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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH
BUREAU OF DRUG AND ALCOHOL SERVICES

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6110 1-800-852-3345 Ext. 6738
Fax: 603-271-6105 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 27, 2017

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, Bureau of Drug and Alcohol Services, to enter into an agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, for the provision of integrated obstetric, primary care, pediatric, and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder in an amount not to exceed $2,755,443, effective upon date of Governor and Executive Council approval, through June 30, 2019. 100% Federal Funds.

Funds are available in the following account(s) for SFY 2018 and SFY 2019, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval from Governor and Executive Council.

05-95-92-920510-25590000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, OPIOID STR GRANT

SFY	Class/Account	Class Title	Job Number	Total Amount
2018	102-500731	Contracts for Program Services	92052559	$ 862,630
2019	102-500731	Contracts for Program Services	92052559	$1,892,813
			Total	$2,755,443

EXPLANATION

The purpose of this request is to provide integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. Medication Assisted Treatment services will be integrated with prenatal and postpartum care, and provided with parenting support and education at eight (8) sites across New Hampshire, including sites in

the high need areas of Belknap and Coos Counties where opioid use disorder treatment services are limited.

The Contractor will deliver these services through both a Perinatal Addiction Treatment Program in Lebanon, NH that is integrated with obstetrics/gynecology and pediatric care on-site and at seven (7) other sites which are obstetrical/gynecological practices that are enhanced with Medication Assisted Treatment services and pediatric care.

The State of New Hampshire was awarded funding authorized through the 21st Century CURES Act by the Substance Abuse and Mental Health Services Administration which is overseeing the process for states to receive federal funding through the State Targeted Response to the Opioid Crisis Grants Program. New Hampshire's application is a joint effort by several state agencies and proposes to use evidence-based methods to expand treatment, recovery and prevention services to targeted populations. These critical funds will strengthen established programs that have had a positive impact on the opioid crisis as well as expanding the capacity for programs that have shown promise in helping individuals battling a substance misuse issue and combatting the epidemic in New Hampshire.

In 2016, the State of New Hampshire experienced four hundred eighty-five (485) deaths from drug overdoses. At present, the State is experiencing an increase in the need for population-specific Substance Use Disorder Treatment and Recovery Support Services for pregnant women due to a rise in Neonatal Abstinence Syndrome in infants born to mothers who have used opioids. Babies with this syndrome experience symptoms of drug withdrawal and require special treatment prior to leaving the hospital. It is critical that providers develop integration of services, approaches to meet individual client needs, and approaches to maximize State and Federal dollars to meet the public's demand for these specific services. The services provided by the Contractor will be comprehensive and focused not only on the mother's recovery, but also on ensuring that the infant is receiving the necessary health and social supports and services to mitigate risk associated with maternal opioid use.

Mary Hitchcock Memorial Hospital was selected for this project through a competitive bid process. A Request for Proposals was posted on The Department of Health and Human Services' web site from August 28, 2017 through September 25, 2017. The Department received one (1) proposal. The proposal was reviewed and scored by a team of individuals with program specific knowledge. The review included a thorough discussion of the strengths and weaknesses of the proposals/applications. The Score Summary is attached.

As referenced in the Request for Proposals and in Exhibit C-1, Revisions to General Provisions, of this contract, the Department reserves the option to extend contract services for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council.

Should the Governor and Executive Council not authorize this request, pregnant and postpartum women in New Hampshire diagnosed with opioid use disorder may not receive the support necessary to overcome their addiction which could negatively impact their health and the health of their newborn child(ren).

Area served: Statewide

Source of Funds: 100% Federal Funds from DHHS, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. CFDA #93.788. 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,

Katja S. Fox
Director

Approved by:

Jeffrey A. Meyers
Commissioner

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

Integrated Medication Assisted Treatment for Pregnant and Postpartum Women
RFP Name

RFP-2018-BDAS-05-INTEG
RFP Number

Reviewer Names

1. Jamie Powers, Clinical & Recovery Serv Unit Administrator II, BDAS
2. Rhonda Siegel, Administrator II, DPHS Health Mgmt Ofc
3. Abby Shockley, Senior Policy Analyst, Substance Use Servcs, DPHS
4. Laurie Heath, Business Adminstr III, DBH/BDAS Finance
5. Don Hunter, Planning and Review Analyst, BDAS

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Mary Hitchcock Memorial Hospital		575	444
2. 0		575	0
3. 0		575	0

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

January 3, 2018

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a contract with Mary Hitchcock Memorial Hospital, of Lebanon NH as described below and referenced as DoIT No. 2018-047.

> This is a request to enter into a contract with Mary Hitchcock Memorial Hospital to provide integrated obstetric, primary care, pediatric, and medication assisted treatment for pregnant and postpartum women with substance use disorder (SUD). This will also include utilizing the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions.
>
> The amount of the contract is not to exceed $2,755,443.00, and shall become effective upon the date of Governor and Executive Council approval through June 30, 2019.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/kaf
DoIT #2018-047

cc: Bruce Smith, IT Manager, DoIT

Subject: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women (RFP-2018-BDAS-05-INTEG)

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 NH Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address Dartmouth-Hitchcock One Medical Center Drive Lebanon, NH 03756	
1.5 Contractor Phone Number 603-650-8960	1.6 Account Number 05-95-92-920510-25590000	1.7 Completion Date June 30, 2019	1.8 Price Limitation $2,755,443
1.9 Contracting Officer for State Agency E. Maria Reinemann, Esq. Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9330	
1.11 Contractor Signature Edward J Merrens		1.12 Name and Title of Contractor Signatory Edward Merrens Chief Clinical Officer	

1.13 Acknowledgement: State of New Hampshire, County of Grafton

On 12/15/17, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or ~~Justice of the Peace~~

Faith Johnston

[Seal]

FAITH E. JOHNSTON
MY COMMISSION EXPIRES SEPT. 21, 2021
NOTARY PUBLIC
NEW HAMPSHIRE

1.13.2 Name and Title of Notary or Justice of the Peace

1.14 State Agency Signature Date: 12/28/17	1.15 Name and Title of State Agency Signatory Katja S Fox, Director

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)*

By: Megan A. Lenox-Attorney On: 1/3/18

1.18 Approval by the Governor and Executive Council *(if applicable)*

By: On:

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

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

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

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

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

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

Contractor Initials
Date 12.15.17

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

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

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

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

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

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

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

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

Contractor Initials DM
Date 12-15-17

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

15. WORKERS' COMPENSATION.

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

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

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

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

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

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

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

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

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

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

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

Contractor Initials BM

Date 12·15·17

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

2. Scope of Services

2.1. The Contractor shall provide comprehensive Medication Assisted Treatment (MAT) for pregnant and postpartum women diagnosed with opioid use disorder (OUD) and co-occurring mental health disorders, integrated with prenatal and postpartum care, and provide parenting support and education for parents at eight (8) sites across the State of New Hampshire, including sites in Belknap and Coos Counties.

2.2. The Contractor shall deliver the required services in Lebanon through the Dartmouth Hitchcock (D-H) Perinatal Addiction Treatment Program (PATP), a comprehensive addiction treatment service with integrated obstetrical/gynecological (OB/Gyn) services and pediatric care offered on-site.

2.3. The Contractor shall ensure delivery of the required services at the seven (7) other sites where services shall be offered by OB/Gyn practices that are enhanced with integrated addiction services and pediatric support.

2.4. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall develop an implementation plan with each site to include, but not be limited to:

2.4.1. Training and implementing new practices, using a combination of Contractor staff and the local site to fill key roles.

2.4.2. Migrating the required core staffing to the practice while the Contractor provides ongoing coaching and consultation for complex situations.

2.4.3. Providing or developing, locally, the adjunct services including, but not limited to child supervision, transportation, and case management as required.

2.5. The Contractor shall provide project management, program consultation, and clinical consultation through their D-H Center for Addiction Recovery in Pregnancy and Parenting team to each site.

2.6. The Contractor shall provide services at all eight (8) sites including, but not limited to:

2.6.1. On-site family support for children.

2.6.2. Peer recovery coaches.

2.6.3. Resource/Employment specialists.

2.6.4. Case management/Care coordination.

2.6.5. Parenting education groups.

2.6.6. Health education.

2.6.7. Social supports including, but not limited to access and/or referrals to food, housing, and transportation services.

2.7. The Contractor shall collaborate with Coos County Family Health Services and implement two (2) of the seven (7) enhanced programs in OB/Gyn practices in Laconia and Littleton by providing intensive support to facilitate the development of an integrated perinatal MAT program at each practice.

2.8. The Contractor shall employ a licensed behavioral health clinician whose responsibilities shall include, but not be limited to:

2.8.1. Conducting weekly visits to each practice for the first six (6) months of the contract.

2.8.2. Providing direct clinical services at all sites.

2.8.3. Supporting and mentoring for weekly MAT visits.

2.8.4. Leading group therapy for participating women.

2.8.5. Collaborating with each site to identify or develop behavioral health resources in the local community.

2.9. The Contractor shall ensure each site identifies at least one (1) provider willing to become waivered to prescribe buprenorphine before the project launch and shall provide initial on-site mentoring to waivered providers at each practice, followed by consultative phone calls over a twelve (12)-month period in a frequency determined necessary by the providers and the Contractor.

2.10. The Contractor shall provide services through the D-H PATP which include, but are not limited to:

2.10.1. Collaborating with the Family Resource Centers, whose services include, but are not limited to:

2.10.1.1. Home visiting.

2.10.1.2. Lactation support.

2.10.1.3. Case management.

2.10.2. Providing parent education groups to program participants on a regular basis which integrate the parenting education curriculum with addiction treatment, so that participants have the opportunity to learn about the impact of substance use on family functioning and healthy child development.

2.10.3. Providing educational sessions to all pregnancy groups which include, but are not limited to "The Period of Purple Crying," safe sleep practices, and car seat safety and are integrated with newborn nursery and outpatient pediatric follow up.

2.10.4. Collaborating with Continuum of Care Coordinators as part of Region 1 Integrated Delivery Network (IDN).

2.10.5. Participating in the Boyle Program, which co-sponsors and facilitates the Child Focus Forum, a bi-monthly collaborative of medical, governmental and community agencies serving parents and children.

2.10.6. Offering co-located child "play time," which provides supportive child engagement that allows women to participate fully in group therapy and receive care without distraction.

2.10.7. Sponsoring co-location of resources such as a food pantry, infant books, and diaper bank through active partnerships with community agencies such as The Upper Valley Haven and The Family Place.

2.11. The Contractor shall ensure patient-centered, effective, integrated care and attention to overdose prevention by employing educational materials which include, but are not limited to:

2.11.1. Center for Disease Control (CDC) opioid prescribing guidelines.

2.11.2. Substance Abuse and Mental Health Services Administration's (SAMHSA's) Opioid Overdose Prevention Toolkit.

2.11.3. State-published Guidance Document on Best Practices: Key Components for Delivering Community Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire.

2.11.4. Care guidelines for OB/GYN providers and delivery hospitals developed by the Northern New England Perinatal Quality Improvement Network (NNEPQIN).

2.12. The Contractor shall provide interim OUD treatment services when the needed treatment services are not available to the participant within forty-eight (48) hours of referral.

2.13. The Contractor shall provide OUD treatment services that support the Resiliency and Recovery Oriented Systems of Care (RROSC) by operationalizing the Continuum of Care Model. (More information can be found at http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm.)

2.14. The Contractor shall ensure that participants are able to easily transition between levels of care within a group of services which includes, but is not limited to:

2.14.1. Working with the Continuum of Care Facilitator(s) in the development of a resiliency and recovery oriented system of care (RROSC) in the region(s).

2.14.2. Participating in the Regional Continuum of Care Workgroup(s).

2.14.3. Participating in the Integrated Delivery Network(s) (IDNs).

2.15. The Contractor shall ensure ongoing communication and care coordination with entities involved in the participants' care including child protective services, treatment providers, home visiting services, and pediatric providers.

2.16. The Contractor shall actively participate in the Regional Continuum of Care and IDN Region 1, and maintain good relationships with relevant community partners.

2.17. The Contractor shall assist enhanced sites with creating and hiring for a Recovery Coach position to help participants locate community resources including, but not limited to local recovery centers, peer support meetings, and transitional housing.

2.18. The Contractor shall assist enhanced sites with collaborating with their local/regional Continuum of Care Facilitators and leaders of their regional Integrated Delivery Networks to ensure alignment and coordination across these service networks.

2.19. The Contractor shall collaborate with each enhanced site to modify workflows and electronic records processes to ensure screening and required data collection.

2.20. The Contractor shall modify the obstetrics office electronic health record (EHR) and clinical work flow to ensure required screening activities by OB staff and appropriate required data collection by care coordinators.

2.21. The Contractor shall utilize the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions and shall assess each enhanced site's use and support them to develop protocols to monitor the PDMP regularly.

