protected health information shall be in accordance with the regulatory provisions of HIPAA, 42 CFR Part 2, and applicable state and federal laws and rules. Further, the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, their attorney or guardian. Notwithstanding anything to the contrary contained herein, the covenants and conditions contained in this Section 7 of Exhibit B shall survive the termination of the Contract for any reason whatsoever.

8. **Reporting Requirements.**

8.1. The Contractor shall comply with all aspects of the DHHS Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003, effective April 24, 2019, and any subsequent versions and/or amendments.

8.1.1. The Contractor shall report to DHHS Bureau of Drug and Alcohol Services within twenty-four (24) hours and follow up with written documentation submitted to the Bureau of Quality Assurance and Improvement within 72 hours, as specified in PO.1003, any sentinel event that occurs with any individual who is receiving services under this contract. This does not replace the responsibility of the Contractor's responsibility to notify the appropriate authority if the Contractor suspects a crime has occurred.

8.1.2. The Contractor shall comply with all statutorily mandated reporting requirements, including but not limited to, NH RSA 161-F:42-54 and RSA 169-C:29.

8.1.3. The Contractor shall cooperate with providing any information requested by DHHS as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

8.2. The Contractor shall submit monthly activity reports on templates provided by the Department with data elements that include, but may not be limited to:

8.2.1. call counts,
8.2.2. counts of clients seen,
8.2.3. reason types,
8.2.4. count of clinical evaluations,
8.2.5. count of referrals made and type,
8.2.6. naloxone distribution,

8.2.7. referral statuses,
8.2.8. recovery monitoring contacts,
8.2.9. service wait times, flex fund utilization, and
8.2.10. respite shelter utilization

8.3. The Contractor shall ensure the GPRAs are completed and entered into the WITS system on a timely basis so that the Department can create quarterly de-identified, aggregate client report on each client served, as required by SAMHSA. The GPRA data should include but not be limited to:

8.3.1. Diagnoses.
8.3.2. Demographic characteristics.
8.3.3. Substance use.
8.3.4. Services received and referrals made, by provider organization name.
8.3.5. Types of MAT received.
8.3.6. Length of stay in treatment.
8.3.7. Employment status.
8.3.8. Criminal justice involvement.
8.3.9. Housing.

8.4. The Contractor shall submit monthly reports on naloxone kits distributed, utilizing a template provided by the Department.

8.5. The Contractor shall report quarterly on federally required data points specific to this funding opportunity as identified by SAMHSA over the grant period.

8.6. The Contractor shall be required to prepare and submit ad hoc data reports as deemed necessary by the Department.

**9. Performance Measures**

9.1. The Department shall measure the effectiveness of the Contractor's performance in accordance with the provisions of this Agreement as follows:

9.1.1. The Contractor shall attempt to complete a GPRA interview for 100% of Doorway clients at intake or within three (3) calendar days following initial client contact and at six (6) months post intake, and upon discharge from Doorway referred services.

9.1.2. In accordance with SAMHSA State Opioid Response grant requirements, the Contractor shall attempt to ensure that the GPRA interview follow-up rate at six (6) months post intake for Doorway clients is no less than 80%.

**10. Doorway Implementation and Contract Management**

10.1. The Contractor shall participate in a kick-off meeting with the Department within ten (10) calendar days of the contract effective date to review contract timelines, scope, and deliverables.

10.2. The Contractor shall participate in weekly status telephone calls with the Department to review the status of the development and implementation for the Doorway, for the first three (3) months of the contract. The Contractor shall:

10.2.1. Provide a written weekly progress report in advance of the telephone call that would summarize:

10.2.1.1. Key work performed,

10.2.1.2. Encountered and foreseeable key issues and problems and provide a solution or mitigation strategy for each

10.2.1.3. Scheduled work for the upcoming week

10.2.2. Provide a report summarizing the results of the weekly status telephone call.

10.3. The Contractor shall participate in implementation and operational site visits on a schedule provided by the Department. All contract deliverables, programs, and activities shall be subject to review during this time. The Contractor shall:

10.3.1. Ensure the Department has access sufficient for monitoring of contract compliance requirements.

10.3.2. Ensure the Department is provided with access that includes but is not limited to:

10.3.2.1. Data.

10.3.2.2. Financial records.

10.3.2.3. Scheduled access to Contractor work sites/locations/work spaces and associated facilities.

10.3.2.4. Unannounced access to Contractor work sites/locations/work spaces and associated facilities.

10.3.2.5. Scheduled phone access to Contractor principals and staff.

10.4. The Contractor shall provide a work plan to develop, implement, and operationalize the Doorway for Department for review, within fifteen days of the contract effective date. The work plan shall include but not limited to:

10.4.1. A Staffing plan to provide the hours of operation as identified in Sections 3.1.1 and 3.1.2.1 above.

10.4.2. Identification and description of the tasks to be performed

10.4.3. Identification of the staff responsible for performing the tasks

10.4.4. Milestones.

10.4.5. Start and end dates.
10.4.6. Contingency planning as it relates to identified risks.
10.4.7. Issue tracking and resolution.

**11. State Opioid Response (SOR) Grant Standards**

11.1. The Contractor and/or referred providers shall ensure that only FDA-approved MAT for Opioid Use Disorder (OUD) is utilized. FDA-approved MAT for OUD includes:

11.1.1. Methadone.
11.1.2. Buprenorphine products, including:
11.1.2.1. Single-entity buprenorphine products.
11.1.2.2. Buprenorphine/naloxone tablets,
11.1.2.3. Buprenorphine/naloxone films.
11.1.2.4. Buprenorphine/naloxone buccal preparations.
11.1.2.5. Long-acting injectable buprenorphine products.
11.1.2.6. Buprenorphine implants.
11.1.2.7. Injectable extended-release naltrexone.

11.2. The Contractor and/or referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.3. The Contractor and/or referred providers shall ensure that clients receiving financial aid for recovery housing utilizing SOR funds shall only be in a recovery housing facility that is aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.4. The Contractor and/or referred providers shall assist clients with enrolling in public or private health insurance, if the client is determined eligible for such coverage.

11.5. The Contractor and/or referred providers shall accept clients on MAT and facilitate access to MAT on-site or through referral for all clients supported with SOR Grant funds, as clinically appropriate.

11.6. The Contractor and/or referred providers shall coordinate with the NH Ryan White HIV/AIDs program for clients identified as at risk of or with HIV/AIDS.

11.7. The Contractor and/or referred providers shall ensure that all clients are regularly screened for tobacco use, treatment needs and referral to the QuitLine as part of treatment planning.

**12. Data Management Requirements**

12.1. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements, which is attached hereto and incorporated by reference herein.

**13. Termination Report/Transition Plan**

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

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

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

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

13.5. During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

**14. Credits and Copyright Ownership**

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

14.2. All materials produced or purchased under the contract shall have prior approval from the Department before printing, production, distribution or use. The Department will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. The Contractor shall not reproduce any materials produced under the contract without prior written approval from the Department.

**15. Operation of Facilities: Compliance with Laws and Regulations**

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

**16. Equal Employment Opportunity Plan (EEOP)**

16.1. The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non- profit organizations, Indian Tribes,

and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

**17. Equipment Purchases**

17.1. The Contractor shall submit to the Department's Contract Unit a list of the purchased office equipment (with funding from this Contract). The list shall include office equipment such as, but not limited to, laptop computers, printers/scanners, and phones with the make, model, and serial number of each piece of office equipment.

17.2. The Contractor shall return said office equipment in Section 17.1 to the Department's Contract Unit within 30 days from the completion date of the Contract.

**18. Compliance with Federal and State Laws**

18.1. If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

18.2. Time and Manner of Determination

18.2.1. Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

18.3. Documentation

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

18.4. Fair Hearings

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

## Payment Terms

1. This contract is funded with funds from the Substance Abuse and Mental Health Services Administration CFDA #93.788, Federal Award Identification Number (FAIN) H79TI081685 and TI080246.
2. 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.
3. The Contractor may invoice the Department in an amount not to exceed $368,370 upon Governor and Executive Council approval of this Agreement. The Contractor shall ensure:
   3.1. The invoice clearly states a request for advance payment for the total advance payment amount.
   3.2. The invoice includes how funds will be utilized toward start up costs, hiring staff and staff readiness activities and furnishings, in accordance with with the implementaton plan in Exhibit B, Scope of Services, Section 10 Doorway Implementaion and Contract Management.
   3.3. Monthly reports detailing the actual costs incurred for items in Section 3.2 above, shall be submitted to the Department prior to submitting invoices for services provided after the period of implementation is completed. The invoices for services after implementaion will be paid on a cost reimbursement basis as stated in Section 2 above. Reimbursement for services after implentation will not occur until the advanced funds in Section 3 above have been fully expended,unless otherwise approved by the Department.
4. During the period of implementation as outlined in Exhibit B, Scope of Services, Section 10 Doorway Implementation and Contract Management, the Contractor may invoice the Department for costs associated with implementation only.
5. The Contractor shall seek reimbursement as follows:
   5.1. First, bill the clients other insurance or payor sources.
   5.2. Medicare
   5.3. For Medicaid enrolled individuals:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.
      5.3.2. Medicaid Fee for Service: The Contractor shall bill Medicaid for services on the Fee for Service (FFS) schedule.

5.4. Sliding Fee Scale Program

5.5. Lastly, the contractor shall bill this Agreement.

6. The Contractor shall submit an invoice in a form satisfactory to the State by the thirtith (30th) day of the following month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment. Invoices shall be net any other revenue received towards the services billed in fulfillment of this agreement.

6.1. Backup documentation shall include, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract

6.1.2. Timesheets and/or time cards that support the hours employees worked for wages reported under this contract.

6.1.2.1. Per 45 CFR Part 75.430(i)(1) Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed.

6.2. The following backup documentation may also be requested as needed:

6.2.1. Invoices supporting expenses reported.

6.2.1.1. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed $3.00 per person for clients.

6.2.2. Cost center reports

6.2.3. Profit and loss report

6.2.4. Remittance Advices from the insurances billed. Remittance Advices do not need to be supplied with the invoice, but should be retained to be available upon request.

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

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

8. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available, subject to Paragraph 4 of the General Provisions (Form Number P-37) of this Agreement.
9. The final invoice shall be due to the State no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.
10. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.
11. Grant Funds shall not be used to:
    11.1. Pay for the purchase or construction of any building or structure to house any part of the program.
    11.2. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.
12. 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.
13. Notwithstanding paragraph 18 of the General Provisions 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.
14. Audits
    14.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:
        14.1.1. 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.
        14.1.2. 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.
        14.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.
    14.2. 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.

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

14.4. Any Contractor that receives an amount equal to or greater than $250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA if the Department's risk assessment determination indicates the Contractor is high-risk.

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

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

Contractor name: Southern New Hampshire Health System, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services ("Doorway"), Greater Nashua Region

Budget Period: March 2020 - June 2020

| 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 | $ 182,700.00 | $ - | $ 182,700.00 | $ - | $ - | $ - | $ 182,700.00 | $ - | $ 182,700.00 |
| 2. Employee Benefits | $ 52,050.00 | $ - | $ 52,050.00 | $ - | $ - | $ - | $ 52,050.00 | $ - | $ 52,050.00 |
| 3. Consultants | $ 1,700.00 | $ - | $ 1,700.00 | $ - | $ - | $ - | $ 1,700.00 | $ - | $ 1,700.00 |
| 4. Equipment: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Rental | $ 900.00 | $ - | $ 900.00 | $ - | $ - | $ - | $ 900.00 | $ - | $ 900.00 |
| Repair and Maintenance | $ 400.00 | $ - | $ 400.00 | $ - | $ - | $ - | $ 400.00 | $ - | $ 400.00 |
| Purchase/Depreciation | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 5. Supplies: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Educational | $ 700.00 | $ - | $ 700.00 | $ - | $ - | $ - | $ 700.00 | $ - | $ 700.00 |
| Lab | $ 400.00 | $ - | $ 400.00 | $ - | $ - | $ - | $ 400.00 | $ - | $ 400.00 |
| Pharmacy | $ 72,153.00 | $ - | $ 72,153.00 | $ - | $ - | $ - | $ 72,153.00 | $ - | $ 72,153.00 |
| Medical | $ 530.00 | $ - | $ 530.00 | $ - | $ - | $ - | $ 530.00 | $ - | $ 530.00 |
| Office | $ 750.00 | $ - | $ 750.00 | $ - | $ - | $ - | $ 750.00 | $ - | $ 750.00 |
| 6. Travel | $ 2,850.00 | $ - | $ 2,850.00 | $ - | $ - | $ - | $ 2,850.00 | $ - | $ 2,850.00 |
| 7. Occupancy | $ 16,175.00 | $ - | $ 16,175.00 | $ - | $ - | $ - | $ 16,175.00 | $ - | $ 16,175.00 |
| 8. Current Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Telephone | $ 1,000.00 | $ - | $ 1,000.00 | $ - | $ - | $ - | $ 1,000.00 | $ - | $ 1,000.00 |
| Postage | $ 700.00 | $ - | $ 700.00 | $ - | $ - | $ - | $ 700.00 | $ - | $ 700.00 |
| Subscriptions | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Audit and Legal | $ 40,000.00 | $ - | $ 40,000.00 | $ - | $ - | $ - | $ 40,000.00 | $ - | $ 40,000.00 |
| Insurance | $ 400.00 | $ - | $ 400.00 | $ - | $ - | $ - | $ 400.00 | $ - | $ 400.00 |
| Board Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 9. Software | $ 20,000.00 | $ - | $ 20,000.00 | $ - | $ - | $ - | $ 20,000.00 | $ - | $ 20,000.00 |
| 10. Marketing/Communications | $ 15,000.00 | $ - | $ 15,000.00 | $ - | $ - | $ - | $ 15,000.00 | $ - | $ 15,000.00 |
| 11. Staff Education and Training | $ 1,000.00 | $ - | $ 1,000.00 | $ - | $ - | $ - | $ 1,000.00 | $ - | $ 1,000.00 |
| 12. Subcontracts/Agreements | $ 3,800.00 | $ - | $ 3,800.00 | $ - | $ - | $ - | $ 3,800.00 | $ - | $ 3,800.00 |
| 13. Other (specific details mandatory): | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Flexible Funds | $ 58,150.00 | $ - | $ 58,150.00 | $ - | $ - | $ - | $ 58,150.00 | $ - | $ 58,150.00 |
| Respite Shelter Voucher | $ 113,650.00 | $ - | $ 113,650.00 | $ - | $ - | $ - | $ 113,650.00 | $ - | $ 113,650.00 |
| Start-Up Expenses (Advance Payment) | $ 368,370.00 | | $ 368,370.00 | $ - | $ - | $ - | $ 368,370.00 | $ - | $ 368,370.00 |
| | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| TOTAL | $ 953,378.00 | $ 95,338.00 | $ 1,048,716.00 | $ - | $ - | $ - | $ 953,378.00 | $ 95,338.00 | $ 1,048,716.00 |
| Indirect As A Percent of Direct | | 10.0% | | | | | | | |



Contractor Initials: AbA
Date: 3/2/2020

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

Contractor name: Southern New Hampshire Health System, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services ("Doorway"), Greater Nashua Region

Budget Period: July 2020 - Sept 2020

| 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 | $ 164,000.00 | $ - | $ 164,000.00 | $ - | $ - | $ - | $ 164,000.00 | $ - | $ 164,000.00 |
| 2. Employee Benefits | $ 47,000.00 | $ - | $ 47,000.00 | $ - | $ - | $ - | $ 47,000.00 | $ - | $ 47,000.00 |
| 3. Consultants | $ 1,250.00 | $ - | $ 1,250.00 | $ - | $ - | $ - | $ 1,250.00 | $ - | $ 1,250.00 |
| 4. Equipment: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Rental | $ 625.00 | $ - | $ 625.00 | $ - | $ - | $ - | $ 625.00 | $ - | $ 625.00 |
| Repair and Maintenance | $ 250.00 | $ - | $ 250.00 | $ - | $ - | $ - | $ 250.00 | $ - | $ 250.00 |
| Purchase/Depreciation | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 5. Supplies: | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Educational | $ 500.00 | $ - | $ 500.00 | $ - | $ - | $ - | $ 500.00 | $ - | $ 500.00 |
| Lab | $ 250.00 | $ - | $ 250.00 | $ - | $ - | $ - | $ 250.00 | $ - | $ 250.00 |
| Pharmacy | $ 66,165.00 | $ - | $ 66,165.00 | $ - | $ - | $ - | $ 66,165.00 | $ - | $ 66,165.00 |
| Medical | $ 457.50 | $ - | $ 457.50 | $ - | $ - | $ - | $ 457.50 | $ - | $ 457.50 |
| Office | $ 687.50 | $ - | $ 687.50 | $ - | $ - | $ - | $ 687.50 | $ - | $ 687.50 |
| 6. Travel | $ 2,125.00 | $ - | $ 2,125.00 | $ - | $ - | $ - | $ 2,125.00 | $ - | $ 2,125.00 |
| 7. Occupancy | $ 14,832.00 | $ - | $ 14,832.00 | $ - | $ - | $ - | $ 14,832.00 | $ - | $ 14,832.00 |
| 8. Current Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Telephone | $ 750.00 | $ - | $ 750.00 | $ - | $ - | $ - | $ 750.00 | $ - | $ 750.00 |
| Postage | $ 500.00 | $ - | $ 500.00 | $ - | $ - | $ - | $ 500.00 | $ - | $ 500.00 |
| Subscriptions | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Audit and Legal | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Insurance | $ 250.00 | $ - | $ 250.00 | $ - | $ - | $ - | $ 250.00 | $ - | $ 250.00 |
| Board Expenses | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 9. Software | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 10. Marketing/Communications | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 11. Staff Education and Training | $ 750.00 | $ - | $ 750.00 | $ - | $ - | $ - | $ 750.00 | $ - | $ 750.00 |
| 12. Subcontracts/Agreements | $ 2,900.00 | $ - | $ 2,900.00 | $ - | $ - | $ - | $ 2,900.00 | $ - | $ 2,900.00 |
| 13. Other (specific details mandatory): | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Flexible Funds | $ 58,000.00 | $ - | $ 58,000.00 | $ - | $ - | $ - | $ 58,000.00 | $ - | $ 58,000.00 |
| Respite Shelter Voucher | $ 113,500.00 | $ - | $ 113,500.00 | $ - | $ - | $ - | $ 113,500.00 | $ - | $ 113,500.00 |
| | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| TOTAL | $ 474,792.00 | $ 47,480.00 | $ 522,272.00 | $ - | $ - | $ - | $ 474,792.00 | $ 47,480.00 | $ 522,272.00 |
| Indirect As A Percent of Direct | | 10.0% | | | | | | | |



Contractor Initials AM
Date 3/2/2020

## CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

**ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS**

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

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

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

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

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

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

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

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

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

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

Vendor Name: Southern New Hampshire Health System, Inc.

3/2/2020
Date

Name: Paul L. Trainer
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: Southern New Hampshire Health System, Inc.

3/2/2020
Date

Name: Paul L. Tramor
Title: CFO

## CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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

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

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

Vendor Name: Southern New Hampshire Health System, Inc.

3/2/2020
Date

Name: Paul L. Tramon
Title: CFO



Vendor Initials plt
Date 3/2/2020

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vendor Name: Southern New Hampshire Health System, Inc

3/2/2020
Date

Name: Paul L. Tramor
Title: CFO

## CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Vendor Name: Southern New Hampshire Health System, Inc.

3/2/2020
Date

Name: Paul L. Tramor
Title: CFO

## HEALTH INSURANCE PORTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

Exhibit I is not applicable.

Remainder of page intentionally left blank.

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

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name: Southern New Hampshire Health System, Inc.

3/2/2020
Date

Name: Paul L. Tramon
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 DUNS number for your entity is: 073971772

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

   X NO _____ YES

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

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

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

   _____ NO _____ YES

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

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

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

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

A. Definitions

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

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

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

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

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

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

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

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

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

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

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

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

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

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

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

## I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

## II. METHODS OF SECURE TRANSMISSION OF DATA

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

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

## III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

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

whole, must have aggressive intrusion-detection and firewall protection.

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

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

## IV. PROCEDURES FOR SECURITY

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

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

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

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

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

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

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

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

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

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

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

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

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

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

16. The Contractor must ensure that all End Users:

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

    b. safeguard this information at all times.

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

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

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

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

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

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

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

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

## V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

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

## VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

# State of New Hampshire

# Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on April 08, 1998. 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: **291619**

Certificate Number: **0004805325**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 14th day of February A.D. 2020.

William M. Gardner

Secretary of State

## CERTIFICATE OF AUTHORITY

I, Michael S. Rose, hereby certify that:

1. I am a duly elected Officer of Southern New Hampshire Health System, Inc.

2. The following is a true copy of a vote taken at a meeting of the Board of Trustees, duly called and held on February 24, 2020, at which a quorum of the Trustees were present and voting.

> **VOTED:** That Paul L. Trainor is duly authorized on behalf of Southern New Hampshire Health System, Inc. to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

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

Dated: March 02, 2020

Signature of Elected Officer
Name: Michael S. Rose
Title: President and Chief Executive Officer

STATE OF NEW HAMPSHIRE

County of Hillsborough

The foregoing instrument was acknowledged before me this 2nd day of March, 2020, by Michael S. Rose

(Notary Public/Justice of the Peace)

(NOTARY SEAL)

Commission Expires: June 21, 2022

HOLLY A. HUDON, Notary Public
State of New Hampshire
My Commission Expires June 21, 2022

ACORD

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 02/18/2020

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

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

PRODUCER
Willis Towers Watson Northeast, Inc. fka Willis of Massachusetts, Inc.
c/o 26 Century Blvd
P.O. Box 305191
Nashville, TN 372305191 USA

CONTACT NAME: Willis Towers Watson Certificate Center
PHONE (A/C, No, Ext): 1-877-945-7378 FAX (A/C, No): 1-888-467-2378
E-MAIL ADDRESS: certificates@willis.com

| INSURER(S) AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: ProMutual Group | B9486 |
| INSURER B: Sentry Insurance a Mutual Company | 24988 |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |
| INSURER F: | |

INSURED
Southern New Hampshire Health System, Inc.
Attn: Kathryn E. Skouteris, Esq.
8 Prospect Street
P.O. Box 2014
Nashua, NH 03060 USA

## COVERAGES

CERTIFICATE NUMBER: W15456901

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<br>[ ] CLAIMS-MADE [X] OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br>[X] POLICY [ ] PRO-JECT [ ] LOC<br>[ ] OTHER: | | | 002NH000015848 | 09/01/2019 | 07/01/2020 | EACH OCCURRENCE | $ 1,000,000 |
| | | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ 50,000 |
| | | | | | | | MED EXP (Any one person) | $ 5,000 |
| | | | | | | | PERSONAL & ADV INJURY | $ 1,000,000 |
| | | | | | | | GENERAL AGGREGATE | $ 3,000,000 |
| | | | | | | | PRODUCTS - COMP/OP AGG | $ 3,000,000 |
| | | | | | | | | $ |
| | AUTOMOBILE LIABILITY<br>[ ] ANY AUTO<br>[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS<br>[ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | | | | | | BODILY INJURY (Per person) | $ |
| | | | | | | | BODILY INJURY (Per accident) | $ |
| | | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | | | | | | | $ |
| | [ ] UMBRELLA LIAB [ ] OCCUR<br>[ ] EXCESS LIAB [ ] CLAIMS-MADE<br>[ ] DED [ ] RETENTION $ | | | | | | EACH OCCURRENCE | $ |
| | | | | | | | AGGREGATE | $ |
| | | | | | | | | $ |
| B | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N [ ]<br>If yes, describe under DESCRIPTION OF OPERATIONS below | N/A | | 90-15563-01 | 01/01/2020 | 01/01/2021 | [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)

Evidence of Coverage

Foundation Medical Partners is a Subsidiary of Southern New Hampshire Health System

## CERTIFICATE HOLDER

Department of Health and Human Services
Contracts and Procurements Unit
129 Pleasant Street
Concord, NH 03301

## CANCELLATION

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

AUTHORIZED REPRESENTATIVE

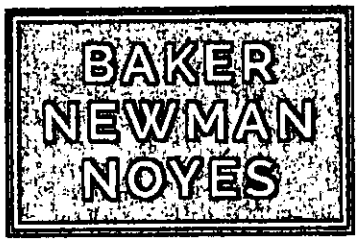
Julia M Powers

southern
new hampshire
health
a SOLUTIONHEALTH

**The Mission:** Southern New Hampshire Health is dedicated to providing exceptional care that improves the health and well-being of individuals and the communities we serve.

8 Prospect Street
Nashua, NH 03060
603.577.2000

snhhealth.org




# Southern New Hampshire Health System, Inc.

## Consolidated Financial Statements and Other Financial Information

*Nine Month Period Ended June 30, 2019*
*and Year Ended September 30, 2018*
*With Independent Auditors' Report*

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

# SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.

CONSOLIDATED FINANCIAL STATEMENTS
AND OTHER FINANCIAL INFORMATION

Nine Month Period Ended June 30, 2019
and Year Ended September 30, 2018

TABLE OF CONTENTS

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

# INDEPENDENT AUDITORS' REPORT

Board of Trustees
Southern New Hampshire Health System, Inc.