2.22. The Contractor shall develop and implement outreach activities, which may include marketing designed to engage pregnant women with an OUD in the community. The Contractor and Contractor's sites are not required to market themselves publicly as substance use disorder treatment centers.

2.22.1. The Contractor shall ensure that their staff at the Center for Addiction Recovery in Pregnancy and Parenting collaborate with the appropriate D-H department to develop appropriate materials and methods to promote the program throughout our service areas.

2.22.2. The Contractor shall collaborate with each implementing site to ensure marketing materials, if any, and outreach methods used, are consistent with the Contractor's standards and policies in its discretion.

2.22.3. The Contractor shall actively engage with referral networks in the service areas to increase awareness of the program with pregnant women with OUD and to enable the program to be utilized to its greatest capacity.

2.23. The Contractor shall maintain formal and effective partnerships with behavioral health, OUD specialty treatment and Recovery Support Services (RSS), and medical practitioners to meet the needs of the target population and the goals of MAT Expansion.

2.24. The Contractor shall ensure meaningful input of consumers in program assessment, planning, implementation, and improvement which includes, but is not limited to:

2.24.1. Using their Patient Advisory Board which meets quarterly and is composed of participants in long-term recovery.

2.24.2. Engaging participants in all stages of recovery in the development of key program elements through focus groups and targeted interviews.

2.25. The Contractor shall ensure that treatment is provided in a child-friendly environment with childcare support available to participants which includes, but is not limited to:

2.25.1. Developmentally-appropriate childcare support as well as integration with pediatric and developmental services at all enhanced sites.

2.25.2. Co-located child "Play Time" where children engage in developmentally appropriate play while their mothers participate in group treatment and receive care in both Lebanon and Keene.

2.25.3. On-site well-child care at D-H Lebanon PATP.

2.26. The Contractor shall ensure participants' transportation needs are met to maintain participant involvement in the program by utilizing a Resource Specialist whose duties related to transportation may include, but not be limited to:

2.26.1. Assisting participants to enroll in Medicaid transportation services.

2.26.2. Developing a network of support to help with transportation needs.

2.26.3. Helping participants to attain a valid driver's license or an affordable car loan.

2.26.4. Collaborating with Good News Garage or similar programs.

2.26.5. Finding housing in close proximity to social services.

2.27. The Contractor shall use data to support quality improvement including, but not limited to:

2.27.1. Developing, disseminating, and implementing best practices for pregnant and parenting women with OUD, including, but not limited to hosting monthly webinars related to topics such as screening and treatment of co-occurring psychiatric disorders.

2.27.2. Collecting data on participant demographics and more than thirty (30) key perinatal, neonatal, and treatment outcomes for all program participants, using a REDCap database designed for this purpose.

2.27.2.1. REDCap allows de-identified, participant-level data to be entered remotely by sites.

2.27.2.2. Data shall be entered for each participant from the time of entry into the program until three (3) months postpartum. For example, a participant entering care in the late first trimester, data would entered at entry to care, at 24-28 weeks of pregnancy, at delivery, and at three (3) months postpartum.

2.27.2.3. Data shall be utilized for quality improvement purposes and program evaluation, as well as development of targeted services at all sites.

2.27.3. Collecting data on key measures identified by the Department and the Contractor's multidisciplinary stakeholder group and using the data to track performance.

2.27.3.1. The existing REDCap database shall be expanded as needed to include additional measures identified by the Department.

2.27.3.2. Site specific data shall be reviewed quarterly.

2.27.4. Reporting data to sites quarterly and addressing areas flagged for improvement both directly through discussion and process improvement at the individual practice level and through learning collaborative sessions with multiple practices.

2.27.5. Employing a research assistant to support sites with data entry challenges and ensure data quality.

2.27.6. Analyzing the data and promoting quality improvement efforts.

2.28. The Contractor shall maintain the infrastructure necessary to achieve the goals of MAT Expansion for the target population, to meet SAMHSA requirements, and to deliver effective medical care to pregnant and postpartum women with an OUD.

2.29. The Contractor shall participate in the State-funded "Community of Practice for MAT" along with other State-funded projects which include, but are not limited to:

2.29.1. Project-specific trainings.

2.29.2. Quarterly web-based discussions.

2.29.3. On-site Technical Assistance (TA) visits.

2.29.4. Ad hoc communication with expert consultants on MAT clinical care topics such as Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) prevention, diversion risk mitigation, and other relevant issues.

2.30. The Contractor shall participate in the development of a Safe Plan of Care with birth attendants and the New Hampshire Division of Children, Youth, and Families (DCYF) for each infant affected by illegal substance use, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

2.30.1. The Contractor shall employ a social worker with experience in the Contractor's Child Advocacy and Protection Program.

2.30.2. The Contractor shall ensure that planning and communication regarding the Safe Plan of Care will also involve other community agency supports including, but not limited to home visitation, WIC, housing, and other services central to recovery and parenting.

2.31. The Contractor shall establish formal agreements with hospitals to aid in preparing the hospital system with the clinical policies and procedures necessary to address neonatal abstinence syndrome in the newborn while supporting the mother's recovery.

2.31.1. The Contractor shall engage with the NNEPQIN learning collaborative, the organization that has developed policies and procedures to effectively address neonatal abstinence syndrome while supporting the mother's recovery.

2.32. The Contractor shall have billing capabilities which include, but are not limited to:

2.32.1. Enrolling with Medicaid and other third party payers.

2.32.2. Contracting with managed care organizations and insurance companies for MAT and delivery of prenatal care.

2.32.3. Having a proper understanding of the hierarchy of the billing process.

2.33. The Contractor shall assist the participant with obtaining either on-site or off-site RSS's including, but not limited to:

2.33.1. Transportation.

2.33.2. Childcare.

2.33.3. Peer support groups.

2.33.4. Recovery coach.

2.34. The Contractor shall use the New Hampshire Alcohol and Drug Treatment Locator (http://www.nhtreatment.org) to identify specific services that are available by location, population, and payer to enable patient choice.

2.35. The Contractor shall establish agreements with specialty treatment organizations that can provide higher levels of OUD treatment and co-occurring mental health treatment.

2.36. The Contractor shall deliver parenting and personal development education using evidence-based curriculum including, but not limited to:

2.36.1. Marsha Linehan's Dialectical Behavior Therapy approach to treatment and Lisa Najavits' Seeking Safety curriculum to increase emotion regulation skills in participants to address Post-Traumatic Stress Disorder (PTSD) symptoms and decrease emotional vulnerability that could lead to relapse.

2.36.2. SAMHSA materials, 12-Step information, and other materials that the program has developed to increase participants' knowledge of the disease model of addiction and to enhance understanding of biological vulnerability and the progression of addiction.

2.36.3. Cognitive Behavioral Therapy (CBT), SAMSHA materials, 12-Step materials, and mindfulness-based stress reduction approaches to bolster relapse prevention strategies and improve resiliency.

2.36.4. Duluth Model Domestic Abuse Intervention Programs and Dialectical Behavior Therapy (DBT) to promote healthy relationships and decrease risk of interpersonal violence.

2.36.5. Circle of Security and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curricula to increase parent-child attachment and increase parents' knowledge of healthy child development.

2.37. The Contractor shall improve participants' access to a sober network of support and increased resiliency to relapse which includes, but is not limited to.

2.37.1. Utilizing an on-site Recovery Coach who participates in group therapy sessions and engages one-on-one with participants to provide additional support between sessions.

2.37.2. Inviting representatives from 12-Step groups and peer-run recovery groups on a regular basis to speak to participants.

2.38. The Contractor shall refer relapsing participants to residential or intensive outpatient care and provide support for accessing appropriate services including, but not limited to follow-up care after intensive treatment services are completed.

2.39. The Contractor shall provide parenting supports to participants including, but not limited to:

2.39.1. Parenting groups.

2.39.2. Childbirth education.

2.39.3. Safe sleep education.

2.40. The Contractor shall collaborate with other providers that offer services to pregnant women with an OUD including, but not limited to programs funded by the Cures Act resources for similar populations.

2.41. The Contractor shall ensure compliance with confidentiality requirements, which include, but are not limited to:

2.41.1. Applicable federal and state laws.

2.41.2. HIPAA Privacy Rule.

2.41.3. 42 C.F.R Part 2.

2.41.3.1. The D-H PATP shall be required to follow 42 C.F.R Part 2 rules.

2.41.3.2. The OB/Gyn programs that will be enhanced with integrated addiction services are not required to follow 42 C.F.R. Part 2.

2.42. The Contractor shall participate in all evaluation activities associated with the funding opportunity, including national evaluations.

2.43. The Contractor shall develop and submit a work plan to the Department for review and approval, which describes the process for ensuring the completion of all aspects of the Scope of Services (Section 2), Staffing (Section 3), and Training (Section 4) as outlined in this Contract within thirty (30) days of Governor and Executive Council approval of the Contract. The Contractor shall use four (4) phases when designing the work plan.

2.43.1. Phase 1: The Contractor shall engage in an intensive planning process and simultaneous development of the infrastructure of the Center for Addiction Recovery in Pregnancy and Parenting which will include hiring key staff such as a project manager and gathering more information about the current state at implementation sites.

2.43.2. Phase 2: The Contractor shall solidify services at the D-H Lebanon PATP and D-H Keene so that they fully meet the service requests of this Contract. The Contractor shall also begin the data collection process.

2.43.3. Phase 3: The Contractor shall plan and implement enhanced services at three (3) new sites (Berlin, Manchester, and Nashua).

2.43.4. Phase 4: The Contractor shall use lessons learned from previous implementations to plan and implement enhanced services at the final three (3) sites (Laconia, Littleton, and Dover).

2.44. The Contractor shall maintain policies and procedures and have regular required employee training (at least annually) in the areas of ethical conduct, confidentiality, compliance, cyber security, and conflict of interest.

3. Staffing

3.1. The Contractor shall meet the minimum MAT team staffing requirements to provide the Scope of Services which includes, but is not limited to at least one (1):

3.1.1. Waivered prescriber.

3.1.2. Masters Licensed Alcohol and Drug Counselor (MLADC) or behavioral health provider with addiction training.

3.1.3. Obstetrician or midwife.

3.1.4. Care coordinator.

3.1.5. Non-clinical/administrative staff.

3.2. The Contractor shall ensure that all unlicensed staff providing treatment, education, and/or recovery support services are under the direct supervision of a licensed supervisor.

3.3. The Contractor shall ensure that no licensed supervisor oversees more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.

3.4. The Contractor shall ensure that at least one Certified Recovery Support Worker (CRSW) is available for every fifty (50) participants or portion thereof.

3.5. The Contractor shall ensure that unlicensed staff providing clinical or recovery support services must hold a CRSW within six (6) months of hire or from the effective date of this contract, whichever is later.

4. Training

4.1. The Contractor shall make available initial and on-going training resources to all staff including, but not limited to buprenorphine waiver training for physicians, nurse practitioners, and physician assistants. The Contractor shall develop a plan for Department approval to train and engage appropriate staff.

4.2. The Contractor shall participate in training and technical assistant activities as directed by the Department including, but not limited to the Community of Practice for MAT which may include, but is not limited to:

4.2.1. Project-specific trainings.

4.2.2. Quarterly web-based discussions.

4.2.3. On-site technical assistance visits.

4.2.4. Ad hoc communication with expert consultants regarding MAT clinical care topics including, but not limited to:

4.2.4.1. HCV and HIV prevention.

4.2.4.2. Diversion risk mitigation.

4.2.4.3. Other relevant issues.

4.3. The Contractor shall train staff on relevant topics which may include, but are not limited to:

4.3.1. Integrated care.

4.3.2. Trauma-informed care.

4.3.3. MAT (e.g. prescriber training for buprenorphine).

4.3.4. Care coordination.

4.3.5. Trauma-informed wrap around care/RSS delivery best practices.

4.3.6. Evidence-Based Practices (EBPs) such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

4.3.7. Buprenorphine waiver trainings, available locally and at websites including, but not limited to:

4.3.7.1. https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

4.3.7.2. https://www.asam.org/education/live-online-cme/buprenorphine-course

4.3.7.3. https://aanp.inreachce.com/Details?groupId=714cb0a9-73b2-4daf-8382-27cbdb70ef5a

4.3.8. Cognitive behavioral therapy, dialectical behavior therapy, motivational enhancement therapy, mindfulness, and relapse prevention.

4.4. The Contractor shall provide ongoing supervision for buprenorphine prescribers with access to consultation from experienced providers.

4.5. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall offer online training, CME/CNE events, and monthly learning collaboratives to each practice including, but not limited to:

4.5.1.1. Two (2) hour initial in-service training in preparation for opening clinic regarding providing trauma-informed and recovery-friendly care.