We have audited the accompanying consolidated financial statements of Southern New Hampshire Health System, Inc. (the System), which comprise the consolidated balance sheets as of June 30, 2019 and September 30, 2018, and the related consolidated statements of operations and changes in net assets, and cash flows for the nine month period ended June 30, 2019 and year ended September 30, 2018, 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 Trustees
Southern New Hampshire Health System, Inc.

*Opinion*

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the System as of June 30, 2019 and September 30, 2018, and the results of its operations and changes in its net assets, and its cash flows for the nine month period ended June 30, 2019 and year ended September 30, 2018 in accordance with accounting principles generally accepted in the United States of America.

*Emphasis of Matter*

As discussed in Note 2 to the consolidated financial statements, in 2019, the System adopted the provisions of Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958) – Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
September 6, 2019

**SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.**

CONSOLIDATED BALANCE SHEETS

June 30, 2019 and September 30, 2018

ASSETS

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Current assets: | | |
| Cash and cash equivalents | $ 32,002,213 | $ 39,242,039 |
| Accounts receivable, less allowances for doubtful accounts of $13,204,880 in 2019 and $11,670,284 in 2018 (notes 2 and 4) | 37,568,047 | 36,334,705 |
| Inventories | 4,725,407 | 4,475,956 |
| Prepaid expenses and other current assets | 3,885,810 | 8,285,556 |
| Funds held by trustee for current payment of bond principal and interest (notes 5, 8 and 13) | 2,193,014 | 3,277,264 |
| Total current assets | 80,374,491 | 91,615,520 |
| Investments (notes 5 and 13) | 107,419,194 | 95,287,661 |
| Assets whose use is limited (notes 5 and 13): | | |
| Employee benefit plans and other (note 2) | 32,934,869 | 31,383,403 |
| Board designated and donor-restricted | 103,449,322 | 101,098,156 |
| | 136,384,191 | 132,481,559 |
| Property, plant and equipment, net (notes 7, 8 and 11) | 127,093,513 | 126,672,190 |
| Other assets (note 2) | 10,803,946 | 11,896,523 |
| Total assets | $462,075,335 | $457,953,453 |

## LIABILITIES AND NET ASSETS

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Current liabilities: | | |
| Accounts payable and other accrued expenses | $ 21,262,554 | $ 24,268,863 |
| Accrued compensation and related taxes | 28,088,110 | 29,348,758 |
| Accrued interest payable | 593,310 | 1,217,091 |
| Amounts payable to third-party payors (note 3) | 16,377,450 | 14,759,243 |
| Current portion of long-term debt | 3,599,502 | 3,585,083 |
| Total current liabilities | 69,920,926 | 73,179,038 |
| Other liabilities (notes 2 and 9) | 53,350,863 | 45,613,906 |
| Long-term debt, less current portion and net of unamortized financing costs (note 8) | 63,373,251 | 66,780,672 |
| Net assets: | | |
| Without donor restrictions | 272,838,540 | 269,847,011 |
| With donor restrictions (note 6) | 2,591,755 | 2,532,826 |
| | 275,430,295 | 272,379,837 |
| Total liabilities and net assets | $462,075,335 | $457,953,453 |

See accompanying notes.

## SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.

### CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

Nine Month Period Ended June 30, 2019 and Year Ended September 30, 2018

| | Nine Month Period Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Revenue: | | |
| Net patient service revenue (net of contractual allowances and discounts) (note 3) | $277,159,887 | $348,873,308 |
| Provision for bad debts | (12,392,930) | (16,425,825) |
| Net patient service revenue less provision for bad debts | 264,766,957 | 332,447,483 |
| Disproportionate share hospital revenue (note 14) | 7,014,331 | 9,139,274 |
| Interest and dividends (note 5) | 2,602,093 | 2,530,082 |
| Other revenue (note 3) | 9,135,321 | 11,502,866 |
| Total revenue | 283,518,702 | 355,619,705 |
| Operating expenses (note 10): | | |
| Salaries and wages | 158,266,225 | 197,990,824 |
| Employee benefits (notes 2 and 9) | 23,375,385 | 28,806,820 |
| Supplies and other expenses (note 11) | 71,484,311 | 86,857,007 |
| Depreciation | 10,624,142 | 13,727,756 |
| New Hampshire Medicaid enhancement tax (note 14) | 9,545,778 | 12,322,604 |
| Interest (note 8) | 1,611,401 | 2,216,246 |
| Total operating expenses | 274,907,242 | 341,921,257 |
| Income from operations | 8,611,460 | 13,698,448 |
| Nonoperating gains (losses): | | |
| Investment return (note 5) | 4,239,894 | 10,858,987 |
| Loss on bond refunding (note 8) | – | (125,134) |
| Contributions, nonoperating revenues and other (losses) | (525,090) | (376,848) |
| Total nonoperating gains, net | 3,714,804 | 10,357,005 |
| Excess of revenues and nonoperating gains over expenses | 12,326,264 | 24,055,453 |
| Transfer to SolutionHealth, Inc. | (706,222) | – |
| Pension adjustment (note 9) | (8,628,513) | 4,241,004 |
| Net assets released from restriction for capital purchases | – | 80,000 |
| Increase in net assets without donor restrictions | 2,991,529 | 28,376,457 |
| Contributions of net assets with donor restrictions | 172,486 | 234,554 |
| Net assets released from restriction for capital purchases | – | (80,000) |
| Net assets released from restriction for operations | (113,557) | (216,504) |
| Increase (decrease) in net assets with donor restrictions | 58,929 | (61,950) |
| Increase in net assets | 3,050,458 | 28,314,507 |
| Net assets at beginning of period | 272,379,837 | 244,065,330 |
| Net assets at end of period | $275,430,295 | $272,379,837 |

See accompanying notes.

## SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.

### CONSOLIDATED STATEMENTS OF CASH FLOWS

Nine Month Period Ended June 30, 2019 and Year Ended September 30, 2018

| | Nine Month Period Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Operating activities and net gains and losses: | | |
| Increase in net assets | $ 3,050,458 | $ 28,314,507 |
| Adjustments to reconcile increase in net assets to net cash provided by operating activities and net gains: | | |
| Net gains on investments | (1,528,070) | (8,701,505) |
| Depreciation | 10,624,142 | 13,727,756 |
| Restricted gifts and bequests | (172,486) | (234,554) |
| Pension adjustment | 8,628,513 | (4,241,004) |
| Loss on bond refunding | – | 125,134 |
| Bond premium and issuance cost amortization | (240,984) | (329,339) |
| Changes in cash from certain working capital and other items: | | |
| Accounts receivable, net | (1,233,342) | (1,808,931) |
| Inventories, prepaid expense and other assets | 5,242,872 | (3,097,037) |
| Accounts payable, other accrued expenses and other liabilities | (6,073,112) | 6,484,799 |
| Accrued compensation and related taxes | (1,260,648) | 1,008,621 |
| Amounts payable to third-party payors | 1,618,207 | 479,416 |
| Net cash provided by operating activities and net gains | 18,655,550 | 31,727,863 |
| Investing activities: | | |
| Purchases of property, plant and equipment, net | (11,045,465) | (14,974,999) |
| Decrease in funds held by trustee under equipment financing and revenue bond agreements | 1,084,250 | 19,458,288 |
| Net purchase of investments | (12,954,629) | (15,696,412) |
| Net cash used by investing activities | (22,915,844) | (11,213,123) |
| Financing activities: | | |
| Payment of long-term debt | (3,152,018) | (22,101,074) |
| Restricted gifts and bequests | 172,486 | 234,554 |
| Net cash used by financing activities | (2,979,532) | (21,866,520) |
| Decrease in cash and cash equivalents | (7,239,826) | (1,351,780) |
| Cash and cash equivalents at beginning of period | 39,242,039 | 40,593,819 |
| Cash and cash equivalents at end of period | $ 32,002,213 | $ 39,242,039 |

See accompanying notes.

## 1. Organization

Southern New Hampshire Health System, Inc. is a not-for-profit entity organized under New Hampshire law to support Southern New Hampshire Medical Center (the Medical Center) and Foundation Medical Partners, Inc. (the Foundation), collectively referred to as "the System". Both the Medical Center and the Foundation are not-for-profit entities, established to provide medical services to the people of the greater Nashua area.

In the year ended September 30, 2018, the board of the System, accompanied by the board of Elliot Health System, approved an affiliation agreement between the organizations. The sole corporate member of the System became SolutionHealth, Inc.

On January 8, 2019, the System elected to change its fiscal year end from September 30 to June 30. There were nine months in the fiscal period ended June 30, 2019 and twelve months in the fiscal year ended September 30, 2018.

## 2. Significant Accounting Policies

*Principles of Consolidation*

These consolidated financial statements include the accounts of the System, which has no separate assets, liabilities, or operations other than its interests in the Medical Center and Foundation which fully eliminate in consolidation. All other significant intercompany accounts and transactions have been eliminated in consolidation.

*Use of Estimates*

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities, at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Estimates are used when accounting for the allowance for doubtful accounts, impairment and depreciable lives of long-lived assets, insurance costs, employee benefit plans, contractual allowances, third-party payor settlements and contingencies. It is reasonably possible that actual results could differ from those estimates.

*Net Assets With Donor Restrictions*

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), restricted net assets are reclassified as net assets without donor restriction and reported in the statement of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions used for capital purchases (capital related items). Some restricted net assets have been restricted by donors to be maintained by the System in perpetuity.

Except for contributions related to capital purchases, donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

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

*Performance Indicator*

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

The consolidated statements of operations and changes in net assets includes excess of revenues and nonoperating gains over expenses. Changes in net assets without donor restrictions which are excluded from excess of revenues and nonoperating gains over expenses, consistent with industry practice, include pension adjustments, net assets released from restrictions for capital purchases, and transfers to affiliates.

*Income Taxes*

The System, Medical Center and Foundation are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code, and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Management evaluated the System's tax positions and concluded the System has maintained its tax-exempt status, does not have any significant unrelated business income and has taken no uncertain tax positions that require adjustment to the consolidated financial statements.

*Net Patient Service Revenue*

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in those estimates are reflected in the financial statements in the year in which they occur (see note 3).

The System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients, the System provides a discount equal to that of its largest private insurance payors and Medicare. On the basis of historical experience, a significant portion of the System's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the System records a significant provision for bad debts related to uninsured patients in the period the services are provided.

*Charity Care*

The System has a formal charity care policy under which patient care is provided without charge or at amounts less than its established rates to patients who meet certain criteria. The System does not pursue collection of amounts determined to qualify as charity care and, therefore, they are not reported as revenue. The System determines the costs associated with providing charity care by calculating a ratio of cost to gross charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care.

## 2. Significant Accounting Policies (Continued)

*Cash and Cash Equivalents*

Cash and cash equivalents include short-term investments and secured repurchase agreements which have an original maturity of three months or less when purchased.

The System maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The System has not experienced any losses on such accounts.

*Accounts Receivable and the Allowance for Doubtful Accounts*

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the System records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The System's allowance for doubtful accounts was approximately 13% and 12% of gross accounts receivable as of June 30, 2019 and September 30, 2018, respectively. The System's self-pay bad debt writeoffs were $11.1 million for the nine month period ended June 30, 2019 and $15.4 million for the year ended September 30, 2018. The System experienced consistent collection trends during 2019 and 2018.

*Inventories*

Inventories of supplies and pharmaceuticals are carried at the lower of cost (determined by a weighted average method) or net realizable value.

*Funds Held by Trustee Under Financing and Revenue Bond Agreements*

Funds held by trustee under financing and revenue bond agreements are recorded at fair value and are comprised of short-term investments and United States government obligations.

## 2. Significant Accounting Policies (Continued)

*Investments and Investment Income*

Investments are measured at fair value in the balance sheet. Interest and dividend income on unlimited use investments and operating cash is reported within operating revenues. Investment income or loss on assets whose use is limited (including gains and losses on investments, and interest and dividends) is included in the excess of revenues and nonoperating gains over expenses as the System has elected to reflect changes in the fair value of investments and assets whose use is limited, including both increases and decreases in value in nonoperating gains or losses unless the income or loss is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions.

*Endowment, Investment and Spending Policies*

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

The goal of the board designated funds is to support the System's future capital expenditures and other major program needs, and to generally increase the financial strength of the corporation. In addition to occasional capital expenditures, board designated funds are invested in a prudent manner with regard to preserving principal while providing reasonable returns.

The goal of the endowment funds is to provide a source of financial support to the System's patient care activities. The System appropriates all earnings from the endowment funds to offset the costs of patient care activities according to the intent of the donor. The endowment funds are invested in a prudent manner with regard to preserving principal while providing reasonable returns.

To satisfy its long-term rate-of-return objectives, the System relies on a total return strategy in which investment returns are achieved through both capital appreciation and current yield. The System targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term objective within prudent risk constraints.

*Property and Equipment*

The investments in plant assets are stated at cost less accumulated depreciation. The System's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. The provision for depreciation has been computed using the straight-line method at rates intended to amortize the cost of related assets over their estimated useful lives, which have generally been determined by reference to the recommendations of the American Hospital Association.

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

*Unamortized Financing Costs*

Expenses incurred in obtaining long-term financing are being amortized to interest expense using the straight-line method, which approximates the effective interest method, over the repayment period of the related debt obligation. Unamortized financing costs are presented as a reduction of long-term debt on the accompanying consolidated balance sheets.

*Retirement and Deferred Compensation Plans*

The Medical Center has a noncontributory defined benefit pension plan that prior to October 8, 2011 covered all qualified employees. The benefits were based on years of service and the employee's average monthly earnings during the period of employment. The Medical Center's policy is to contribute to the plan an amount which meets the funding standards required under the *Employee Retirement Income Security Act of 1974* (ERISA).

The System also sponsors retirement savings plans (a 401(a) plan and a 403(b) plan) available to employees depending upon certain service requirements. Eligible employees can contribute up to 100% of their total salary to the plans, subject to Internal Revenue Service limitations. The System provides a tiered matching contribution up to the first 6% of the employee contribution. In 2012, the System approved a discretionary employer core contribution with the level to be reviewed annually. Contributions to these plans made by the System and recorded as expense for the nine month period ended June 30, 2019 and year ended September 30, 2018 were $5,429,239 and $6,304,860, respectively.

The System sponsors deferred compensation plans for certain qualifying employees. The amounts ultimately due to the employees are to be paid upon the employees attaining certain criteria, including age. At June 30, 2019 and September 30, 2018, approximately $32,696,000 and $31,145,000, respectively, is reflected in both assets whose use is limited and in other long-term liabilities related to such agreements.

*Employee Fringe Benefits*

The System has an "earned time" plan. Under this plan, each employee "earns" paid leave for each period worked. These hours of paid leave may be used for vacations, holidays or illnesses. Hours earned but not used are vested with the employee and are paid to the employee upon termination. The System accrues a liability for such paid leave as it is earned.

*Malpractice Loss Contingencies*

The System has been and is insured against malpractice loss contingencies under claims-made insurance policies. A claims-made policy provides specific coverage for claims made during the policy period. The System has established a reserve to cover professional liability exposure that may not be covered by prior or current insurance policies. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System.

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

At June 30, 2019 and September 30, 2018, the System recorded a liability of approximately $6,175,000 and $7,378,500, respectively, related to estimated professional liability losses. At June 30, 2019 and September 30, 2018, the System also recorded a receivable of $4,101,000 and $5,400,500, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in other liabilities and other assets, respectively, on the consolidated balance sheets.

*Fair Value of Financial Instruments*

The fair value of financial instruments is determined by reference to various market data and other valuation techniques as appropriate. Financial instruments consist of cash and cash equivalents, investments, accounts receivable, assets whose use is limited or restricted, accounts payable, estimated third-party payor settlements and long-term debt.

The fair value of all financial instruments other than long-term debt approximates their relative book value as these financial instruments have short-term maturities or are recorded at fair value, Note 13. The fair value of the System's long-term debt is estimated using discounted cash flow analyses, based on the System's current incremental borrowing rates for similar types of borrowing arrangements, and is disclosed in Note 8 to the financial statements.

*Advertising Expense*

Advertising costs are expensed as incurred and totaled approximately $682,000 and $1,033,000 for the nine month period ended June 30, 2019 and year ended September 30, 2018, respectively.

*Reclassifications*

Certain 2018 amounts have been reclassified to permit comparison with the 2019 consolidated financial statements presentation format.

*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 September 6, 2019, which is the date the consolidated financial statements were available to be issued.

*Recent Accounting Pronouncements*

In August 2016, FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities.* The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the System for the nine month period ended June 30, 2019. The System has adjusted the presentation of these consolidated financial statements and related footnotes accordingly. The ASU has been applied retrospectively to all periods presented.

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

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the System expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the System on July 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The System is evaluating the impact that ASU 2014-09 will have on its consolidated financial statements and related disclosures.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842),* which requires that lease arrangements longer than twelve months result in an entity recognizing an asset and liability. The pronouncement is effective for the System beginning July 1, 2020 but likely to be deferred one year, with early adoption permitted. The guidance may be adopted retrospectively. Management is currently evaluating the impact this guidance will have on the System's consolidated financial statements.

In March 2017, the FASB issued ASU No. 2017-07, *Compensation — Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* (ASU 2017-07). ASU 2017-07 will require that an employer report the service cost component of net periodic pension cost in the same line item as other compensation costs arising from services rendered by employees during the period. The other components of net periodic pension cost are required to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations, if one is presented. ASU 2017-07 is effective for the System on July 1, 2019 with early adoption permitted. The System would have presented net periodic pension revenue, net of service cost of approximately $834,000 and $925,000 for the nine month period ended June 30, 2019 and year ended September 30, 2018, respectively, as a separate line item in the consolidated statement of operations, outside a subtotal of income from operations had ASU 2017-07 been adopted.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for the System on July 1, 2019, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-08 will have on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement.* The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the System on July 1, 2020, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-13 will have on the consolidated financial statements.

## 3. Net Patient Service Revenues

An estimated breakdown of patient service revenue, net of contractual allowances, discounts and provision for bad debts recognized from these major payor sources, is as follows for the nine month period ended June 30, 2019 and year ended September 30, 2018:

| | Gross Patient Service Revenues | Contractual Allowances and Discounts | Provision for Bad Debts | Net Patient Services Revenues Less Provision for Bad Debts |
|---|---|---|---|---|
| **2019 (9 Months)** | | | | |
| Private payors (includes coinsurance and deductibles) | $286,288,667 | $(105,459,187) | $ (7,088,681) | $173,740,799 |
| Medicaid | 74,062,253 | (62,458,274) | (382,769) | 11,221,210 |
| Medicare | 269,010,179 | (188,892,834) | (1,595,516) | 78,521,829 |
| Self-pay | 13,196,647 | (8,587,564) | (3,325,964) | 1,283,119 |
| | $642,557,746 | $(365,397,859) | $(12,392,930) | $264,766,957 |
| **2018 (12 Months)** | | | | |
| Private payors (includes coinsurance and deductibles) | $355,533,176 | $(133,237,001) | $ (9,154,540) | $213,141,635 |
| Medicaid | 100,919,488 | (79,902,181) | (662,399) | 20,354,908 |
| Medicare | 323,150,060 | (223,518,375) | (2,224,765) | 97,406,920 |
| Self-pay | 17,469,416 | (11,541,275) | (4,384,121) | 1,544,020 |
| | $797,072,140 | $(448,198,832) | $(16,425,825) | $332,447,483 |

The System maintains contracts with the Social Security Administration (Medicare) and the State of New Hampshire Department of Health and Human Services (Medicaid). The System is paid a prospectively determined fixed price for each Medicare and Medicaid inpatient acute care service depending on the type of illness or the patient diagnostic related group classification. Medicare's payment methodology for outpatient services is based upon a prospective standard rate for procedures performed or services rendered. Capital costs and certain Medicaid outpatient services are also reimbursed on a prospectively determined fixed price. The System receives payment for other Medicare and Medicaid inpatient and outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports. The percentage of net patient service revenue earned from the Medicare and Medicaid programs prior to the provision for bad debts was 29% and 4%, respectively, for the nine month period ended June 30, 2019 and 29% and 6%, respectively, for the year ended September 30, 2018.

## 3. Net Patient Service Revenues (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The System believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoings. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. There is at least a reasonable possibility that recorded amounts could change by a material amount in the near term. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenue in the year that such amounts become known. Such differences decreased net patient service revenue by approximately $184,000 for the nine month period ended June 30, 2019 and increased net patient service revenue by approximately $825,000 for the year ended September 30, 2018.

The System also maintains contracts with Anthem Health Plans of New Hampshire, managed care providers and various other payors which reimburse the System for services based on charges with varying discount levels.

The System does not pursue collection of amounts determined to qualify as charity care, therefore, they are not reported as revenues.

## 4. Concentration of Credit Risk

The System grants credit without collateral to its patients, most of whom are local area residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Medicare | 32% | 33% |
| Medicaid | 10 | 10 |
| Private payors | 42 | 43 |
| Self-pay | 16 | 14 |
| | 100% | 100% |

## 5. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited, which are recorded at fair value are reported in the accompanying consolidated balance sheets as follows:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Funds held by trustee – current | $ 2,193,014 | $ 3,277,264 |
| Investments | 107,419,194 | 95,287,661 |
| Employee benefit plans and other | 32,934,869 | 31,383,403 |
| Board designated and donor-restricted | 103,449,322 | 101,098,156 |
| | $245,996,399 | $231,046,484 |

The composition of the fair value of investments and assets whose use is limited is set forth in the following table:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Cash and cash equivalents | $ 2,508,930 | $ 3,503,757 |
| Fixed income securities | 82,960,300 | 76,254,243 |
| Marketable equity securities | 124,859,354 | 117,290,679 |
| Real estate investment trust | 1,418,770 | 1,305,581 |
| Other | 1,314,176 | 1,308,821 |
| Employee benefit plans | 32,934,869 | 31,383,403 |
| | $245,996,399 | $231,046,484 |

See Note 13 for additional information with respect to fair values.

Investments, board designated and donor-restricted investments are comprised of the following:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Investments | $107,419,194 | $ 95,287,661 |
| Board designated for capital, working capital and community service | 100,857,567 | 98,565,330 |
| Donor-restricted | 2,591,755 | 2,532,826 |
| | $210,868,516 | $196,385,817 |

## 5. Investments and Assets Whose Use is Limited (Continued)

Unrestricted investment income and gains on investments are summarized as follows:

| | Nine Months Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Operating interest and dividend income | $2,602,093 | $ 2,530,082 |
| Other interest and dividend income | 2,711,824 | 2,157,482 |
| Net gains on investments | 1,528,070 | 8,701,505 |
| Nonoperating investment return | 4,239,894 | 10,858,987 |
| Total investment return | $6,841,987 | $13,389,069 |

All board designated and donor-restricted investment income and gains including unrealized gains are included as part of nonoperating gains, net in the accompanying consolidated statements of operations and changes in net assets.

## 6. Net Assets With Donor Restrictions

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

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Purpose restriction: | | |
| Equipment and capital improvements | $ 55,000 | $ – |
| Education and scholarships | 130,978 | 112,598 |
| Designated for certain communities | 40,264 | 54,715 |
| | 226,242 | 167,313 |
| Perpetual in nature: | | |
| Investments, gains and income from which is donor restricted | 2,365,513 | 2,365,513 |
| Total net assets with donor restrictions | $2,591,755 | $2,532,826 |

Net assets with donor restrictions are managed in accordance with donor intent and are invested in various portfolios.

## 7. Property and Equipment

A summary of property and equipment follows:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Land and land improvements | $ 19,995,548 | $ 19,629,160 |
| Buildings and fixed equipment | 185,034,852 | 182,850,298 |
| Major movable equipment | 113,207,305 | 107,157,195 |
| Construction in progress | 6,377,925 | 3,933,510 |
| | 324,615,630 | 313,570,163 |
| Less accumulated depreciation | (197,522,117) | (186,897,973) |
| | $ 127,093,513 | $ 126,672,190 |

## 8. Long-Term Debt

Long-term debt consists of the following:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| New Hampshire Health and Education Facilities Authority (the Authority): | | |
| Series 2016 Revenue Bonds with interest ranging from 3.0% to 5.0% per year. Principal and sinking fund installments are required in amounts ranging from $2,040,000 to $4,270,000 through October 1, 2037 | $57,305,000 | $59,345,000 |
| Tax-exempt equipment lease financing with a fixed interest rate of 1.29% with required monthly payments of $130,791 through June 7, 2023 | 6,115,671 | 7,227,689 |
| Unamortized original issue premium | 3,988,596 | 4,262,370 |
| | 67,409,267 | 70,835,059 |
| Less unamortized financing costs | (436,514) | (469,304) |
| Less current portion | (3,599,502) | (3,585,083) |
| | $63,373,251 | $66,780,672 |

The Obligated Group for the Series 2016 bonds is comprised of the System and the Medical Center. However, the System has no revenues, expenses or net assets independent of the Medical Center or the Foundation.