4.5.1.2. Toolkit of training materials.

4.5.1.3. Weekly team meetings on day of clinic facilitated by the behavioral health clinician.

4.5.1.4. Monthly webinar learning collaboratives for all participating practices with rotating topics

4.5.1.5. Quarterly in-person gatherings for all participating practices, focused on relationship building and sharing of experiences, hosted at rotating locations to maximize participation.

4.5.1.6. Annual CME event aimed at all staff involved in this model of care.

4.6. The Contractor shall provide assistance to all sites regarding training and logistics for the distribution of naloxone kits to patients and family members.

4.7. The Contractor shall assist practice staff in attending the following externally provided formal trainings:

4.7.1. CRSW training for prospective Recovery Coaches

4.7.2. Circle of Security training for BHCs and Recovery Coaches

4.7.3. Buprenorphine training for MDs/PAs/ARNPs

4.7.4. Smoking cessation training for any interested staff

4.7.5. Motivational Interviewing training for any interested staff

4.7.6. Additional trainings on trauma-informed care and other evidence based treatment strategies as indicated

5. Reporting

5.1. The Contractor shall gather, monitor, and submit data to the Department monthly. Participant data will be submitted in de-identified, aggregate form to the Department using a Department-approved method. The data being collected includes all data points required in the Treatment Episode Data for Admissions which includes, but is not limited to:

5.1.1. Treatment Setting

5.1.2. Number of prior treatment episodes

5.1.3. Primary source of referral

5.1.4. Age at admission

5.1.5. Pregnancy status

5.1.6. Race/Ethnicity

5.1.7. Education

5.1.8. Employment status

5.1.9. Primary substance

5.1.10. Route of administration

5.1.11. Frequency of use

5.1.12. Age at first use

5.1.13. Co-Occurring Substance Abuse and Mental Health Status

5.1.14. Veteran status

5.1.15. Living arrangements

5.1.16. Primary source of income

5.1.17. Health insurance status

5.1.18. Primary source of payment

5.1.19. Details for those not-in-labor-force

5.1.20. Marital status

5.1.21. Days waiting to enter treatment

5.1.22. Number of arrests in past 30 days

5.1.23. Frequency at self-help programming 30 days prior to admission

5.2. The Contractor shall report on federally-required data points specific to this funding opportunity quarterly and send the results in de-identified, aggregate form to the Department using a Department-approved method. The required data points include, but are not limited to:

5.2.1. Number of participants with OUD's:

5.2.1.1. In total.

5.2.1.2. Receiving integrated MAT with prenatal care.

5.2.1.3. Receiving care coordination/case management.

5.2.1.4. Receiving peer recovery support services.

5.2.1.5. Participating in parenting education programming.

5.2.1.6. Referred to or placed in recovery housing.

5.2.1.7. Referred to higher levels of care.

5.2.2. Number of providers in the program implementing MAT.

5.2.3. Number of OUD prevention and treatment providers trained by the program including, but not limited to Nurse Practitioners, Physician's Assistants, physicians, nurses, counselors, social workers, and case managers.

5.2.4. Numbers and rates of opioid overdose-related deaths within population served.

5.2.5. Number of children receiving childcare services by MAT program.

5.2.6. Number of infants in the program born with NAS not attributable to the mother taking prescribed MAT medications.

5.2.7. Number of referrals made to DCYF for substance-exposed infants not attributable to the mother taking prescribed MAT medications.

5.3. The Contractor shall require that all MAT-providing implementation sites report on the data points specified by the Department, utilizing a standardized protocol.

5.3.1. Each site will have exclusive access to protected health information for its own participants, and REDCap will be used to facilitate reporting of de-identified, aggregated data.

5.3.2. The Contractor shall provide a research assistant to help sites develop and implement appropriate site-specific data collection strategies to ensure compliance with reporting protocols.

5.4. The Contractor shall provide a final report to the Department within thirty (30) days of the termination of the contract which will include the following de-identified information based on the work plan progress, but shall not be limited to:

5.4.1. Policies and practices established.

5.4.2. Outreach activities.

5.4.3. Demographics of participants.

5.4.4. Outcome data (as directed by the Department).

5.4.5. Participant satisfaction.

5.4.6. Description of challenges encountered and action taken.

5.4.7. Other progress to date.

5.4.8. A sustainability plan to continue to provide MAT services to the target population beyond the completion date of the contract, subject to approval by the Department.

6. Performance Measures

6.1. The following aggregate performance indicators are to be annually achieved and monitored monthly to measure the effectiveness of the agreement:

6.1.1. The Contractor shall ensure that fifty percent (50%) of women referred to the program who consent to treatment and qualify based on clinical evaluation will enter OUD treatment as reported by the Contractor.

6.1.2. The Contractor shall ensure seventy-five percent (75%) of women identified by ASAM criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.

6.1.3. The Contractor shall attempt to ensure that NAS rates of infants born to mothers served in this program not attributable to the mother taking MAT medications as prescribed will decline by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.4. The Contractor shall attempt to lower positive urine drug screens for illicit substances for pregnant women served in this program by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.5. The Contractor shall seek to help lower reports to DCYF of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed by five percent (5%) from SFY18 to SFY19. This performance measure will be reported by the Contractor and through the use of collected hospital and DCYF data.

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

Methods and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Form P-37, Block 1.8, Price Limitation for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. The Contractor agrees to provide the services in Exhibit A, Scope of Service in compliance with funding requirements. Failure to meet the scope of services may jeopardize the funded contractor's current and/or future funding.
3. This contract is funded with funds from the US Department of Health and Human Services, Substance Abuse and Mental Health Administration, Catalog of Federal Domestic Assistance (CFDA #) 93.788, Federal Award Identification Number (FAIN) TIO80246.
4. Payment for said services shall be made monthly as follows:
   - 4.1. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this agreement, and shall be in accordance with the approved line item.
   - 4.2. The Contractor will submit an invoice in a form satisfactory to the State by the twentieth (20th) working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The invoice must be completed, signed, dated, and returned to the Department in order to initiate payment. The Contractor agrees to keep records of their activities related to Department programs and services.
   - 4.3. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available. Contractors will keep detailed records of their activities related to DHHS-funded programs and services.
   - 4.4. The final invoice shall be due to the State no later than forty (40) days after the contract Form P-37, Block 1.7 Completion Date.
   - 4.5. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to:

     Department of Health and Human Services
     Division of Behavioral Health
     129 Pleasant Street
     Concord, NH 03301
     Email addresses: laurie.heath@dhhs.nh.gov AND abby.shockley@dhhs.nh.gov
   - 4.6. Payments may be withheld pending receipt of required reports or documentation as identified in Exhibit A, Scope of Services, and in this Exhibit B.
5. Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts between budget line items, related items, amendments of related budget exhibits within the price limitation, and to adjusting encumbrances between State Fiscal Years, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B-1
Budget for SFY 2018

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: January 1, 2018 - June 30, 2018

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	**Direct Incremental**	**Indirect Fixed**	**Total**	**Direct Incremental**	**Indirect Fixed**	**Total**	**Direct Incremental**	**Indirect Fixed**	**Total**
1. Total Salary/Wages	$ 336,926	$ 98,719	$ 435,645	$ -	$ -	$ -	$ 336,926	$ 98,719	$ 435,645
2. Employee Benefits	$ 87,361	$ 25,597	$ 112,958	$ -	$ -	$ -	$ 87,361	$ 25,597	$ 112,958
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 60,000	$ 17,580	$ 77,580	$ -	$ -	$ -	$ 60,000	$ 17,580	$ 77,580
Office	$ 16,500	$ 4,835	$ 21,335	$ -	$ -	$ -	$ 16,500	$ 4,835	$ 21,335
6. Travel	$ 10,000	$ 2,930	$ 12,930	$ -	$ -	$ -	$ 10,000	$ 2,930	$ 12,930
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 4,000	$ 1,172	$ 5,172	$ -	$ -	$ -	$ 4,000	$ 1,172	$ 5,172
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 50,000	$ 14,650	$ 64,650	$ -	$ -	$ -	$ 50,000	$ 14,650	$ 64,650
11. Staff Education and Training	$ 40,000	$ 11,720	$ 51,720	$ -	$ -	$ -	$ 40,000	$ 11,720	$ 51,720
12. Subcontracts/Agreements	$ 73,315	$ 7,325	$ 80,640	$ -	$ -	$ -	$ 73,315	$ 7,325	$ 80,640
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ 678,102**	**$ 184,528**	**$ 862,630**	**$ -**	**$ -**	**$ -**	**$678,102**	**$184,528**	**$862,630**
Indirect As A Percent of Direct		27.2%							

Contractor Initials _____

Date 9.15.17

Exhibit B-2
Budget for SFY 2019

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: July 1, 2018 -June 30, 2019

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 866,506	$ 253,886	$ 1,120,392	$ -	$ -	$ -	$ 866,506	$ 253,886	$ 1,120,392
2. Employee Benefits	$ 229,427	$ 67,222	$ 296,649	$ -	$ -	$ -	$ 229,427	$ 67,222	$ 296,649
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Lab		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 5,000	$ 1,465	$ 6,465	$ -	$ -	$ -	$ 5,000	$ 1,465	$ 6,465
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 40,000	$ 11,720	$ 51,720	$ -	$ -	$ -	$ 40,000	$ 11,720	$ 51,720
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 4,000	$ 1,172	$ 5,172	$ -	$ -	$ -	$ 4,000	$ 1,172	$ 5,172
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 1,500	$ 440	$ 1,940	$ -	$ -	$ -	$ 1,500	$ 440	$ 1,940
11. Staff Education and Training	$ 7,500	$ 2,198	$ 9,698	$ -	$ -	$ -	$ 7,500	$ 2,198	$ 9,698
12. Subcontracts/Agreements	$ 378,803	$ 21,975	$ 400,778	$ -	$ -	$ -	$ 378,803	$ 21,975	$ 400,778
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ 1,532,736**	**$ 360,077**	**$ 1,892,813**	**$ -**	**$ -**	**$ -**	**$1,532,736**	**$360,077**	**$1,892,813**
Indirect As A Percent of Direct		23.5%							

Contractor Initials _____
Date 9.15.17

SPECIAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

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

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

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

DEPARTMENT: NH Department of Health and Human Services.

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

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

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

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

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

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

Exhibit C-1

REVISIONS TO GENERAL PROVISIONS

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

   4. CONDITIONAL NATURE OF AGREEMENT.

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

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

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

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

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

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

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

3. Extension:

   The Department reserves the right to renew the Contract for up to two (2) additional years, subject to the continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

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

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

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

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

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

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

Contractor Name:

12.15.17
Date

Edward Merrens
Name:
Title: Chief Clinical Officer

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Contractor Name:

12.15.17
Date

Edward J Memos
Name:
Title:

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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

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

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

Contractor Name:

12.15.17
Date

Edward J Mercer
Name:
Title:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contractor Name:

12.15.17
Date

Name:
Title:

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Contractor Name:

12.15.17
Date

Name:
Title:

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:

12.15.17
Date

Name:
Title:

FORM A

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

1. The DUNS number for your entity is: 06-99102-97

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: _____

DHHS INFORMATION SECURITY REQUIREMENTS

1. Confidential Information: In addition to Paragraph #9 of the General Provisions (P-37) for the purpose of this RFP, the Department's Confidential information 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 Personal Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

2. The vendor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services. Minimum expectations include:

   2.1. 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.).

   2.2. Maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

   2.3. Encrypt, at a minimum, any Department confidential data stored on portable media, e.g., laptops, USB drives, as well as when transmitted over public networks like the Internet using current industry standards and best practices for strong encryption.

   2.4. 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.

   2.5. Provide security awareness and education for its employees, contractors and sub-contractors in support of protecting Department confidential information

   2.6. Maintain a documented breach notification and incident response process. The vendor will contact the Department within twenty-four 24 hours to the Department's contract manager, and additional email addresses provided in this section, of 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.

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

      Breach notifications will be sent to the following email addresses:

      2.6.1.1. DHHSChiefInformationOfficer@dhhs.nh.gov

      2.6.1.2. DHHSInformationSecurityOffice@dhhs.nh.gov

   2.7. If the vendor will maintain any Confidential Information on its systems (or its sub-contractor systems), the vendor 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 vendor 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, or otherwise physically destroying the media (for example, degaussing). The vendor 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 vendor prior to destruction.

2.8. If the vendor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the vendor 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 vendor, including breach notification requirements.

3. The vendor 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 vendor and any applicable sub-contractors prior to system access being authorized.

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

5. The vendor will work with the Department at its request to complete a survey. The purpose of the survey is to enable the Department and vendor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the vendor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the vendor, or the Department may request the survey be completed when the scope of the engagement between the Department and the vendor changes. The vendor 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 appropriate authorized data owner or leadership member within the Department.