8. **Long-Term Debt (Continued)**

No debt service reserve funds are required under the Series 2016 bonds so long as the Medical Center meets certain debt covenants. The funds held by the trustee under the revenue bond and equipment financing agreements are comprised of the following:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Debt service principal fund – Series 2016 | $1,589,098 | $2,053,081 |
| Debt service interest fund – Series 2016 | 603,916 | 1,224,183 |
| Total funds held by trustees | $2,193,014 | $3,277,264 |

The Medical Center's revenue bond agreements with the Authority grant the Authority a security interest in the Medical Center's gross receipts. In addition, under the terms of the master indentures, the Medical Center is required to meet certain covenant requirements. At June 30, 2019, the Medical Center was in compliance with these requirements.

Aggregate annual principal payments required under the bonds and equipment financing agreement for each of the five years ending June 30, 2024 are approximately $3,599,000, $3,679,000, $3,759,000, $3,854,000 and $2,390,000, respectively.

In June 2016, the Medical Center entered into a seven year $10,500,000 tax-exempt equipment lease financing with the Authority and Bank of America. The proceeds of the financing are held by a trustee, under the terms of an escrow agreement which allow for withdrawals only for approved purchases of capital equipment. The agreement grants Bank of America security interest in the equipment financed with the proceeds for the duration of the lease.

Interest paid on long-term debt totaled $2,476,167 for the nine month period ended June 30, 2019 and $3,070,821 for the year ended September 30, 2018. There was no interest capitalized during the nine month period ended June 30, 2019 and year ended September 30, 2018.

The fair value of long-term debt is estimated to be approximately $69,025,000 at June 30, 2019 and $68,946,000 at September 30, 2018.

Subsequent to June 30, 2019, the System entered into a ten year $24,500,000 equipment lease financing with Bank of America to update an electronic medical record system and acquire various other medical equipment. The financing agreement is due in monthly principal and interest payments at an interest rate of 1.92%

## 9. Pension Plan

The following table presents a reconciliation of the beginning and ending balances of the Medical Center's defined benefit pension plan projected benefit obligation and the fair value of plan assets, and funded status of the plan.

| | Nine Months Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Changes in benefit obligations: | | |
| Projected benefit obligation, beginning of period | $(77,530,841) | $(80,168,143) |
| Interest cost | (2,512,797) | (3,201,688) |
| Benefits paid | 1,957,958 | 2,457,685 |
| Actuarial gain | (7,716,665) | 3,381,305 |
| Projected benefit obligations, end of period | $(85,802,345) | $(77,530,841) |
| Changes in plan assets: | | |
| Fair value of plan assets, beginning of period | $ 71,839,114 | $ 69,310,178 |
| Actual return on plan assets | 2,435,392 | 4,986,621 |
| Benefits paid | (1,957,958) | (2,457,685) |
| Fair value of plan assets, end of period | $ 72,316,548 | $ 71,839,114 |
| Funded status of the plan | $(13,485,797) | $ (5,691,727) |
| Net accrued liability | $(13,485,797) | $ (5,691,727) |

Amounts recognized as pension adjustments in net assets without donor restrictions consist of:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Net actuarial loss | $35,341,214 | $26,712,701 |

The accumulated benefit obligation as of the plan's measurement date of June 30, 2019 and September 30, 2018, was $85,802,345 and $77,530,841, respectively.

The weighted-average assumptions used to determine the pension benefit obligation are as follows:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Discount rate | 3.75% | 4.35% |

## 9. Pension Plan (Continued)

*Pension Plan Asset Fair Value Measurements*

The fair values of the System's pension plan assets as of June 30, 2019 and September 30, 2018, by asset category, are as follows (see note 13 for level definitions):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| **June 30, 2019**: | | | | |
| Pooled separate accounts: | | | | |
| Money market | $ – | $ 2,001,348 | $ – | $ 2,001,348 |
| International equity | – | 4,663,271 | – | 4,663,271 |
| Large cap equity | – | 23,112,760 | – | 23,112,760 |
| Mid cap equity | – | 5,094,575 | – | 5,094,575 |
| Small cap equity | – | 3,624,599 | – | 3,624,599 |
| Bond funds | – | 33,819,995 | – | 33,819,995 |
| | $ – | $72,316,548 | $ – | $72,316,548 |
| **September 30, 2018**: | | | | |
| Pooled separate accounts: | | | | |
| Money market | $ – | $ 1,419,670 | $ – | $ 1,419,670 |
| International equity | – | 5,254,881 | – | 5,254,881 |
| Large cap equity | – | 23,633,494 | – | 23,633,494 |
| Mid cap equity | – | 5,242,565 | – | 5,242,565 |
| Small cap equity | – | 4,087,486 | – | 4,087,486 |
| Bond funds | – | 32,201,018 | – | 32,201,018 |
| | $ – | $71,839,114 | $ – | $71,839,114 |

Net periodic pension gain includes the following components:

| | Nine Months Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Interest cost on projected benefit obligation | $ 2,512,797 | $ 3,201,688 |
| Expected return on plan assets | (3,853,020) | (4,935,897) |
| Recognized loss | 505,780 | 808,975 |
| Total gain | $ (834,443) | $ (925,234) |

## 9. Pension Plan (Continued)

The weighted-average assumptions used to determine net periodic benefit cost are as follows:

| | Nine Months Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Discount rate | 4.35% | 4.00% |
| Expected long-term rate of return on plan assets | 7.25% | 7.25% |

Other changes in plan assets and benefit obligations recognized in adjustments to net assets without donor restrictions are as follows:

| | Nine Months Ended June 30, 2019 | Year Ended September 30, 2018 |
|---|---|---|
| Net loss (gain) | $8,628,513 | $(4,241,004) |
| Total recognized in net periodic pension benefit cost and adjustment to net assets without donor restrictions | $8,628,513 | $(4,241,004) |

The estimated net loss for the defined benefit pension plan that will be amortized from net assets without donor restrictions into net periodic benefit cost over the next fiscal year is $931,141.

*Plan Amendments*

On August 15, 2011, the Board of Directors of the System resolved to freeze the defined benefit pension plan effective October 8, 2011. Any employee who was a participant of the plan on that date will continue as a participant. No other person will become a participant after that date. Benefits to participants also stopped accruing on October 8, 2011. This amendment impacted the present value of accumulated plan benefits by eliminating the increase due to annual benefit accruals. Also effective October 8, 2011, the System provides qualifying employees with an additional 2% contribution under its existing defined contribution plan to supplement their retirement benefits.

*Plan Assets*

The primary investment objective of the Medical Center's retirement plan is to provide pension benefits for its members and their beneficiaries by ensuring a sufficient pool of assets to meet the plan's current and future benefit obligations. These funds are managed as permanent funds with disciplined longer-term investment objectives and strategies designed to meet cash flow requirements of the plan. Funds are managed in accordance with ERISA and all other regulatory requirements.

Management of the assets is designed to maximize total return while preserving the capital values of the fund, protecting the fund from inflation, and providing liquidity as needed for plan benefits. The objective is to provide a rate of return that meets inflation, plus 5.5%, over a long-term horizon.

## 9. Pension Plan (Continued)

The Plan aims to diversify its holdings among sectors, industries and companies. No more than 10% of the plan's portfolio, excluding U.S. Government obligations and cash, may be held in an individual company's stock or bonds.

A periodic review is performed of the pension plan's investment in various asset classes. The current asset allocation target is 50% to 70% equities, 30% to 50% fixed income, and 0% to 5% cash and other.

The Medical Center's pension plan weighted-average asset allocation by asset category is as follows:

| | June 30, 2019 | September 30, 2018 |
|---|---|---|
| Marketable equity securities | 50% | 53% |
| U.S. Government obligations and corporate bonds | 50 | 47 |
| | 100% | 100% |

*Contributions*

The Medical Center does not have a minimum required contribution for 2020 and does not expect to voluntarily contribute to its pension plan in 2020.

*Estimated Future Benefit Payments*

The following benefit payments are expected to be paid as follows for the years ended June 30:

| | |
|---|---|
| 2020 | $ 3,167,392 |
| 2021 | 3,390,541 |
| 2022 | 3,635,442 |
| 2023 | 3,868,094 |
| 2024 | 4,110,787 |
| Years 2025 – 2029 | 23,324,753 |

## 10. Functional Expenses

The Medical Center and the Foundation provide general health care services to residents within their geographic location. Expenses related to providing these services are as follows for the nine month period ended June 30, 2019:

| | Health Services | General and Administrative | Total |
|---|---|---|---|
| Salaries and wages | $135,266,038 | $ 23,000,187 | $158,266,225 |
| Employee benefits | 20,086,372 | 3,289,013 | 23,375,385 |
| Supplies and other | 57,513,764 | 13,970,547 | 71,484,311 |
| Interest | 1,370,042 | 241,359 | 1,611,401 |
| Provider tax | 9,545,778 | – | 9,545,778 |
| Depreciation | 7,899,050 | 2,725,092 | 10,624,142 |
| | $231,681,044 | $ 43,226,198 | $274,907,242 |

The financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as, depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits were allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

## 11. Leases

The System leases equipment as well as office and storage space for operations under various noncancelable lease agreements. These leases are treated as operating leases and expire at various dates through 2029. Rental expense on all operating leases for the nine month period ended June 30, 2019 and year ended September 30, 2018 was $1,327,783 and $1,768,188, respectively.

Future minimum lease payments required under operating leases as of June 30, 2019 are as follows:

| | |
|---|---|
| Year ending June 30: | |
| 2020 | $1,291,433 |
| 2021 | 1,112,701 |
| 2022 | 934,552 |
| 2023 | 892,792 |
| 2024 | 847,342 |
| Thereafter | 3,073,767 |
| Total future minimum lease payments | $8,152,587 |

## 12. Community Benefits (Unaudited)

In accordance with its mission, the System provides substantial benefits to the southern New Hampshire region. The following community benefits were provided by the System for the nine month period ended June 30, 2019 and year ended September 30, 2018:

| | Community Benefit Costs | Offsetting Revenues | Net Community Benefit Expense |
|---|---|---|---|
| **2019 (9 Months)** | | | |
| Charity care (see note 3) | $ 3,024,317 | $ – | $ 3,024,317 |
| Uncompensated care | 3,051,980 | – | 3,051,980 |
| Subsidized care | 141,717,507 | 98,899,076 | 42,818,431 |
| Cash and in-kind contributions | 5,506,911 | 237,153 | 5,269,758 |
| Total | $153,300,715 | $ 99,136,229 | $54,164,486 |
| **2018 (12 Months)** | | | |
| Charity care (see note 3) | $ 3,867,066 | $ – | $ 3,867,066 |
| Uncompensated care | 3,998,506 | – | 3,998,506 |
| Subsidized care | 177,915,896 | 127,730,197 | 50,185,699 |
| Cash and in-kind contributions | 5,990,006 | 148,578 | 5,841,428 |
| Total | $191,771,474 | $127,878,775 | $63,892,699 |

*Charity care*: The System provides care to patients who meet certain criteria under its board established charity care policy without charge or at amounts less than its established rates. The System does not pursue collection of amounts determined to qualify as charity care, therefore, they are not reported as revenues. The estimated costs of caring for charity care patients for the nine month period ended June 30, 2019 and year ended September 30, 2018 were approximately $3.0 million and $3.9 million, respectively.

*Uncompensated care*: The System provides care to patients without insurance, regardless of their ability to pay. Though the System attempts to assist all patients enrolling in available public assistance programs or qualification under its charity care policy, many patients either fail to comply with administrative requirements, or do not qualify. In these instances, the System attempts to collect for these services. However, the overwhelming majority of these accounts are ultimately uncollectible.

*Subsidized care*: The System provides services to patients enrolled in public service programs, i.e., Medicare and Medicaid, at rates substantially below cost.

*Cash and in-kind contributions*: The System supports various community initiatives including healthcare outreach, research and education. Other cash and in-kind contributions can be found in the community benefits report posted on the System's website.

## 13. Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the System uses various methods including market, income and cost approaches. Based on these approaches, the System often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and/or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The System utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the System is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

In determining the appropriate levels, the System performs a detailed analysis of the assets and liabilities. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3.

For the nine month period ended June 30, 2019 and year ended September 30, 2018, the application of valuation techniques applied to similar assets and liabilities has been consistent. The following is a description of the valuation methodologies used:

*Marketable Equity Securities*

Marketable equity securities are valued based on stated market prices and at the net asset value of shares held by the System at year end, which results in classification as Level 1 or Level 2 within the fair value hierarchy.

*Fixed Income Securities*

The fair value for debt instruments is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The System holds U.S. governmental and federal agency debt instruments, municipal bonds, corporate bonds, and foreign bonds which are classified as Level 1 or Level 2 within the fair value hierarchy.