State of New Hampshire
Department of State

CERTIFICATE

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

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

William M. Gardner
Secretary of State

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

CERTIFICATE OF VOTE/AUTHORITY

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 15th day of December 2017

Anne-Lee Verville, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 15th day of December 2017 by Anne-Lee Verville.

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

Notary Public
My Commission Expires: April 19, 2022

CERTIFICATE OF INSURANCE

DATE: June 12, 2017

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

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

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

COVERAGES

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

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002017-A	07/01/2017	06/30/2018	EACH OCCURRENCE	$1,000,000
					PRODUCTS-COMP/OP AGGREGATE	
X	CLAIMS MADE				PERSONAL ADV INJURY	
					GENERAL AGGREGATE	$3,000,000
	OCCURRENCE				FIRE DAMAGE	
OTHER					MEDICAL EXPENSES	
PROFESSIONAL LIABILITY					EACH CLAIM	
	CLAIMS MADE				ANNUAL AGGREGATE	
	OCCURENCE					
OTHER						

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

Certificate of Insurance issued as evidence of insurance.

CERTIFICATE HOLDER

DHHS
129 Pleasant Street
Concord, NH 03301

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

AUTHORIZED REPRESENTATIVES

DARTHIT-01 DMCDONALD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/15/2017

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

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

PRODUCER License # 1780862
HUB International New England
299 Ballardvale Street
Wilmington, MA 01887

CONTACT NAME: Dan McDonald
PHONE (A/C, No, Ext): (508) 808-7293 FAX (A/C, No): (866) 235-7129
E-MAIL ADDRESS: dan.mcdonald@hubinternational.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Safety National Casualty Corporation	15105
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Dartmouth-Hitchcock Health
1 Medical Center Dr.
Lebanon, NH 03756

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			AGC4057405	07/01/2017	07/01/2018	X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH)		N / A				E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
John Zawlinski

Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

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

Our Vision

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

Values

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

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2016 and 2015

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2016 and 2015

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Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and Subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the consolidated financial statements of The Cheshire Medical Center, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 8.8% and 9.7% of consolidated total assets at June 30, 2016 and 2015, respectively, and total revenues of 9.2% and 3.5%, respectively, of consolidated total revenues for the years then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for The Cheshire Medical Center, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

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

pwc

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of June 30, 2016 and 2015, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2016

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Assets		
Current assets		
Cash and cash equivalents	$ 40,592	$ 38,909
Patient accounts receivable, net of estimated uncollectibles of $118,403 and $92,532 at June 30, 2016 and 2015 (Note 4)	260,988	204,272
Prepaid expenses and other current assets	95,820	100,586
Total current assets	397,400	343,767
Assets limited as to use (Notes 5, 7, and 10)	592,468	620,425
Other investments for restricted activities (Notes 5 and 7)	142,036	132,016
Property, plant, and equipment, net (Note 6)	612,564	601,355
Other assets	91,199	88,450
Total assets	$ 1,835,667	$ 1,786,013
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 18,307	$ 17,179
Line of credit (Note 13)	36,550	1,200
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,176	3,249
Accounts payable and accrued expenses (Note 13)	107,544	120,221
Accrued compensation and related benefits	103,554	94,864
Estimated third-party settlements (Note 4)	30,550	36,599
Total current liabilities	299,681	273,312
Long-term debt, excluding current portion (Note 10)	629,274	575,484
Insurance deposits and related liabilities (Note 12)	56,887	62,356
Interest rate swaps (Notes 7 and 10)	28,917	24,740
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	272,493	190,280
Other liabilities	58,911	56,109
Total liabilities	1,346,163	1,182,281
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)		
Net assets		
Unrestricted (Note 9)	360,183	474,194
Temporarily restricted (Notes 8 and 9)	75,731	76,457
Permanently restricted (Notes 8 and 9)	53,590	53,081
Total net assets	489,504	603,732
Total liabilities and net assets	$ 1,835,667	$ 1,786,013

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Unrestricted revenue and other support		
Net patient service revenue, net of provision for bad debt ($55,121 and $17,562 in 2016 and 2015), (Notes 1 and 4)	$ 1,634,154	$ 1,380,559
Contracted revenue (Note 2)	65,982	80,835
Other operating revenue (Note 2 and 5)	82,352	82,993
Net assets released from restrictions	9,219	15,637
Total unrestricted revenue and other support	1,791,707	1,560,024
Operating expenses		
Salaries	872,465	778,387
Employee benefits	234,407	214,627
Medical supplies and medications	309,814	219,967
Purchased services and other	255,141	218,704
Medicaid enhancement tax (Note 4)	58,565	51,996
Depreciation and amortization	80,994	67,213
Interest (Note 10)	19,301	18,442
Total operating expenses	1,830,687	1,569,336
Operating loss	(38,980)	(9,312)
Nonoperating gains (losses)		
Investment losses (Notes 5 and 10)	(20,103)	(11,015)
Other losses	(3,845)	(1,241)
Contribution revenue from acquisition (Note 3)	18,083	92,499
Total nonoperating (losses) gains, net	(5,865)	80,243
(Deficiency) excess of revenue over expenses	$ (44,845)	$ 70,931

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Unrestricted net assets		
(Deficiency) excess of revenue over expenses	$ (44,845)	$ 70,931
Net assets released from restrictions	3,248	2,411
Change in funded status of pension and other postretirement benefits (Note 11)	(66,541)	(60,892)
Change in fair value of interest rate swaps (Note 10)	(5,873)	(931)
(Decrease) increase in unrestricted net assets	(114,011)	11,519
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	12,227	10,625
Investment gains	518	1,797
Change in net unrealized gains on investments	(1,674)	(1,619)
Net assets released from restrictions	(12,467)	(18,048)
Contribution of temporarily restricted net assets from acquisition	670	19,038
(Decrease) increase in temporarily restricted net assets	(726)	11,793
Permanently restricted net assets		
Gifts and bequests	699	389
Investment losses in beneficial interest in trust	(219)	(187)
Contribution of permanently restricted net assets from acquisition	29	16,610
Increase in permanently restricted net assets	509	16,812
Change in net assets	(114,228)	40,124
Net assets		
Beginning of year	603,732	563,608
End of year	$ 489,504	$ 603,732

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Cash flows from operating activities		
Change in net assets	$ (114,228)	$ 40,124
Adjustments to reconcile change in net assets to net cash (used) provided by operating and nonoperating activities		
Change in fair value of interest rate swaps	4,177	(104)
Provision for bad debt	55,121	17,562
Depreciation and amortization	81,138	67,414
Contribution revenue from acquisition	(18,782)	(128,147)
Change in funded status of pension and other postretirement benefits	66,541	60,892
Loss on disposal of fixed assets	2,895	670
Net realized losses and change in net unrealized losses on investments	27,573	15,795
Restricted contributions	(4,301)	(11,040)
Proceeds from sale of securities	496	723
Changes in assets and liabilities		
Patient accounts receivable, net	(101,567)	(17,151)
Prepaid expenses and other current assets	4,767	9,165
Other assets, net	2,188	(4,388)
Accounts payable and accrued expenses	(23,668)	(5,169)
Accrued compensation and related benefits	5,343	8,684
Estimated third-party settlements	(3,652)	2,637
Insurance deposits and related liabilities	(14,589)	(17,177)
Liability for pension and other postretirement benefits	15,599	(25,471)
Other liabilities	2,109	(669)
Net cash (used) provided by operating and nonoperating activities	(12,840)	14,350
Cash flows from investing activities		
Purchase of property, plant, and equipment	(73,021)	(87,196)
Proceeds from sale of property, plant, and equipment	612	1,533
Purchases of investments	(67,117)	(166,589)
Proceeds from maturities and sales of investments	66,105	195,950
Cash received through acquisition	12,619	29,914
Net cash used by investing activities	(60,802)	(26,388)
Cash flows from financing activities		
Proceeds from line of credit	140,600	60,904
Payments on line of credit	(105,250)	(60,700)
Repayment of long-term debt	(104,343)	(54,682)
Proceeds from issuance of debt	140,031	43,452
Payment of debt issuance costs	(14)	6
Restricted contributions	4,301	11,040
Net cash provided by financing activities	75,325	20
Increase (decrease) in cash and cash equivalents	1,683	(12,018)
Cash and cash equivalents		
Beginning of year	38,909	50,927
End of year	$ 40,592	$ 38,909
Supplemental cash flow information		
Interest paid	$ 22,298	$ 21,659
Asset (depreciation) appreciation due to affiliations	(960)	15,596
Construction in progress included in accounts payable and accrued expenses	16,427	12,259
Equipment acquired through issuance of capital lease obligations	2,001	1,741
Donated securities	688	685

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

1. Organization and Community Benefit Commitments

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

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

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

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

Fiscal year 2016 includes a full year of operations of D-HH, D-H, NLH, MAHHC, Cheshire and four months of operations of APD. Fiscal year 2015 includes a full year of operations of D-HH, D-H, NLH, MAHHC and four months of operations of Cheshire.

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

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

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

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

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

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

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

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

- *Charity care (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2016 and 2015, the Health System provided financial assistance to patients in the amount of approximately $30,637,000 and $50,076,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2016 and 2015 was approximately $12,257,000 and $18,401,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.

  Charity care provided by the Health System decreased by approximately $19,400,000 from 2015 to 2016. This change was due to the implementation of the Federal Exchange in December of 2013 and the NH Medicaid Expansion Plan in August of 2014. The Health System began to experience decreases in uninsured patients and increases in patients covered by the Federal Exchange NH in summer of calendar 2015 (fiscal year 2015) which continued to decrease as more NH uninsured and underinsured patients were able to receive coverage by the Federal or NH Medicaid plans specifically impacting fiscal 2016.

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

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2015 was approximately $146,758,000. The 2016 Community Benefits Reports are expected to be filed in February 2017.

The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2015:

(Unaudited, in thousands of dollars)

Community health services	$	4,373
Health professional education		30,157
Subsidized health services		13,645
Research		5,361
Financial contributions		5,829
Community building activities		623
Community benefit operations		582
Charity care		18,401
Government-sponsored healthcare services		258,189
Total community benefit value	$	337,160

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the years ended June 30, 2016 and 2015, the Health System reported a provision for bad debt expense of approximately $55,121,000 and $17,562,000, respectively.

2. Summary of Significant Accounting Policies

Basis of Presentation

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

Use of Estimates

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

(Deficiency) Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include (deficiency) excess of revenue over expenses. Operating revenues consist of those items attributable to the care of

patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisitions, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

per share or its equivalent as a practical expedient, subject to the Health System's ability to redeem its investment.

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

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

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

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

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

Trade Names
The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $2,700,000 as intangible assets associated with its affiliations as of June 30, 2016 and 2015. There were no impairment charges recorded for the years ended June 30, 2016 and 2015.

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

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

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

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

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

Reclassifications
Certain amounts in the 2015 consolidated financial statements have been reclassified to conform to the 2016 presentation. In 2016 the presentation of net assets released from restrictions was changed from a single line presentation in the consolidated statement of operations to one in which the net assets released from restriction are classified in their natural expense classifications.

Recently Issued Accounting Pronouncements
In May 2014, the Financial Accounting Standards Board (FASB) issued ASU 2014-09 - Revenue from Contracts with Customers at the conclusion of a joint effort with the International Accounting Standards Board to create common revenue recognition guidance for U.S. GAAP and international accounting standards. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services, by allocating transaction price to identified performance obligations, and recognizing that revenue as performance obligations are satisfied. Qualitative and quantitative disclosures will be required to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The original standard was effective for fiscal years beginning after December 15, 2016; however, in July 2015, the FASB approved a one-year deferral of this standard, with a new effective date for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System. The Health System is evaluating the impact this will have on the consolidated financial statements.

In May 2015, the FASB issued ASU 2015-07- Disclosures for Certain Entities That Calculate Net Asset Value per Share (or its Equivalent), which removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using net asset value per share as the practical expedient. This guidance is effective in fiscal year 2017. The Health System is evaluating the impact this will have on the consolidated financial statements.

In April 2015, the FASB issued ASU 2015-03 - Imputation of Interest: Simplifying the Presentation of Debt Issuance Costs, which requires all costs incurred to issue debt to be presented in the balance sheet as a direct deduction from the carrying value of the associated debt liability. This guidance is effective for fiscal years beginning after December 15, 2015, or fiscal 2017 for the Health System. The Health System is evaluating the impact this will have on the consolidated financial statements.

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

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

beginning after December 15, 2018 or fiscal year 2020 for the Health System. The provision to eliminate the requirement to disclose the fair value of financial instruments measured at cost (such as the fair value of debt) may be early adopted. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14 - Presentation of Financial Statements for Not-for-Profit Entities, which makes targeted changes to the not-for-profit financial reporting model. The new ASU marks the completion of the first phase of a larger project aimed at improving not-for-profit financial reporting. Under the new ASU, net asset reporting will be streamlined and clarified. The existing three-category classification of net assets will be replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property, plant, and equipment have also been simplified and clarified. New disclosures will highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. Not-for-profits will continue to have flexibility to decide whether to report an operating subtotal and if so, to self-define what is included or excluded. However, if the operating subtotal includes internal transfers made by the governing board, transparent disclosure must be provided. The ASU also imposes several new requirements related to reporting expenses, including providing information about expenses by their natural classification. The ASU is effective for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System and early adoption is permitted. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

3. Acquisitions

Effective March 1, 2016, D-HH became the sole corporate member of APD through an affiliation agreement. APD is a not-for-profit corporation providing inpatient and outpatient services to residents of the Upper Valley in NH and VT. APD has a fiscal year end of September 30.

The D-HH 2016 consolidated financial statements reflect four months of activity for APD beginning March 1, 2016.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, The Health System recorded contribution income of approximately $18,782,000 reflecting the fair value of the contributed net assets of APD, on the transaction date. Of this amount $18,083,000 represents unrestricted net assets and is included as a nonoperating gain in the accompanying consolidated statement of operations. Restricted contribution income of $670,000 and $29,000 was recorded within temporarily and permanently net assets, respectively in the accompanying consolidated statement of changes in net assets. No consideration was exchanged for the net assets contributed and acquisition costs are expensed as incurred.

The fair value of assets, liabilities, and net assets contributed by APD at March 1, 2016 were as follows:

(in thousands of dollars)

Assets		
Cash and cash equivalents	$	12,619
Patient accounts receivable, net		10,271
Property, plant, and equipment, net		16,600
Other assets		4,939
Estimated third-party settlements		2,397
Total assets acquired	$	46,826
Liabilities		
Accounts payable and accrued expenses	$	6,823
Accrued compensation and related benefits		3,347
Long-term debt		17,181
Other liabilities		693
Total liabilities assumed		28,044
Net Assets		
Unrestricted		18,083
Temporarily restricted		670
Permanently restricted		29
Total net assets		18,782
Total liabilities and net assets	$	46,826

A summary of the financial results of APD included in the consolidated statement of operations and changes in net assets for the period from the date of acquisition March 1, 2016 through June 30, 2016 is as follows:

(in thousands of dollars)

Total operating revenues	$	20,973
Total operating expenses		21,374
Operating gain		(401)
Nonoperating gains		235
Excess of revenue over expenses		(166)
Net assets transferred to affiliate		18,782
Changes in temporarily and permanently net assets		24
Increase in net assets	$	18,640

A summary of the consolidated financial results of the Health System for the years ended June 30, 2016 and 2015 as if the transactions had occurred on July 1, 2014 are as follows (unaudited):

(in thousands of dollars)	2016	2015
Total operating revenues	$ 1,835,177	$ 1,658,250
Total operating expenses	1,872,167	1,671,124
Operating loss	(36,990)	(12,874)
Nonoperating gains	(6,045)	81,277
(Deficiency) excess of revenue over expenses	(43,035)	68,403
Net assets released from restriction used for capital purchases	3,248	2,411
Change in funded status of pension and other post retirement benefits	(66,541)	(65,128)
Change in fair value on interest rate swaps	(5,873)	(931)
(Decrease) increase in unrestricted net assets	$ (112,201)	$ 4,755

4. Patient Service Revenue and Accounts Receivable

Patient service revenue is reported net of contractual allowances and the provision for bad debts as follows for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Gross patient service revenue	$ 4,426,305	$ 3,656,514
Less: Contractual allowances	2,737,030	2,258,393
Provision for bad debt	55,121	17,562
Net patient service revenue	$ 1,634,154	$ 1,380,559

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

Accounts receivable, prior to adjustment for estimated uncollectibles, are summarized as follows at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Receivables		
Patients	$ 126,320	$ 123,881
Third-party payors	244,716	171,141
Nonpatient	8,355	1,782
	$ 379,391	$ 296,804

The allowance for estimated uncollectibles is $118,403,000 and $92,532,000 as of June 30, 2016 and 2015.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2016 and 2015:

	2016	2015
Medicare	42 %	40 %
Anthem/blue cross	19	21
Commercial insurance	22	20
Medicaid	14	15
Self-pay/other	3	4
	100 %	100 %

The Health System has agreements with third-party payors that provide for payments at amounts different from their established rates. A summary of the acute care payment arrangements in effect during the years ended June 30, 2016 and 2015 with major third-party payors follows:

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

Certain of the Health System's affiliates qualify as Critical Access Hospitals (CAH), which are reimbursed by Medicare at 101% (subject to sequestration of 2%) of reasonable costs for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. They are reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. The nursing home and the rehabilitation distinct-

part-unit are not impacted by CAH designation. Medicare reimburses both services based on an acuity driven prospective payment system with no retrospective settlement.

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

During the years ended June 30, 2016 and 2015, the Health System recorded State of NH Medicaid Enhancement Tax (MET) and State of VT Provider Tax of $58,565,000 and $51,996,000, respectively. The taxes are calculated at 5.5% for NH and 6% for VT of certain net patient revenues in accordance with instructions received from the States. The provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax "SB 369". As part of the agreement the parties have agreed to resolve all pending litigation related to MET and Medicaid Rates, including the Catholic Medical Center Litigation, the Northeast Rehabilitation Litigation, 2014 DRA Refund Requests, and the State Rate Litigation. As part of the Medicaid Enhancement Tax Agreement Effective July 1, 2014, a "Trust / Lock Box" dedicated fund mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services. During the years ended June 30, 2016 and 2015, the Health System received disproportionate share hospital (DSH) payments of approximately $56,718,000 and $10,152,000, respectively which is included in Net Patient Service Revenue in the consolidated statement of operations and changes in net assets.

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the American Recovery and Reinvestment Act (ARRA) provides incentives for the adoption and use of health information technology by Medicare and Medicaid providers and eligible professionals over the next several years with an anticipated end date of December 31, 2016, depending on the program. The Health System has recognized $2,330,000 and $4,175,000 in meaningful use incentives for both the Medicare and VT Medicaid programs during the years ended June 30, 2016 and 2015, respectively.

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

Other

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

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

The Health System has provided for its estimated final settlements with all payors based upon applicable contracts and reimbursement legislation and timing in effect for all open years (2007 - 2015). The differences between the amounts provided and the actual final settlement, if any, is recorded as an adjustment to net patient service revenue as amounts become known or as years are no longer subject to audits, reviews and investigations. During 2016 and 2015, changes in prior estimates related to the Health System's settlements with third-party payors resulted in (decreases) increases in net patient service revenue of ($859,000) and $5,550,000 respectively, in the consolidated statements of operations and changes in net assets.

5. Investments

The composition of investments at June 30, 2016 and 2015 is set forth in the following table:

(in thousands of dollars)	2016	2015
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 12,915	$ 8,475
U.S. government securities	33,578	36,634
Domestic corporate debt securities	65,610	80,254
Global debt securities	119,385	111,156
Domestic equities	100,009	106,350
International equities	61,768	69,965
Emerging markets equities	34,282	36,591
Real Estate Investment Trust	432	621
Private equity funds	33,209	26,843
Hedge funds	52,337	56,590
	513,525	533,479
Investments held by captive insurance companies (Note 12)		
U.S. government securities	22,484	27,730
Domestic corporate debt securities	29,123	32,017
Global debt securities	5,655	4,883
Domestic equities	7,830	7,669
International equities	11,901	12,869
	76,993	85,168
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	1,950	1,778
Total assets limited as to use	$ 592,468	$ 620,425

(in thousands of dollars)	2016	2015
Other investments for restricted activities		
Cash and short-term investments	$ 12,219	$ 5,448
U.S. government securities	21,351	19,730
Domestic corporate debt securities	33,203	34,548
Global debt securities	20,808	18,947
Domestic equities	19,215	18,354
International equities	13,986	14,777
Emerging markets equities	4,887	5,077
Real Estate Investment Trust	470	533
Private equity funds	4,780	3,653
Hedge funds	11,087	10,921
Other	30	28
Total other investments for restricted activities	$ 142,036	$ 132,016

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

The following tables summarize the investments by the accounting method utilized, as of June 30, 2016 and 2015. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

(in thousands of dollars)	2016		
	Fair Value	**Equity**	**Total**
Cash and short-term investments	$ 27,084	$ -	$ 27,084
U.S. government securities	77,413	-	77,413
Domestic corporate debt securities	101,271	26,665	127,936
Global debt securities	40,356	105,492	145,848
Domestic equities	115,082	11,972	127,054
International equities	23,271	64,384	87,655
Emerging markets equities	331	38,838	39,169
Real Estate Investment Trust	20	882	902
Private equity funds	-	37,989	37,989
Hedge funds	-	63,424	63,424
Other	30	-	30
	$ 384,858	$ 349,646	$ 734,504

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

Investment income (losses) is comprised of the following for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Unrestricted		
Interest and dividend income, net	$ 5,088	$ 7,927
Net realized gains on sales of securities	(1,223)	12,432
Change in net unrealized gains on investments	(22,980)	(28,824)
	(19,115)	(8,465)
Temporarily restricted		
Interest and dividend income, net	536	1,151
Net realized gains on sales of securities	(18)	646
Change in net unrealized gains on investments	(1,674)	(1,619)
	(1,156)	178
Permanently restricted		
Change in net unrealized losses on beneficial interest in trust	(219)	(187)
	(219)	(187)
	$ (20,490)	$ (8,474)

For the years ended June 30, 2016 and 2015 unrestricted investment income (losses) is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $988,000 and $2,550,000 and as nonoperating (losses) gains of approximately ($20,103,000) and ($11,015,000), respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2016 and 2015, the Health System has committed to contribute approximately $116,851,000 and $105,782,000 to such funds, of which the Health System has contributed approximately $80,019,000 and $66,918,000 and has outstanding commitments of $36,832,000 and $38,864,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Land	$ 33,004	$ 29,558
Land improvements	36,899	31,750
Buildings and improvements	801,840	714,689
Equipment	744,443	590,501
Equipment under capital leases	20,823	17,824
	1,637,009	1,384,322
Less: Accumulated depreciation and amortization	1,046,617	818,816
Total depreciable assets, net	590,392	565,506
Construction in progress	22,172	35,849
	$ 612,564	$ 601,355

As of June 30, 2016 construction in progress primarily consists of the construction of the Hospice & Palliative Care building and the renovation of the Borwell building in Lebanon, NH. The estimated cost to complete these projects at June 30, 2016 is $20,300,000 and $580,000, respectively. New London Hospital's construction in progress primarily consists of a building addition at Newport Health Center which is expected to be completed in October 2016 at a cost of $1,200,000.

The construction in progress for the Williamson building reported as of June 30, 2015 was completed during the first quarter of fiscal year 2016 and the major inpatient and outpatient rehabilitation renovations taking place at Mt. Ascutney Hospital reported as construction in progress as of June 30, 2015 were completed during the third quarter of fiscal year 2016.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $81,138,000 and $67,414,000 for 2016 and 2015, respectively.

7. Fair Value Measurements

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

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

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

U.S. Government Securities, Domestic Corporate and Global Debt Securities
Consists of U.S. government securities, domestic corporate and global debt securities, mutual funds and pooled/commingled funds that invest in U.S. government securities, domestic corporate and global debt securities. Securities are valued based on quoted market prices or dealer quotes where available (Level 1 measurement). If quoted market prices are not available, fair values are

based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings and maturities, rather than on specific bids and offers for a designated security. Investments in mutual funds are measured based on the quoted NAV as of the close of business in the respective active market (Level 1 measurements).

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

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2016 and 2015:

	2016					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 27,084	$ -	$ -	$ 27,084	Daily	1
U.S. government securities	77,413	-	-	77,413	Daily	1
Domestic corporate debt securities	27,626	73,645	-	101,271	Daily–Monthly	1–15
Global debt securities	23,103	17,253	-	40,356	Daily–Monthly	1–15
Domestic equities	115,082	-	-	115,082	Daily–Monthly	1–10
International equities	23,271	-	-	23,271	Daily–Monthly	1–11
Emerging market equities	331	-	-	331	Daily–Monthly	1–7
Real Estate Investment Trust	20	-	-	20	Daily–Monthly	1–7
Other	-	30	-	30	Not applicable	Not applicable
Total investments	293,930	90,928	-	384,858		
Deferred compensation plan assets						
Cash and short-term investments	2,478	-	-	2,478		
U.S. government securities	30	-	-	30		
Domestic corporate debt securities	6,710	-	-	6,710		
Global debt securities	794	-	-	794		
Domestic equities	23,502	-	-	23,502		
International equities	8,619	-	-	8,619		
Emerging market equities	2,113	-	-	2,113		
Real estate	2,057	-	-	2,057		
Multi strategy fund	9,188	-	-	9,188		
Guaranteed contract	-	-	80	80		
Total deferred compensation plan assets	55,491	-	80	55,571	Not applicable	Not applicable
Beneficial interest in trusts			9,087	9,087	Not applicable	Not applicable
Total assets	$ 349,421	$ 90,928	$ 9,167	$ 449,516		
Liabilities						
Interest rate swaps	$ -	$ 28,917	$ -	$ 28,917	Not applicable	Not applicable
Total liabilities	$ -	$ 28,917	$ -	$ 28,917		

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

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

	2016		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,345	$ 78	$ 9,423
Purchases			-
Sales			-
Net unrealized gains (losses)	(258)	2	(256)
Net asset transfer from affiliate			-
Balances at end of year	$ 9,087	$ 80	$ 9,167

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

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2016 and 2015.

8. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Healthcare services	$ 44,561	$ 43,822
Research	16,680	16,376
Purchase of equipment	2,826	2,483
Charity care	1,543	2,900
Health education	8,518	9,181
Other	1,603	1,695
	$ 75,731	$ 76,457

Permanently restricted net assets consist of the following at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Healthcare services	$ 32,105	$ 25,015
Research	7,767	7,689
Purchase of equipment	5,266	6,291
Charity care	2,991	5,609
Health education	5,408	8,454
Other	53	23
	$ 53,590	$ 53,081

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

9. Board Designated and Endowment Funds

Net assets include approximately 65 individual funds established for a variety of purposes including both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

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

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

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2016 and 2015.

Endowment net asset composition by type of fund consists of the following at June 30, 2016 and 2015:

	2016			
(in thousands of dollars)	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Donor-restricted endowment funds	$ -	$ 25,780	$ 45,402	$ 71,182
Board-designated endowment funds	26,205	-	-	$ 26,205
Total endowed net assets	$ 26,205	$ 25,780	$ 45,402	$ 97,387

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

Changes in endowment net assets for the years ended June 30, 2016 and 2015:

	2016			
(in thousands of dollars)	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Balances at beginning of year	$ 26,405	$ 28,296	$ 44,491	$ 99,192
Net investment return	(54)	(1,477)	3	$ (1,528)
Contributions	-	271	699	$ 970
Transfers	-	(216)	180	$ (36)
Release of appropriated funds	(146)	(1,094)	-	$ (1,240)
Net asset transfer from affiliates	-	-	29	$ 29
Balances at end of year	$ 26,205	$ 25,780	45,402	$ 97,387
Balances at end of year			45,402	
Beneficial interest in perpetual trust			8,188	
Permanently restricted net assets			$ 53,590	

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

Balances at end of year	44,491
Beneficial interest in perpetual trust	8,590
Permanently restricted net assets	$ 53,081

10. Long-Term Debt

A summary of long-term debt at June 30, 2016 and 2015 follows:

(in thousands of dollars)	2016	2015
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2015A, principal maturing in varying annual amounts, through August 2031 (1)	$ 86,710	$ -
Series 2013, principal maturing in varying annual amounts, through August 2043 (9)*	19,230	17,668
Series 2011, principal maturing in varying annual amounts, through August 2031 (6)	-	90,005
Vermont Educational and Health Buildings Financing Agency (VEHFBA) Revenue Bonds		
Series 2010A, principal maturing in varying annual amounts, through August 2030 (11)*	7,881	8,182
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2014A, principal maturing in varying annual amounts, through August 2022 (3)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (3)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (4)	72,720	73,725
Series 2012B, principal maturing in varying annual amounts, through August 2031 (4)	39,900	40,455
Series 2012, principal maturing in varying annual amounts, through July 2039 (10)*	27,490	28,818
Series 2010, principal maturing in varying annual amounts, through August 2040 (7)	75,000	75,000
Series 2010, principal maturing in varying annual amounts, through August 2040 (12)	16,287	
Series 2009, principal maturing in varying annual amounts, through August 2038 (8)	63,370	68,970
*Represents nonobligated group bonds		
Other		
Revolving Line of Credit, principal maturing through March 2019 (2)	49,750	-
Series 2012, principal maturing in varying annual amounts, through July 2025 (5)	140,000	144,000
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	313	4
Note payable to a financial institution due in monthly interest only payments from October 2011 through September 2012, and monthly installments from October 2016 through 2016, including principal and interest at 3.25%; collateralized by savings account	2,952	1,915
Note payable to a financial institution payable in interest free entire principal due June 2029 collateralized by land and building	494	555
Obligations under capital leases	4,875	3,369
	648,462	594,156
Less		
Original issue discount, net	881	1,493
Current portion	18,307	17,179
	$ 629,274	$ 575,484

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

(in thousands of dollars)		2016
2017	$	18,307
2018		19,117
2019		69,159
2020		20,262
2021		20,290
Thereafter		501,327
	$	648,462

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds

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

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

(1) Series 2015A Revenue Bonds

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2015A in September 2015 through a private placement with a financial institution. The Series 2015A Revenue Bonds were primarily used to refinance a portion of the Series 2011 Revenue Bonds and to cover cost of issuance. The Series 2015A Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30 2016 was 1.11%

(2) Revolving Line of Credit

Through the DHOG, entered into Revolving Line of Credit TD Bank, N.A. (TD Bank). Interest on the TD Bank loan accrues variably and matures at various dates through March 2019. The variable rate as of June 30 2016 was 1.04%

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

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

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

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

(6) Series 2011 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2011 in August 2011. The proceeds from the Series 2011 Revenue Bonds were primarily used to advance refund the Series 2001A Revenue Bonds. The Series 2011 Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30 2016 was 1.04%. The Series 2011 Bonds are callable by the bank upon the end of seven years or may be renegotiated at that time. These bonds were paid with the proceeds of the Series 2015A Revenue Bonds.

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

(8) Series 2009 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 3.00% and 6.00% and mature at various dates through August 2038. Outstanding joint and several indebtedness of the DHOG at June 30, 2016 and 2015 approximates $568,940,000 and $533,645,000, respectively.

Non Obligated Group Bonds

(9) Series 2013 Revenue Bonds
Issued through the NHHEFA $15,520,000 tax exempt Revenue Bonds (Series 2013A). The Series 2013A funds were used to refund Series 2007 Revenue Bonds. Additional borrowings were obtained (up to $9,480,000 Revenue Bonds, Series 2013B) for the construction of a new health center building in Newport, NH. The bonds are collateralized by the gross receipts and property. The bonds mature in variable amounts through 2043, the maturity date of the bonds, but are subject to mandatory tender in ten years. Interest is payable monthly and is equal to the sum of .72 times the Adjusted LIBOR Rate plus .72 times the credit spread rate. As part of the bond refinancing, the swap arrangement was effectively terminated for federal tax purposes with respect to the Series 2007 Revenue Bonds but remains in effect.

(10)Series 2012 Revenue Bonds

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

(11)Series 2010A Revenue Bonds

Issued through the VEHBFA $9,244,000 of Revenue Bonds (Series 2010A). The funds were used to refund 2004 and 2005 Series A Bonds. The bonds are collateralized by gross receipts. The bonds shall bear interest at the one-month LIBOR rate plus 3.50%, multiplied by 6% adjusting monthly. The interest rate at June 30, 2016 was 2.48%. The bonds were purchased by TD Bank on March 1, 2010. Principal payments began on April 1, 2010 for a period of 20 years ranging in amounts from $228,000 in 2014 to $207,000 in 2030.

(12)Series 2010 Revenue Bonds

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

The estimated fair value of the Health Systems total long-term debt as of June 30, 2016 and 2015 was approximately $620,217,000 and $606,772,000, respectively, which was determined by discounting the future cash flows of each instrument at rates that reflect rates currently observed in publicly traded debt markets for debt of similar terms to organizations with comparable credit risk. The inputs to the assumptions used to determine the estimated fair value are based on observable inputs and are classified as Level 2. For variable rate debt, the carrying value is equal to the fair value.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $1,950,000 and $1,778,000 at June 30, 2016 and 2015, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets.

For the years ended June 30, 2016 and 2015 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately 19,301,000 and $18,442,000 and is included in other nonoperating losses of $3,201,000 and $3,449,000, respectively.

Swap Agreements

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

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

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

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

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

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

At June 30, 2016 and 2015 the fair value of the Health System's interest rate swaps was a liability of $28,917,000 and $24,740,000, respectively. The change in fair value during the years ended June 30, 2016 and 2015 was a decrease of $4,177,000 and $327,000, respectively. For the years ended June 30, 2016 and 2015 the Health System recognized a nonoperating gain of $1,696,000 and 1,035,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

11. Employee Benefits

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

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

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

Defined Benefit Plans

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Service cost for benefits earned during the year	$ 11,084	$ 12,257
Interest cost on projected benefit obligation	48,036	42,276
Expected return on plan assets	(63,479)	(60,458)
Net prior service cost	848	380
Net loss amortization	26,098	21,133
Special/contractural termination benefits	300	56
	$ 22,887	$ 15,644

The following assumptions were used to determine net periodic pension expense as of June 30, 2016 and 2015:

	2016	2015
Weighted average discount rate	4.30 % – 4.90%	4.40 % – 4.90 %
Rate of increase in compensation	Age Graded/0.00 % - 2.50 %	Age Graded/0.00 % - 2.50 %
Expected long-term rate of return on plan assets	7.50 % – 7.75 %	7.50 % – 7.75 %

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Change in benefit obligation		
Benefit obligation at beginning of year	$ 988,143	$ 877,082
Additional benefit obligation resulting from new affiliations	-	95,314
Total benefit obligation at beginning of year	988,143	972,396
Service cost	11,084	12,257
Interest cost	48,108	42,276
Benefits paid	(39,001)	(34,803)
Expenses paid	(180)	(139)
Actuarial (gain) loss	99,040	41,079
Settlements	(13,520)	(44,979)
Plan change	2,645	-
Special/contractual termination benefits	300	56
Benefit obligation at end of year	1,096,619	988,143
Change in plan assets		
Fair value of plan assets at beginning of year	845,052	783,890
Additional plan assets at fair value resulting from new affiliations	-	77,608
Total fair value of plan assets at beginning of year	845,052	861,498
Actual return on plan assets	81,210	25,473
Benefits paid	(42,494)	(34,803)
Expenses paid	(180)	(139)
Employer contributions	2,252	38,002
Settlements	(13,520)	(44,979)
Fair value of plan assets at end of year	872,320	845,052
Funded status of the plans	(224,299)	(143,091)
Current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(224,253)	(143,045)
Liability for pension	$ (224,299)	$ (143,091)

For the years ended June 30, 2016 and 2015 the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in unrestricted net assets as of June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Net actuarial loss	$ 423,640	$ 368,959
Prior service cost	228	608
	$ 423,868	$ 369,567

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension expense in 2017 are as follows:

(in thousands of dollars)	
Unrecognized prior service cost	$ 182
Net actuarial loss	30,515
	$ 30,697

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,082,818,000 and $971,193,000 at June 30, 2016 and 2017, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2016 and 2015:

	2016	2015
Weighted average discount rate	4.20 % – 4.30 %	4.90 % - 5.00 %
Rate of increase in compensation	Age Graded/0.00 % - 2.50 %	Age Graded/0.00 % - 2.50
Expected long-term rate of return on plan assets	7.50 % - 7.75 %	7.50 % - 7.75 %

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of June 30, 2016 and 2015, it is expected that the LDI strategy will hedge approximately 65% and 65%, respectively, of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

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

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

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

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

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

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2016 and 2015:

	2016					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 5,463	$ 10,879	$ -	$ 16,342	Daily	1
U.S. government securities	4,177			4,177	Daily–Monthly	1–15
Domestic debt securities	95,130	296,362		391,492	Daily–Monthly	1–15
Global debt securities	409	88,589		88,998	Daily–Monthly	1–15
Domestic equities	148,998	15,896		164,894	Daily–Monthly	1–10
International equities	12,849	77,299		90,148	Daily–Monthly	1–11
Emerging market equities	352	37,848		38,200	Daily–Monthly	1–17
REIT funds	356	1,465		1,821	Daily–Monthly	1–17
Private equity funds			255	255	See Note 7	See Note 7
Hedge funds		37,005	38,988	75,993	Quarterly–Annual	60–96
Total investments	$ 267,734	$ 565,343	$ 39,243	$ 872,320		

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

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2016 and 2015:

	2016		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 42,076	$ 437	$ 42,513
Transfers	-	-	-
Purchases	-	-	-
Sales	(468)	(142)	(610)
Net realized (losses) gains	(55)	155	100
Net unrealized gains	(2,565)	(195)	(2,760)
Balances at end of year	$ 38,988	$ 255	$ 39,243

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

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2016 and 2015 were approximately $8,808,000 and $5,234,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2016 and 2015.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2016 and 2015.