## 13. Fair Value Measurements (Continued)

*Employee Benefit Plans*

Underlying plan investments within these funds are stated at quoted market prices. These investments are generally classified as Level 1 within the fair value hierarchy.

*Fair Value on a Recurring Basis*

The following presents the balances of assets (funds held by trustee, investments and assets whose use is limited) measured at fair value on a recurring basis at June 30, 2019 and September 30, 2018:

| | Total | Level 1 | Level 2 | Level 3 |
|---|---|---|---|---|
| **June 30, 2019** | | | | |
| Cash and cash equivalents | $ 2,508,930 | $ 2,508,930 | $ – | $ – |
| Marketable equity securities: | | | | |
| Large cap | 96,364,728 | 64,395,808 | 31,968,920 | – |
| Mid cap | 7,733,694 | – | 7,733,694 | – |
| Small cap | 7,521,376 | 3,301,270 | 4,220,106 | – |
| International | 13,239,556 | 9,354,972 | 3,884,584 | – |
| Fixed income securities: | | | | |
| U.S. Government obligations | 14,504,602 | 14,504,602 | – | – |
| Corporate bonds | 64,496,392 | 64,496,392 | – | – |
| Foreign bonds | 3,959,306 | 3,959,306 | – | – |
| Other investments | 2,732,946 | 1,762,559 | 970,387 | – |
| Employee benefit plans | 32,934,869 | 32,934,869 | – | – |
| | $245,996,399 | $197,218,708 | $48,777,691 | $ – |
| **September 30, 2018** | | | | |
| Cash and cash equivalents | $ 3,503,757 | $ 3,503,757 | $ – | $ – |
| Marketable equity securities: | | | | |
| Large cap | 86,183,243 | 47,883,059 | 38,300,184 | – |
| Mid cap | 10,291,183 | – | 10,291,183 | – |
| Small cap | 7,905,146 | 3,383,320 | 4,521,826 | – |
| International | 12,911,107 | 9,051,901 | 3,859,206 | – |
| Fixed income securities: | | | | |
| U.S. Government obligations | 17,732,529 | 13,011,616 | 4,720,913 | – |
| Corporate bonds | 54,923,228 | 54,923,228 | – | – |
| Foreign bonds | 3,598,486 | 3,598,486 | – | – |
| Other investments | 2,614,402 | 1,596,615 | 1,017,787 | – |
| Employee benefit plans | 31,383,403 | 31,383,403 | – | – |
| | $231,046,484 | $168,335,385 | $62,711,099 | $ – |

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 fair value of investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated balance sheets and statements of operations.

## 13. Fair Value Measurements (Continued)

*Investment Strategies*

Marketable Equity Securities

The primary purpose of equity investments is to provide appreciation of principal and growth of income with the recognition that this requires the assumption of greater market volatility and risk of loss. The total equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics including style and capitalization. The System may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

Fixed Income Securities (Debt Instruments)

The primary purpose of fixed income investments is to provide a highly predictable and dependable source of income, preserve capital, and reduce the volatility of the total portfolio and hedge against the risk of deflation or protracted economic contraction.

*Fair Value of Other Financial Instruments*

The following methods and assumptions were used by the System in estimating the "fair value" of other financial instruments in the accompanying consolidated financial statements and notes thereto:

*Cash and cash equivalents*: The carrying amounts reported in the accompanying consolidated balance sheets for these financial instruments approximate their fair values.

*Accounts receivable and accounts payable*: The carrying amounts reported in the accompanying consolidated balance sheets approximate their respective fair values due to the short maturities of these instruments.

*Long-term debt:* The fair value of the notes payable and long-term debt, as disclosed in Note 8, was calculated based upon discounted cash flows through maturity based on market rates currently available for borrowing with similar maturities.

## 14. Medicaid Enhancement Tax and Medicaid Disproportionate Share

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.4% of the Medical Center's net patient service revenues in State fiscal years 2019 and 2018, with certain exclusions. The amount of the tax incurred by the Medical Center for the nine month period ended June 30, 2019 and year ended September 30, 2018 was $9,545,778 and $12,322,604, respectively.

## 14. Medicaid Enhancement Tax and Medicaid Disproportionate Share (Continued)

The State provides disproportionate share payments (DSH) to hospitals based on a set percentage of uncompensated care provided. The Medical Center received DSH interim funding of $10,284,949 and $10,245,347 during the nine month period ended June 30, 2019 and year ended September 30, 2018, respectively. Reserves on these receipts were established for $1,542,742 and $1,536,802 at June 30, 2019 and September 30, 2018, respectively, as these payments are subject to the State DSH annual audit and potential redistributions.

## 15. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, consisted of the following as of June 30, 2019:

| | |
|---|---|
| Cash and cash equivalents | $32,002,213 |
| Accounts receivable | 37,568,047 |
| Funds held by trustee for current payment of bond principal and interest | 2,193,014 |
| | $71,763,274 |

To manage liquidity, the System maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the System. In addition, the System has board-designated and long-term investments without donor restrictions that can be utilized to help fund both operational needs and/or capital projects. As of June 30, 2019, the balance in board-designated and long-term investments were $100,857,567 and $107,419,194, respectively.

Baker Newman & Noyes LLC
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## INDEPENDENT AUDITORS' REPORT ON OTHER FINANCIAL INFORMATION

Board of Trustees
Southern New Hampshire Health System, Inc.

We have audited the consolidated financial statements of Southern New Hampshire Health System, Inc. (the System) as of and for the nine month period ended June 30, 2019 and year ended September 30, 2018, and have issued our report thereon, which contains an unmodified opinion on those consolidated financial statements. See page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations and cash flows of the individual entities and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Newman & Noyes LLC

Manchester, New Hampshire
September 6, 2019

**SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.**

CONSOLIDATING BALANCE SHEETS

June 30, 2019 and September 30, 2018

ASSETS

| | June 30, 2019 | | | | September 30, 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. |
| Current assets: | | | | | | | | |
| Cash and cash equivalents | $ 32,002,213 | $ – | $ 32,599,728 | $ (597,515) | $ 39,242,039 | $ – | $ 39,935,647 | $ (693,608) |
| Accounts receivable, less allowances for doubtful accounts | 37,568,047 | – | 26,414,725 | 11,153,322 | 36,334,705 | – | 26,087,823 | 10,246,882 |
| Inventories | 4,725,407 | – | 3,936,587 | 788,820 | 4,475,956 | – | 3,413,584 | 1,062,372 |
| Prepaid expenses and other current assets | 3,885,810 | (289,636) | 3,035,939 | 1,139,507 | 8,285,556 | (271,186) | 6,282,930 | 2,273,812 |
| Funds held by trustee for current payment of bond principal and interest | 2,193,014 | – | 2,193,014 | – | 3,277,264 | – | 3,277,264 | – |
| Total current assets | 80,374,491 | (289,636) | 68,179,993 | 12,484,134 | 91,615,520 | (271,186) | 78,997,248 | 12,889,458 |
| Investments | 107,419,194 | – | 107,419,194 | – | 95,287,661 | – | 95,287,661 | – |
| Assets whose use is limited: | | | | | | | | |
| Employee benefit plans and other | 32,934,869 | – | 4,743,771 | 28,191,098 | 31,383,403 | – | 4,592,183 | 26,791,220 |
| Board designated and donor-restricted | 103,449,322 | – | 103,449,322 | – | 101,098,156 | – | 101,098,156 | – |
| | 136,384,191 | – | 108,193,093 | 28,191,098 | 132,481,559 | – | 105,690,339 | 26,791,220 |
| Property, plant and equipment, net | 127,093,513 | (97,513) | 118,558,576 | 8,632,450 | 126,672,190 | (106,378) | 117,792,415 | 8,986,153 |
| Other assets | 10,803,946 | (4,301,404) | 15,044,274 | 61,076 | 11,896,523 | (4,523,244) | 16,300,128 | 119,639 |
| Total assets | $462,075,335 | $(4,688,553) | $417,395,130 | $49,368,758 | $457,953,453 | $(4,900,808) | $414,067,791 | $48,786,470 |

## LIABILITIES AND NET ASSETS

| | June 30, 2019 | | | | September 30, 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. |
| Current liabilities: | | | | | | | | |
| Accounts payable and other accrued expenses | $ 21,262,554 | $ – | $ 17,155,513 | $ 4,107,041 | $ 24,268,863 | $ – | $ 19,730,992 | $ 4,537,871 |
| Accrued compensation and related taxes | 28,088,110 | – | 16,087,573 | 12,000,537 | 29,348,758 | – | 17,430,983 | 11,917,775 |
| Accrued interest payable | 593,310 | – | 593,310 | – | 1,217,091 | – | 1,217,091 | – |
| Amounts payable to third-party payors | 16,377,450 | – | 16,377,450 | – | 14,759,243 | – | 14,759,243 | – |
| Current portion of long-term debt | 3,599,502 | – | 3,599,502 | – | 3,585,083 | – | 3,585,083 | – |
| Total current liabilities | 69,920,926 | – | 53,813,348 | 16,107,578 | 73,179,038 | – | 56,723,392 | 16,455,646 |
| Other liabilities | 53,350,863 | (4,688,553) | 24,035,163 | 34,004,253 | 45,613,906 | (4,900,808) | 17,813,232 | 32,701,482 |
| Long-term debt, less current portion and net of unamortized financing costs | 63,373,251 | – | 63,373,251 | – | 66,780,672 | – | 66,780,672 | – |
| Net assets: | | | | | | | | |
| Without donor restrictions | 272,838,540 | – | 273,581,613 | (743,073) | 269,847,011 | – | 270,217,669 | (370,658) |
| With donor restrictions | 2,591,755 | – | 2,591,755 | – | 2,532,826 | – | 2,532,826 | – |
| | 275,430,295 | – | 276,173,368 | (743,073) | 272,379,837 | – | 272,750,495 | (370,658) |
| Total liabilities and net assets | $462,075,335 | $(4,688,553) | $417,395,130 | $49,368,758 | $457,953,453 | $(4,900,808) | $414,067,791 | $48,786,470 |

## SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.

CONSOLIDATING STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

Nine Month Period Ended June 30, 2019 and Year Ended September 30, 2018

| | Nine Month Period Ended June 30, 2019 | | | | Year Ended September 30, 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. |
| Net patient service revenue (net of contractual allowances and discounts) | $277,159,887 | $ (3,233,918) | $192,874,444 | $ 87,519,361 | $348,873,308 | $ (4,333,572) | $246,694,563 | $106,512,317 |
| Provision for bad debts | (12,392,930) | – | (8,693,827) | (3,699,103) | (16,425,825) | – | (11,282,535) | (5,143,290) |
| Net patient service revenue less provision for bad debts | 264,766,957 | (3,233,918) | 184,180,617 | 83,820,258 | 332,447,483 | (4,333,572) | 235,412,028 | 101,369,027 |
| Disproportionate share hospital revenue | 7,014,331 | – | 7,014,331 | – | 9,139,274 | – | 9,139,274 | – |
| Interest and dividends | 2,602,093 | – | 2,602,093 | – | 2,530,082 | – | 2,530,082 | – |
| Other revenue | 9,135,321 | (8,682,812) | 7,858,071 | 9,960,062 | 11,502,866 | (10,692,105) | 9,403,230 | 12,791,741 |
| Total revenue | 283,518,702 | (11,916,730) | 201,655,112 | 93,780,320 | 355,619,705 | (15,025,677) | 256,484,614 | 114,160,768 |
| Operating expenses: | | | | | | | | |
| Salaries and wages | 158,266,225 | (71,940) | 79,293,089 | 79,045,076 | 197,990,824 | (90,026) | 101,061,641 | 97,019,209 |
| Employee benefits | 23,375,385 | (3,233,918) | 12,908,384 | 13,700,919 | 28,806,820 | (4,333,572) | 16,720,715 | 16,419,677 |
| Supplies and other expenses | 71,484,311 | (8,379,581) | 52,220,669 | 27,643,223 | 86,857,007 | (10,276,419) | 65,069,973 | 32,063,453 |
| Depreciation | 10,624,142 | – | 9,450,781 | 1,173,361 | 13,727,756 | – | 12,189,882 | 1,537,874 |
| New Hampshire Medicaid enhancement tax | 9,545,778 | – | 9,545,778 | – | 12,322,604 | – | 12,322,604 | – |
| Interest | 1,611,401 | (231,291) | 1,611,401 | 231,291 | 2,216,246 | (325,660) | 2,216,246 | 325,660 |
| Total operating expenses | 274,907,242 | (11,916,730) | 165,030,102 | 121,793,870 | 341,921,257 | (15,025,677) | 209,581,061 | 147,365,873 |
| Income (loss) from operations | 8,611,460 | – | 36,625,010 | (28,013,550) | 13,698,448 | – | 46,903,553 | (33,205,105) |