The weighted average asset allocation for the Health System's Plans at June 30, 2016 and 2015 by asset category is as follows:

	2016	2015
Cash and short-term investments	2 %	5 %
U.S. government securities	1	-
Domestic debt securities	45	39
Global debt securities	10	10
Domestic equities	19	20
International equities	10	11
Emerging market equities	4	5
Hedge funds	9	10
	100 %	100 %

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

The Health System is expected to contribute approximately $47,000,000 to the Plans in 2017 however actual contributions may vary from expected amounts.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2017 and thereafter:

(in thousands of dollars)	Pension Plans
2017	$ 42,067
2018	44,485
2019	47,235
2020	50,490
2021	53,778
2022 – 2026	310,773

Defined Contribution Plans

The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $29,416,000 and $30,204,000 in 2016 and 2015, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

The Health System also has available to employees of certain affiliates various 403(b) and tax-sheltered annuity plans in which they can participate. Plan specifications vary by affiliate and plan. No employer contributions were made to any of these plans in 2016 and 2015, respectively.

Postretirement Medical and Life Benefits

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

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Service cost	$ 544	$ 527
Interest cost	2,295	2,347
Amortization net prior service income	(5,974)	-
Amortization net loss	610	-
	$ (2,525)	$ 2,874

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Change in benefit obligation		
Benefit obligation at beginning of year	$ 50,438	$ 51,006
Additional benefit obligation resulting from new affiliations	-	471
	50,438	51,477
Service cost	544	527
Interest cost	2,295	2,347
Benefits paid	(3,277)	(5,236)
Actuarial loss	1,404	1,323
Employer contributions	(34)	-
Benefit obligation at end of year	51,370	50,438
Funded status of the plans	(51,370)	(50,438)
Current portion of liability for postretirement medical and life benefits	(3,130)	(3,203)
Long term portion of liability for postretirement medical and life benefits	(48,240)	(47,235)
Liability for postretirement medical and life benefits	$ (51,370)	$ (50,438)

During the year ended June 30, 2015 the plan amendments were primarily related to the Board's decision to offer retiree health care benefits to certain affiliates post-65 retirees and covered post-65 dependents through a private Medicare exchange beginning in April 2015.

For the years ended June 30, 2016 and 2015 the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

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

(in thousands of dollars)	2016	2015
Net prior service income	$ (27,478)	$ (33,452)
Net actuarial loss	11,080	10,260
	$ (16,398)	$ (23,192)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement income in 2016 and 2015 are as follows:

(in thousands of dollars)	2016	2015
Net prior service income	$ (5,974)	$ (5,974)
Net loss	689	610
	$ (5,285)	$ (5,364)

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.10% in 2016 and an assumed healthcare cost trend rate of 7.25%, trending down to 4.75% in 2021 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2016 and 2015 by $4,685,000 and $4,479,000 and the net periodic postretirement medical benefit cost for the years then ended by $284,000 and $275,000, respectively. Decreasing the assumed healthcare cost trend rates by one percentage point in each year would decrease the accumulated postretirement medical benefit obligation as of June 30, 2016 and 2015 by $3,884,000 and $3,790,000 and the net periodic postretirement medical benefit cost for the years then ended by $234,000 and $233,000, respectively.

12. Professional and General Liability Insurance Coverage

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

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

Selected financial data of HAC and RRG, taken from the latest available audited and unaudited financial statements, respectively at June 30, 2016 and 2015 are summarized as follows:

	2016		
	HAC	RRG	Total
(in thousands of dollars)	*(audited)*	*(unaudited)*	
Assets	$ 86,101	$ 2,237	$ 88,338
Shareholders' equity	13,620	806	14,426
Net income	-	50	50

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

13. Commitments and Contingencies

Litigation

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

Operating Leases and Other Commitments

The Health System leases certain facilities and equipment under operating leases with varying expiration dates. The Health System's rental expense totaled approximately $10,571,000 and $10,215,000 for the years ended June 30, 2016 and 2015, respectively. Minimum future lease payments under noncancelable operating leases at June 30, 2016 were as follows:

(in thousands of dollars)	
2017	$ 8,441
2018	6,210
2019	4,062
2020	2,663
2021	2,009
Thereafter	274
	$ 23,659

Lines of Credit

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $2,000,000 up to $85,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire ranging from December 31, 2015 through July 31, 2016. The Health System has outstanding balances under the lines of credits in the amount of $36,550,000 and $1,200,000 at

June 30, 2016 and 2015, respectively. Interest expense was approximately $551,000 and $193,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Program services	$ 1,553,377	$ 1,335,316
Management and general	271,409	225,983
Fundraising	5,901	8,037
	$ 1,830,687	$ 1,569,336

15. Subsequent Events

The Health System has assessed the impact of subsequent events through November 26, 2016, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

The Visiting Nurse and Hospice for VT and NH (VNH) became an affiliate of D-HH effective July 1, 2016. The affiliation is designed to improve healthcare for the communities served by VNH and D-H by facilitating collaboration, innovation and cost efficiencies between D-H and VNH. The VNH is a non-profit organization that has provided home health and hospice care services in VT and NH since 1907. The agency is dedicated to delivering outstanding home and community based health and hospice services that enrich the lives of the people they serve. The VNH makes home visits to people of all ages and all states of life regardless of the ability to pay.

Effective October 1, 2016, NLH and MAHHC will be provided professional and general liability insurance through the Hamden Assurance Risk Retention Group, Inc. (RRG) under a modified claims made policy. NLH and MAHHC will join RRG along with existing insureds D-H, Cheshire Medical Center and Dartmouth College.

During the year ended June 30, 2016, Dartmouth College restructured a number of activities at the Geisel School of Medicine (Geisel) to address increasing financial constraints, to improve Geisel's education and research programs, and to align resources and support for these activities. These changes included migration of the operations and fiscal responsibility for clinical academic activities from Dartmouth College to D-H, which included responsibility for the employment, finances, and operational support for clinical research programs. D-H agreed to assume responsibility for the clinical practice of psychiatry and employment of approximately 250 staff (which are either part of the psychiatry practice or clinical research) effective July 1, 2016.

Effective July 1, 2016, NLH, MAHHC and Cheshire were admitted to the Dartmouth-Hitchcock Obligated Group. In connection with the admission of these three members, the Dartmouth-Hitchcock Obligated Group assumed new debt in the amount of $28,039,000 from Cheshire. In addition, $24,605,000 of NLH debt was refinanced in combination with new debt in the amount $10,970,000 to fund the new Williamson Building.

Consolidating Supplemental Information

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Assets								
Current assets								
Cash and cash equivalents	$ 607	$ 2,066	$ 16,640	$ 6,699	$ 5,388	$ 9,192	$ -	$ 40,592
Patient accounts receivable, net	-	220,173	17,836	7,377	5,347	10,255	-	260,988
Prepaid expenses and other current assets	7,463	95,738	5,458	3,209	2,022	4,863	(22,933)	95,820
Total current assets	8,070	317,977	39,934	17,285	12,757	24,310	(22,933)	397,400
Assets limited as to use	-	551,724	17,525	10,345	8,260	4,614	-	592,468
Other investments for restricted activities	217	114,719	18,486	2,843	5,742	29	-	142,036
Property, plant, and equipment, net	76	457,570	75,591	43,204	19,659	16,464	-	612,564
Other assets	17,950	68,921	9,794	5,409	3,943	111	(14,929)	91,199
Total assets	$ 26,313	$ 1,510,911	$ 161,330	$ 79,086	$ 50,361	$ 45,528	$ (37,862)	$ 1,835,667
Liabilities and Net Assets								
Current liabilities								
Current portion of long-term debt	$ -	$ 15,638	$ 755	$ 941	$ 466	$ 507	$ -	$ 18,307
Line of credit	-	35,000	-	-	1,550	-	-	36,550
Current portion of liability for pension and other postretirement plan benefits	-	3,176	-	-	-	-	-	3,176
Accounts payable and accrued expenses	9,857	88,557	15,866	6,791	4,589	4,817	(22,933)	107,544
Accrued compensation and related benefits	-	86,997	7,728	2,052	3,128	3,649	-	103,554
Estimated third-party settlements	-	21,434	1,569	5,206	917	1,424	-	30,550
Total current liabilities	9,857	250,802	25,918	14,990	10,650	10,397	(22,933)	299,681
Long-term debt, excluding current portion	-	553,229	27,283	21,148	11,159	16,455	-	629,274
Insurance deposits and related liabilities	-	56,887	-	-	-	-	-	56,887
Interest rate swaps	-	24,148	-	4,646	123	-	-	28,917
Liability for pension and other postretirement plan benefits, excluding current portion	-	246,816	18,662	-	7,015	-	-	272,493
Other liabilities	-	54,218	3,522	1,135	-	36	-	58,911
Total liabilities	9,857	1,186,100	75,385	41,919	28,947	26,888	(22,933)	1,346,163
Commitments and contingencies								
Net assets								
Unrestricted	16,456	234,609	58,978	32,706	14,099	18,264	(14,929)	360,183
Temporarily restricted	-	57,091	16,454	345	1,496	345	-	75,731
Permanently restricted	-	33,111	10,513	4,116	5,819	31	-	53,590
Total net assets	16,456	324,811	85,945	37,167	21,414	18,640	(14,929)	489,504
Total liabilities and net assets	$ 26,313	$ 1,510,911	$ 161,330	$ 79,086	$ 50,361	$ 45,528	$ (37,862)	$ 1,835,667

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Assets					
Current assets					
Cash and cash equivalents	$ 1,535	$ 176	$ 355	$ -	$ 2,066
Patient accounts receivable, net	220,173	-	-	-	220,173
Prepaid expenses and other current assets	95,158	487	93	-	95,738
Total current assets	316,866	663	448	-	317,977
Assets limited as to use	551,724	-	-	-	551,724
Other investments for restricted activities	91,879	22,840	-	-	114,719
Property, plant, and equipment, net	454,894	1	2,675	-	457,570
Other assets	68,752	4	165	-	68,921
Total assets	$ 1,484,115	$ 23,508	$ 3,288	$ -	$ 1,510,911
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 15,638	$ -	$ -	$ -	$ 15,638
Line of Credit	35,000	-	-	-	35,000
Current portion of liability for pension and other postretirement plan benefits	3,176	-	-	-	3,176
Accounts payable and accrued expenses	87,373	1,181	3	-	88,557
Accrued compensation and related benefits	86,997	-	-	-	86,997
Estimated third-party settlements	21,434	-	-	-	21,434
Total current liabilities	249,618	1,181	3	-	250,802
Long-term debt, excluding current portion	553,229	-	-	-	553,229
Insurance deposits and related liabilities	56,887	-	-	-	56,887
Interest rate swaps	24,148	-	-	-	24,148
Liability for pension and other postretirement plan benefits, excluding current portion	246,816	-	-	-	246,816
Other liabilities	54,218	-	-	-	54,218
Total liabilities	1,184,916	1,181	3	-	1,186,100
Commitments and contingencies					
Net assets					
Unrestricted	217,033	14,456	3,120	-	234,609
Temporarily restricted	51,173	5,753	165	-	57,091
Permanently restricted	30,993	2,118	-	-	33,111
Total net assets	299,199	22,327	3,285	-	324,811
Total liabilities and net assets	$ 1,484,115	$ 23,508	$ 3,288	$ -	$ 1,510,911

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

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	Eliminations	Health System Consolidated
Assets							
Current assets							
Cash and cash equivalents	$ 388	$ 9,279	$ 16,525	$ 7,612	$ 5,105	$ -	$ 38,909
Patient accounts receivable, net	-	177,287	14,053	7,388	5,544	-	204,272
Prepaid expenses and other current assets	11,574	102,954	7,921	3,632	2,616	(28,111)	100,586
Total current assets	11,962	289,520	38,499	18,632	13,265	(28,111)	343,767
Assets limited as to use	-	570,057	23,302	13,412	13,654	-	620,425
Other investments for restricted activities	-	113,117	18,899	-	-	-	132,016
Property, plant, and equipment, net	618	461,044	82,793	37,597	19,303	-	601,355
Other assets	4,263	66,837	10,130	5,451	3,903	(2,134)	88,450
Total assets	$ 16,843	$ 1,500,575	$ 173,623	$ 75,092	$ 50,125	$ (30,245)	$ 1,786,013
Liabilities and Net Assets							
Current liabilities							
Current portion of long-term debt	$ -	$ 15,196	$ 952	$ 661	$ 370	$ -	$ 17,179
Line of credit	-	-	-	-	1,200	-	1,200
Current portion of liability for pension and other postretirement plan benefits	-	3,249	-	-	-	-	3,249
Accounts payable and accrued expenses	15,708	104,697	20,024	3,843	4,059	(28,110)	120,221
Accrued compensation and related benefits	-	85,064	4,936	2,373	2,491	-	94,864
Estimated third-party settlements	-	26,961	-	6,755	2,883	-	36,599
Total current liabilities	15,708	235,167	25,912	13,632	11,003	(28,110)	273,312
Long-term debt, excluding current portion	-	518,799	28,083	18,020	10,582	-	575,484
Insurance deposits and related liabilities	-	62,356	-	-	-	-	62,356
Interest rate swaps	-	20,937	-	3,531	272	-	24,740
Liability for pension and other postretirement plan benefits, excluding current portion	-	175,948	8,374	-	5,958	-	190,280
Other liabilities	-	51,303	3,671	1,135	-	-	56,109
Total liabilities	15,708	1,064,510	66,040	36,318	27,815	(28,110)	1,182,281
Commitments and contingencies							
Net assets							
Unrestricted	1,135	346,900	79,700	34,227	14,367	(2,135)	474,194
Temporarily restricted	-	56,751	17,330	326	2,050	-	76,457
Permanently restricted	-	32,414	10,553	4,221	5,893	-	53,081
Total net assets	1,135	436,065	107,583	38,774	22,310	(2,135)	603,732
Total liabilities and net assets	$ 16,843	$ 1,500,575	$ 173,623	$ 75,092	$ 50,125	$ (30,245)	$ 1,786,013