| | Nine Month Period Ended June 30, 2019 | | | | Year Ended September 30, 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. | Consolidated | Elimination Entries | Southern New Hampshire Medical Center | Foundation Medical Partners, Inc. |
| Nonoperating gains (losses): | | | | | | | | |
| Investment return | $ 4,239,894 | $ – | $ 4,239,894 | $ – | $ 10,858,987 | $ – | $ 10,858,987 | $ – |
| Loss on bond refunding | – | – | – | – | (125,134) | – | (125,134) | – |
| Contributions and nonoperating revenues | (525,090) | – | (525,090) | – | (376,848) | – | (376,848) | – |
| Nonoperating gains, net | 3,714,804 | – | 3,714,804 | – | 10,357,005 | – | 10,357,005 | – |
| Excess (deficiency) of revenues and non-operating gains (losses) over expenses | 12,326,264 | – | 40,339,814 | (28,013,550) | 24,055,453 | – | 57,260,558 | (33,205,105) |
| Transfers from (to) affiliates | – | – | (27,641,135) | 27,641,135 | – | – | (34,426,855) | 34,426,855 |
| Transfer to SolutionHealth, Inc. | (706,222) | – | (706,222) | – | – | – | – | – |
| Pension adjustment | (8,628,513) | – | (8,628,513) | – | 4,241,004 | – | 4,241,004 | – |
| Net assets released from restriction for capital purchases | – | – | – | – | 80,000 | – | 80,000 | – |
| Increase (decrease) in net assets without donor restrictions | 2,991,529 | – | 3,363,944 | (372,415) | 28,376,457 | – | 27,154,707 | 1,221,750 |
| Contributions of net assets with donor restrictions | 172,486 | – | 172,486 | – | 234,554 | – | 234,554 | – |
| Net assets released from restriction for capital purchases | – | – | – | – | (80,000) | – | (80,000) | – |
| Net assets released from restriction for operations | (113,557) | – | (113,557) | – | (216,504) | – | (216,504) | – |
| Increase (decrease) in net assets with donor restrictions | 58,929 | – | 58,929 | – | (61,950) | – | (61,950) | – |
| Increase (decrease) in net assets | 3,050,458 | – | 3,422,873 | (372,415) | 28,314,507 | – | 27,092,757 | 1,221,750 |
| Net assets at beginning of period | 272,379,837 | – | 272,750,495 | (370,658) | 244,065,330 | – | 245,657,738 | (1,592,408) |
| Net assets at end of period | $275,430,295 | $ – | $276,173,368 | $ (743,073) | $272,379,837 | $ – | $272,750,495 | $ (370,658) |

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WE ARE SOLUTIONHEALTH

# Southern New Hampshire Health System

## Board of Trustees Membership

**2020 Term**

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| | |
|---|---|
| Board Chair: | Timothy J. Whitaker |
| Board Vice-Chair: | Thomas A. Pursch |
| President/CEO: | Michael S. Rose |
| Treasurer: | Paul L. Trainor |
| Secretary: | Michael S. Rose |

***Members may be contacted at the following address:***

Southern New Hampshire Medical Center
Administration Office
8 Prospect Street
PO Box 2014
Nashua, NH 03061

# KATHRYN E. SKOUTERIS, ESQ.

## EMPLOYMENT

**SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM** (2016-Present) **Nashua, NH**

*Senior Vice President/General Counsel (December 2018-Present)*
*Vice President, Legal and Regulatory Affairs/General Counsel (February 2017-December 2018)*

- Oversight of human resources, marketing/communications and facilities planning for Health System.
- Leads legal services, risk management and compliance department for Health System, including insurance renewals, lawsuit/claims management, external reporting and all legal advice.
- Manages all litigation and corporate legal activities for Health System.
- Provides legal services to Health System, including internal advice and the management of external counsel.
- Reports and presents to the Board of Trustees on department updates.
- Coordinates and, if appropriate, presents all training and education for Health System.
- Advises Medical Staff, Employees, and Board of Trustees on legal and governance issues.

*Associate Vice President of Legal Services and Privacy Officer/General Counsel (2016-February 2017)*

- Provided legal services to Health System, including internal advice and the management of external counsel.
- Acted as privacy officer and oversaw a privacy coordinator to advise on both privacy and security issues.
- Managed Audit Subcommittee, related duties and review of conflict of interest disclosures.
- Developed, drafted and reviewed policies and procedures to meet regulatory requirements.

**NH DEPARTMENT OF REVENUE ADMINISTRATION** (2010-January 2016) **Concord, NH**

*Assistant Commissioner (Appointed January 2014)*

- Partnered with the Commissioner on all planning, strategy, staffing and general agency management.
- Participated in and, at times, led resolution between New Hampshire hospitals and State of New Hampshire in Medicaid Enhancement Tax dispute.
- Managed all administrative functions of the agency and associated staff, including human resources, the legal bureau, the legislative group, policies and procedures, risk assessments, information security, the hearings bureau, business office, project management team, and the internal auditor to ensure goals and objectives of the agency are carried out effectively and efficiently.
- Oversaw all personnel actions, including hiring, terminations, union-related issues and discipline.
- Testified before legislative committees, as necessary, to support agency mission.

*General Counsel (December 2011-December 2013)*
*Assistant General Counsel (June 2010-December 2011)*

- Areas of practice included contract law, corporate law, bankruptcy, employment law and tax law.
- Advised agency (Commissioner and senior leadership) on all legal matters, strategies and solutions.
- Represented the agency in administrative hearings and rulemaking hearings.
- Managed administrative rulemaking process and drafted proposed rules.

**LAWSON & WEITZEN, LLP** (2003-2010) **Boston, MA**

*Attorney-At-Law*

- Represented a range of clients in litigation claims and court disputes during all phases of litigation process.
- Advised corporate entities on employment issues, contract disputes, and best practices for dispute resolution.
- Areas of commercial litigation practice included administrative, class actions, contract, construction and engineering, employment (ERISA, non-competition agreements, NDAs), FDA approval, insurance coverage, intellectual property, product liability, real estate, securities, trust and probate matters.

## EDUCATION

**SUFFOLK UNIVERSITY LAW SCHOOL** **Boston, MA**

*Juris Doctor, Cum Laude*

**UNIVERSITY OF NEW HAMPSHIRE** **Durham, NH**

*B.A. English, Cum Laude*

# PAUL L. TRAINOR

[redacted]

**Education:**

**Bentley College,** Waltham, MA
BS Degree – Accounting

**New England College,** Henniker, NH
Masters in Management – Healthcare Administration

**Experience:**

**Southern NH Health System,** Nashua, NH
***Senior Vice President/Chief Financial Officer***, July 2016 – Present

- Effectively plans, monitors and controls the financial resources of SNHHS
- Develops budgets approved by the Board, reports out quarterly to the Board, and achieves financial targets
- Provides leadership in strategic cost transformation to ensure long-term sustainability
- Provides leadership in revenue strategies that include both SNHHS and SolutionHealth
- Ensures compliance with state and federal laws as well as accounting principles

**Southern NH Medical Center**, Nashua, NH
***Controller***, August 2007 – June 2016

- Provide leadership role on behalf of Finance to help meet organization's financial goals
- Prepare financial reporting package and presentation for CFO and Finance Committee
- Manage Finance, Accounting, Accounts Payable and Payroll Departments
- Preparation of the annual operating and capital budgets
- Oversee all external financial reporting, audits and taxes
- Ensure adequacy of organization's reserves
- Establish accounting policies and procedures

**Catholic Medical Center**, Manchester, NH
***Director of Accounting***, April 2002 – August 2007

- Prepare financial reporting package and presentation for CFO and Finance Committee
- Ensure financials are prepared in accordance to Generally Accepted Accounting Principles
- Manage Accounting Supervisor, Senior Accountants, Financial Analyst, and Accounts Payable
- Responsible for all external financial reporting (990, Bondholder filings, rating agencies)
- Manage dashboard reporting to directors and senior management
- Preparation of the annual operating and capital budgets
- Analyze adequacy of organization's reserves
- Establish accounting policies and procedures

**Anthem BCBS**, Manchester, NH
***Senior Reimbursement Analyst***, May 2001 – April 2002

- Model proposed reimbursement terms for provider contracting
- Met with providers to negotiate new terms for reimbursement
- Model contract terms for forecasting
- Various data mining projects

**Catholic Medical Center**, Manchester, NH
***Accounting Manager***, November 1998 – May 2001
***Senior Accountant***, April 1997 – November 1998
***Financial Analyst***, May 1994 – April 1997

- Responsible for month-end close and the preparation of Financial Reporting Package for the health system

- Manage staff of 9, which include GL, Fixed Assets, Accounts Payable, Physician Practice and Cashier Staff
- Responsible for the coordination of the year-end audit and workpaper preparation
- Responsible for the preparation of the 990 tax return
- Analyze investment returns and coordinate the changing of investment managers
- Prepare analysis for the reserve for Bad Debt and Charity Care
- Prepare rollforward of unrestricted, temporarily and permanently restricted fund balances
- Prepare price and volume variance analysis

**Hesser College, Inc.**, Manchester, NH
***Staff Accountant***, January 1992 – May 1994
- Analyze, record and report all federal financial aid funding
- Contract with outside agencies for non-federal financial aid
- Responsible for all payroll and human resource functions
- Assist auditors on year-end closing

***Accounts Payable Clerk***, October 1991 – January 1992

**Technical:** Excel, Access, SQL, Powerpoint, Word, Business Objects/Crystal, Monarch, Oracle, Siemens, Infor

**References:** Available upon request

**Resume**

LISA K. MADDEN, MSW, LICSW(MA)

PROFESSIONAL EXPERIENCE

**Southern New Hampshire Health,** Nashua, NH

Associate Vice President of Behavioral Health, 7/15 to present

Executive Director, Region 3 IDN, 2016 to present

Responsible for the oversight of inpatient and outpatient behavioral health services at both the Medical Center and Foundation Medical Partners.

- Support the physicians, allied health professionals and clinicians in the provision of comprehensive behavioral health services including inpatient behavioral health, partial hospital services, substance abuse intensive outpatient services, emergency psychiatric services, integrated care and psychiatric consultation services to Foundation Medical Partners providers.
- Work with the Administrative Lead Team and Community Partners to implement the DSRIP 1115 Waiver as defined by the project plans. Responsible for the coordination of operations, finance, compliance and quality for this project.
- Participate in coalitions, task forces and other forums to assist with developing a collaborative response to the growing mental health and substance abuse issues impacting our community.
- Assist with training the all levels of staff in the health system on issues related to behavioral health.
- Active member of Senior Management for both the Medical Center and Foundation Medical Partners.
- Assist with program development, population health initiatives, value based compensation models of payment, patient centered medical home implementation.

**Center for Life Management,** Derry, NH

Vice President and Chief Operating Officer, 6/05 – 6/15

Responsible for the oversight of efficient operations of outpatient clinical systems of care in accordance with all federal and state requirements.

- Oversee all clinical services for the Community Mental Health Center for Region 10 in New Hampshire. Services include various therapeutic interventions, targeted case management, supported housing, wellness services, integrated care and community support services.
- Established and maintain clinical service goals and incentive pay for performance system within a financially self-sustaining model of care.
- Provide leadership for extensive program development. Responsible for the implementation and expansion of new or existing programs in response to community needs.
- Responsible for monitoring clinical and administrative costs and revenue generation as well as the submission of the annual program budgets to the President and CEO.
- Collaborate with the Vice President of Quality and Compliance to determine the training needs for clinical and administrative staff.
- Assist the President and CEO in developing short and long range strategic plan including program expansions, business development, facilities and capital usage and/or improvements.
- Responsible for the establishment and maintenance of an integrated care model which allows for seamless access to services within the agency, coordination of services with area healthcare providers, as well as provision of behavioral healthcare consultation services at the physicians offices.
- Assisted in the process of consolidating three sites into one new facility in July 2007. Primary responsibility for the expansion of services in Salem in September 2014.
- Worked closely with the COO of a local hospital to develop and expand a long term contract to provide emergency evaluation services at the hospital and to assist with disposition to appropriate level of care.
- Worked extensively with Senior Management to prepare for Medicaid Care Management in New Hampshire. Part of the team that established the first in the state per member per month contract with the MCO's inclusive of incentive metrics.

**Lisa K. Madden, LICSW, LLC**
**Consultant**, 6/04 – 6/05
Independent contractor providing consultation services to a community counseling center and a specialized foster care organization.
Interim Clinic Director, 8/04 – 5/05
Wayside Youth and Family Support, Framingham, MA
Responsible for the turnaround management of a large community counseling center in Framingham. Accomplishments include:
• Reorganized clinical team, supervisory structure and support staff functions
• Implemented necessary performance improvement plans
• Hired staff with significantly increased productivity expectations
• Assisted in the implementation of a new Performance Management and Billing System
• Worked diligently to foster a positive work environment through extensive verbal and written communication; staff involvement in decisions when appropriate; providing direct feedback when necessary; and by providing support. The goal was to foster a positive and cooperative "culture" in the clinic.
• Assisted senior management with budget development.
Clinical Supervisor, 7/04 – 6/05
The Mentor Network, Lawrence MA
• Provide clinical supervision to MSW's seeking independent licensure.
• Provide training and consultation to the staff on such topics as diagnostic evaluations, treatment plans and case presentations.
• Provide group support and trauma debriefing after a critical incident.

**The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)**
**The Family Counseling Center**
**Northeast Regional Clinic Director**, Lawrence, MA 12/99 – 9/03
Responsible for turnaround management of the clinics in the Northeast Region of MSPCC, specifically the cities of Lawrence, Lynn and Lowell. The clinics had been struggling with staff recruitment and retention, reduced revenue, poor management of contracts, as well as significant problems in the medical records department. Responsibilities included budget development, implementation and accountability. Accomplishments include:
• Grew clinical team from 15 to 32 clinicians in three years.
• Developed Multi-Cultural Treatment Team.
• Increased annual third party revenue by 70%; increased annual contract revenue by 65%.
• Contracts with the Department of Social Services; the Department of Mental Health in conjunction with the Professional Parent Advocacy League; the Department of Education and the Community Partnerships for Children and HeadStart.
• Organized a successful site visit for re-licensure from the Department of Public Health (DPH) as well as the Council on Accreditation (COA).
• Reorganized Medical Records to meet DPH and COA standards; reorganize claims support resulting in increased revenue received for services rendered and significantly reduced write-offs.
• Participated on the HIPAA Task force—assisted in the development and implementation of the federally mandated Health Information Portability and Accountability Act policies and procedures for MSPCC.
Clinic Director, Hyannis, MA 9/95-12/99
Responsible for the turnaround management of a regional clinic serving children and families on Cape Cod. The clinic had experienced over 70% turnover, significant reduction in revenue, and a series of very negative stories in the local media because of the agency's response to the implementation of managed care. Responsible for marketing and public relations; redevelopment of a high quality clinical treatment

team; as well as, increasing revenue and program development. Accomplishments include:
• Grew clinical team from 12 to 37 in three years.
• Streamlined intake procedures to increase access to services and reduce wait times.
• Increased annual third party revenue by 80%.
• Developed consultative relationships with two of Cape Cod's most well respected children's services providers.
• Developed first private/public partnership between MSPCC and a private practice to increase the availability of specialty clinical services.
• Developed internship program for Master's level clinician candidates.

**North Essex Community Mental Health Center, (NECMHC, Inc.)**, Newburyport/Haverhill, MA
Employee Assistance Professional, Clinical Social Worker, 9/93-7/95

NECMHC, Inc., Newburyport/Haverhill, MA
Clinical Social Worker – Intern, 5/93-9/93

Worcester Children's Friend Society, Worcester, MA
Clinical Social Worker – Intern, 9/92-4/93

The Jernberg Corporation, Worcester, MA
EAP Case Management Supervisor, 4/90-4/93
EAP Case Manager, 2/89-4/90

The Carol Schmidt Diagnostic Center and Emergency Shelter, YOU, Inc., Worcester, MA, 10/85-2/89
Clinical Counselor I & II

EDUCATION
University of Connecticut, School of Social Work, West Hartford, CT
Masters in Social Work, Casework/Administration, August 1993

Clark University, Worcester, MA
Bachelor of Arts, Government/Human Services, May 1985

PROFESSIONAL LICENSE
Licensed Independent Clinical Social Worker, MA # 1026094

TEACHING
Mental Health Management, New England College, Graduate School
Summer 2007

PUBLICATION
Madden, Lisa K., 2009. Targeted Case Management Implementation at the Center for Life Management, Compliance Watch, volume 2, issue 3, p. 8-10.

References available upon request.

MICHAEL S. ROSE
[redacted]

## PROFESSIONAL EXPERIENCE

**Southern New Hampshire Health System (2007 – Present)**

An integrated delivery network consisting of a 188-bed acute care hospital, 18 bed inpatient behavioral health unit, and a 320 member multi-specialty provider group. Southern New Hampshire Health System employs approximately 2,200 FTEs and maintains an annual operating budget of $355M. A clinical affiliate of Massachusetts General Hospital, Southern New Hampshire Health System is a participant in the Medicare and Cigna Accountable Care Organization programs.

**Chief Executive Officer (July 2016 – Present)**

- Leads an executive steering team and Board of Trustees through an overhaul of strategic direction.
- Reorganized System leadership team promptly filling key positions of CFO, COO, CNO and CMO resulting in the establishment, recruitment and retention of a high performing management team.
- Serves as the prominent and trusted leader of the Granite Healthcare Network resulting in the successful enlistment of Exeter Health Resources (Exeter Hospital) to full member status.
- Acts as the public face of Southern New Hampshire Health System in advocacy and professional circles throughout the region.
- Fosters strong business and clinical ties between executive leadership at tertiary level health systems within the State of New Hampshire and the Commonwealth of Massachusetts.
- Leads significant investment and planning redesigns to establish centers of excellence in the areas of gastroenterology, cardiology and behavioral health.

**Chief Financial Officer (January 2007 – June 2016)**

- Led Granite Healthcare Network in its insurance strategy and cost savings initiatives.
- Provided vision and leadership for a startup New Hampshire health insurance company, Tufts Health Freedom Plan, a joint venture between Tufts Health Plan and Granite Healthcare Network.
- Executed a major corporate restructuring following New Hampshire's defunding of the hospital Medicaid program, resulting in maintenance of profitable operations.
- Participated as a leading voice in the structure and negotiation of the $200MM annual Medicaid settlement with State of New Hampshire.
- Established a clinical affiliation agreement with Massachusetts General Hospital.
- Refocused system performance on growing covered lives as a primary performance indicator resulting in a significant reduction of system dependence on Dartmouth-Hitchcock referrals and rapid growth of an aligned multispecialty physician group.
- Provided sound financial acumen throughout tenure as CFO resulting an increased all-payer case mix index from 1.06 to 1.22, $3MM annual savings from supply chain initiatives and numerous large scale ambulatory development initiatives including a joint venture Ambulatory Surgery Center with St. Joseph's Hospital and Dartmouth-Hitchcock.
- Provided active leadership in all areas of clinical operations and administrative functions.

**Cooper Health System** (2000 – 2006)

Cooper Health System is a 560-bed integrated health system with $650MM annual revenue, 370 employed physicians, 25,000 annual admissions, and 1.2MM annual outpatient visits. Cooper Health System is a core teaching campus for Robert Wood Johnson Medical School.

**Vice President of Finance & Operations, Cooper University Hospital (2003 – 2006)**

- Oversaw all aspects of revenue cycle including physician and hospital patient accounting, admissions, cost reporting, charge master, charge capture and reimbursement.
- Implemented numerous controlling and process measures resulting in three bond upgrades during the period 2003-2005.
- Improved yield on hospital accounts receivable by ~$28.0MM. Reduced days in A/R from 70 to 48.
- Consolidated financial and managerial reporting functions for the Cooper Health System.
- Coordinated $80.0MM tax exempt bond issue, $67.0MM advanced refunding and debt restructure, $5.0MM sale leaseback transaction, $30MM off-balance sheet parking garage.
- Improved investment policy and treasury management, including management of $155MM in construction funds.
- Facilitated numerous practice acquisitions in areas ranging from Radiology to Internal Medicine.

**Senior Vice President/Chief Financial Officer, Cooper University Physicians (2000 – 2003)**

- Oversaw all financial and operational areas of $220MM faculty practice with 370 FTE physicians.
- Increased revenue of $35.0MM and increased margins of $6.0MM.
- Established improved protocols the areas of patient accounting, accounting, finance, business development, accounts payable, cost accounting, financial reporting, budgeting, decision support, and treasury yielding an increase in revenue of $35.0MM and increased margins of $6.0MM.
- Consolidated billing under IDX billing platform, increased collections yield by 10%, generating an additional $8.0MM per year in patient revenue, and reduced days in A/R from 92 to 37.
- Negotiated support agreements with affiliated hospital.
- Secured an additional $6.0MM per year in funding.
- Conducted multiple acquisitions, divestitures, and affiliations with community physician groups.
- Provided analytic and strategic support to the managed care contracting function.
- Designed incentive/compensation program for physicians.
- Developed Cooper Research Institute for clinical trials.

**Virginia Commonwealth University Health System** (1992 – 2000)

**Director of Finance, Medical College of Virginia Physicians (1998 – 2000)**

- Oversaw all financial aspects of $130 million operation with 500 physician multi-specialty academic group practice.
- Developed methodology for capturing and reporting indigent care costs, which aided in obtaining $12 million in additional state funding.

**Director of Operations, Medical College of Virginia Hospital (1997 – 1998)**

- Served as Product Line Administrator for Digestive Diseases, overseeing all fiscal and operational management, and redesigned scheduling system in a manner which optimized facility utilization thereby increasing capacity by approximately 1,000 procedures per year.

**Director of Internal Audit, Medical College of Virginia Physicians (1992 – 1997)**

- Managed Internal Audit function for a multi-specialty, 500 member academic physician practice.
- Coordinated political and legal battle with City of Richmond over disputed business taxes. Succeeded in gaining exempt status resulting in tax savings in excess of $500,000 per year.
- Recommended solutions which resulted in savings which exceeded the departmental operating budget by at least 200% each year.

Commonwealth of Virginia - Auditor of Public Accounts, Staff/Senior Auditor (1989 – 1992)

## RELATED SKILLS AND EXPERIENCE

- Comprehensive Strategic Planning.
- Large Scale Clinical Affiliation Management in Complex Political and Economic Environments.
- Clinical Service Line Development and Ambulatory Network Design.
- Information Technology System Conversions.
- Insurance Strategy for Health Systems.
- Revenue Cycle Management.
- Business Intelligence and Decision Support.
- Payroll and Benefits Administration.
- Managed Care Contracting and Administration.
- Self-insurance for Malpractice, Health Insurance and Equipment Maintenance.
- Debt Financing, Feasibility, Credit Rating Management and Investor Relations.

## EDUCATION AND CERTIFICATIONS

Virginia Commonwealth University Master of Business Administration, 1996
Longwood University Bachelor of Science in Business Administration, Accounting Concentration, 1989
Certified Public Accountant, 1991, State of Virginia, License#15465.

## PUBLICATIONS AND LEGISLATIVE ADVOCACY

- Healthcare Financial Management, "*Providing better care at an affordable cost*", June 2012, p.46-48.
- Medical Group Management Association, "*On with the show, patient no-shows – some surprising findings*", Mike S. Rose and M. Kyue Chung, M.D, January 2003, p. 54-57.
- New Hampshire Task Force for Pricing Transparency.
- New Hampshire MET/DSH Lawsuit – Member Settlement Team.
- New Jersey Medicaid Rate Rebasing Subcommittee.
- New Jersey Department of Banking and Insurance Commission on HMO Claims Processing.
- New Jersey Hospital Association, Subcommittee on NJ Charity Care Funding.
- New Hampshire Medicaid Enhancement Tax Committee.
- Testified before the Virginia General Assembly in support of coverage for colorectal cancer screenings.

## BOARDS AND PROFESSIONAL ASSOCIATIONS

- Rivier University, Board Member, Treasurer, Chair of Finance
- Tufts Health Freedom Plan, Board Member
- Nashua Regional Cancer Center, Board Member, Finance Chair
- Greater Nashua Surgery Center, Board Member, President
- New Hampshire Hospital Association, Board Member
- VHA Northeast Purchasing Coalition, Board Member
- New Hampshire Imaging Alliance, Board Member
- Advantage Physician Hospital Organization, Board Member
- Healthcare Financial Management Association
- Big Brothers, Big Sisters of Greater Nashua
- Nashua Rotary
- Greater Nashua Chamber of Commerce, Board Member

**CONTRACTOR NAME**

Key Personnel

| | | | | |
|---|---|---|---|---|
| Name | Job Title | Salary | % Paid from this Contract | Amount Paid from this Contract |
| Mike Rose | President and CEO | | 0 | 0 |
| Kate Skouteris | Chief Admin. Officer, General Counsel | | 0 | 0 |
| Paul Trainor | CFO | | 0 | 0 |
| Lisa K. Madden | AVP of Behavioral Health | | 0 | 0 |