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

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Unrestricted revenue and other support								
Net patient service revenue	$ -	$ 1,346,605	$ 161,787	$ 59,789	$ 46,431	$ 20,103	$ (561)	$ 1,634,154
Contracted revenue	1,696	64,286	-	-	-	-	-	65,982
Other operating revenue	3,300	71,475	3,187	3,509	4,555	870	(4,544)	82,352
Net assets released from restrictions	-	8,713	322	65	119	-	-	9,219
Total unrestricted revenue and other support	4,996	1,491,079	165,296	63,363	51,105	20,973	(5,105)	1,791,707
Operating expenses								
Salaries	730	732,393	60,406	29,873	24,019	10,408	14,636	872,465
Employee benefits	219	197,165	19,276	6,824	6,260	2,130	2,533	234,407
Medical supplies and medications	-	236,918	59,121	6,597	4,246	2,932	-	309,814
Purchased services and other	22,506	211,611	14,020	12,876	11,955	4,377	(22,204)	255,141
Medicaid enhancement tax	-	46,078	7,132	2,808	1,707	840	-	58,565
Depreciation and amortization	15	62,348	11,069	4,674	2,345	543	-	80,994
Interest	-	16,821	1,046	823	467	144	-	19,301
Total operating expenses	23,470	1,503,334	172,070	64,475	50,999	21,374	(5,035)	1,830,687
Operating (loss) margin	(18,474)	(12,255)	(6,774)	(1,112)	106	(401)	(70)	(38,980)
Nonoperating gains (losses)								
Investment (losses) gains	(1,027)	(18,848)	(1,075)	627	(15)	235	-	(20,103)
Other, net	(529)	(3,647)	-	57	205	-	69	(3,845)
Contribution revenue from acquisition	18,083	-	-	-	-	-	-	18,083
Total nonoperating gains (losses), net	16,527	(22,495)	(1,075)	684	190	235	69	(5,865)
(Deficiency) excess of revenue over expenses	(1,947)	(34,750)	(7,849)	(428)	296	(166)	(1)	(44,845)
Unrestricted net assets								
Net assets released from restrictions (Note 8)	-	2,185	107	23	586	347	-	3,248
Change in funded status of pension and other postretirement benefits	-	(52,262)	(12,982)	-	(1,297)	-	-	(66,541)
Net assets transferred to (from) affiliates	4,475	(22,558)	-	-	-	18,083	-	-
Additional paid in capital	12,793	-	-	-	-	-	(12,793)	-
Change in fair value on interest rate swaps	-	(4,907)	-	(1,115)	149	-	-	(5,873)
Increase (decrease) in unrestricted net assets	$ 15,321	$ (112,292)	$ (20,724)	$ (1,520)	$ (266)	$ 18,264	$ (12,794)	$ (114,011)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Unrestricted revenue and other support					
Net patient service revenue	$ 1,346,605	$ -	$ -	$ -	$ 1,346,605
Contracted revenue	63,188	1,578	-	(480)	64,286
Other operating revenue	69,902	1,957	550	(934)	71,475
Net assets released from restrictions	7,928	785	-	-	8,713
Total unrestricted revenue and other support	1,487,623	4,320	550	(1,414)	1,491,079
Operating expenses					
Salaries	731,721	-	-	672	732,393
Employee benefits	197,050	-	-	115	197,165
Medical supplies and medications	236,918	-	-	-	236,918
Purchased services and other	208,763	4,261	646	(2,059)	211,611
Medicaid enhancement tax	46,078	-	-	-	46,078
Depreciation and amortization	62,348	-	-	-	62,348
Interest	16,821	-	-	-	16,821
Total operating expenses	1,499,699	4,261	646	(1,272)	1,503,334
Operating (loss) margin	(12,076)	59	(96)	(142)	(12,255)
Nonoperating gains (losses)					
Investment losses	(18,537)	(311)	-	-	(18,848)
Other, net	(3,789)	-	-	142	(3,647)
Total nonoperating (losses) gains, net	(22,326)	(311)	-	142	(22,495)
Deficiency of revenue over expenses	(34,402)	(252)	(96)	-	(34,750)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	1,994	191	-	-	2,185
Change in funded status of pension and other postretirement benefits	(52,262)	-	-	-	(52,262)
Net assets transferred from affiliates	(22,558)	-	-	-	(22,558)
Change in fair value on interest rate swaps	(4,907)	-	-	-	(4,907)
Decrease in unrestricted net assets	$ (112,135)	$ (61)	$ (96)	$ -	$ (112,292)

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

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	NLH and Subsidiaries	Cheshire and Subsidiaries	MAHHC and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support							
Net patient service revenue	$ -	$ 1,225,872	$ 56,356	$ 52,536	$ 46,102	$ (307)	$ 1,380,559
Contracted revenue	-	82,091	-	-	-	(1,256)	80,835
Other operating revenue	12,203	69,663	3,063	1,076	3,526	(6,538)	82,993
Net assets released from restrictions	-	15,314	111	212	-	-	15,637
Total unrestricted revenue and other support	12,203	1,392,940	59,530	53,824	49,628	(8,101)	1,560,024
Operating expenses							
Salaries	960	696,358	27,562	20,949	24,076	8,482	778,387
Employee benefits	263	195,271	5,764	5,724	6,112	1,493	214,627
Medical supplies and medications	139	201,451	5,910	8,712	3,736	19	219,967
Purchased services and other	17,448	180,706	13,317	13,747	11,888	(18,402)	218,704
Medicaid enhancement tax	-	45,839	1,941	2,363	1,853	-	51,996
Depreciation and amortization	75	56,649	4,075	3,436	2,978	-	67,213
Interest	-	16,781	849	357	455	-	18,442
Total operating expenses	18,885	1,393,055	59,418	55,288	51,098	(8,408)	1,569,336
Operating (loss) margin	(6,682)	(115)	112	(1,464)	(1,470)	307	(9,312)
Nonoperating gains (losses)							
Investment (losses) gains	-	(12,011)	625	311	60	-	(11,015)
Other, net	339	(2,880)	1,409	141	57	(307)	(1,241)
Contribution revenue from acquisition	92,499	-	-	-	-	-	92,499
Total nonoperating gains (losses), net	92,838	(14,891)	2,034	452	117	(307)	80,243
Excess (deficiency) of revenue over expenses	86,156	(15,006)	2,146	(1,012)	(1,353)	-	70,931
Unrestricted net assets							
Net assets released from restrictions (Note 8)	-	717	5	1,010	679	-	2,411
Change in funded status of pension and other postretirement benefits	-	(62,977)	-	2,875	(790)	-	(60,892)
Net assets transferred (from) to affiliates	(84,626)	(7,873)	-	76,827	15,672	-	-
Additional paid in capital	600	-	-	-	-	(600)	-
Change in fair value on interest rate swaps	-	(869)	(221)	-	159	-	(931)
Increase (decrease) in unrestricted net assets	$ 2,130	$ (86,008)	$ 1,930	$ 79,700	$ 14,367	$ (600)	$ 11,519

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

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Unrestricted revenue and other support					
Net patient service revenue	$ 1,225,874	$ -	$ -	$ (2)	$ 1,225,872
Contracted revenue	81,474	847	-	(230)	82,091
Other operating revenue	64,928	2,356	6,482	(4,103)	69,663
Net assets released from restrictions	14,610	704	-	-	15,314
Total unrestricted revenue and other support	1,386,886	3,907	6,482	(4,335)	1,392,940
Operating expenses					
Salaries	695,392	-	-	966	696,358
Employee benefits	195,119	-	-	152	195,271
Medical supplies and medications	201,458	-	-	(7)	201,451
Purchased services and other	172,061	4,079	6,484	(1,918)	180,706
Medicaid enhancement tax	45,839	-	-	-	45,839
Depreciation and amortization	56,649	-	-	-	56,649
Interest	16,781	-	-	-	16,781
Total operating expenses	1,383,299	4,079	6,484	(807)	1,393,055
Operating margin (loss)	3,587	(172)	(2)	(3,528)	(115)
Nonoperating gains (losses)					
Investment (losses) gains	(12,079)	68	-	-	(12,011)
Other, net	(6,408)	-	-	3,528	(2,880)
Total nonoperating (losses) gains, net	(18,487)	68	-	3,528	(14,891)
Deficiency of revenue over expenses	(14,900)	(104)	(2)	-	(15,006)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	454	263	-	-	717
Change in funded status of pension and other postretirement benefits	(62,977)	-	-	-	(62,977)
Net assets transferred from affiliates	(7,873)	-	-	-	(7,873)
Change in fair value on interest rate swaps	(869)	-	-	-	(869)
(Decrease) increase in unrestricted net assets	$ (86,165)	$ 159	$ (2)	$ -	$ (86,008)

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Supplemental Consolidating Information
June 30, 2016 and 2015

1. Basis of Presentation

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

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

BOARDS OF TRUSTEES AND OFFICERS
Effective: January 1, 2017

Troyen A. Brennan, MD, MPH MHMH/DHC/D-HH Trustee [redacted]		**Laura K. Landy** MHMH/DHC/D-HH Trustee [redacted]
Jeffrey A. Cohen, MD MHMH/DHC Trustee [redacted]		**Robert A. Oden, Jr., PhD** MHMH/DHC/D-HH Boards' Vice Chair [redacted]
Duane A. Compton, PhD MHMH/DHC/D-HH Trustee [redacted]		**Steven "Steve" A. Paris, MD (Susan)** D-HH Trustee [redacted]
William J. Conaty (Sue) MHMH/DHC/D-HH Trustee [redacted]		**Charles G. Plimpton** MHMH/DHC/D-HH Boards' Treasurer [redacted]
Vincent S. Conti MHMH/DHC/D-HH Trustee [redacted]		**Kari M. Rosenkranz, MD** MHMH/DHC (Lebanon Physician) Trustee [redacted]
Denis A. Cortese, MD MHMH/DHC/D-HH Trustee [redacted]		**Timothy D. Scherer, MD** MHMH/DHC Trustee [redacted]
Barbara J. Couch MHMH/DHC/D-HH Boards' Secretary [redacted]		**Brian C. Spence, MD, MHCDS** MHMH/DHC Trustee [redacted]
Paul P. Danos, PhD MHMH/DHC/D-HH Trustee [redacted]		**Anne-Lee Verville** MHMH/DHC/D-HH Boards' Chair [redacted]
Senator Judd A. Gregg MHMH/DHC Trustee [redacted]		**James N. Weinstein, DO, MS** MHMH/DHC/D-HH Trustee [redacted]
M. Brooke Herndon, MD MHMH/DHC (Lebanon Physician) Trustee [redacted]		

MARTHA SUE "SUZY" CATALONA
(603) 653-2224 (work)
Martha.S.Catalona@Hitchcock.ORG

PROFESSIONAL GOAL:
To find an administrative leadership position on a synergistic operations team that values and expects excellence in an environment where commitment to continuous system and process improvement is obvious in daily operations.

WORK EXPERIENCE:

Management

* Stabilized systems and staffing in the Weight and Wellness Center, Sleep Medicine service and Addiction Treatment Programs after reorganizations.

* Collaborated with Primary Care administrative teams to implement and expand behavioral health service integration in Primary Care.

* Developed and maintained the infrastructure, systems and procedures to support the mission and promote the overall function of the Department of Psychiatry.

* Implemented a Corporate Compliance Program for the Department of Psychiatry including developing the plan, coordinating and facilitating medical record compliance audits with an outside consultant, organizing and leading the Compliance Committee and providing compliance training for all Department faculty and staff.

* Developed documentation templates for all services provided within the Department.

* Led administrative efforts associated with the initial implementation of an electronic medical record and appointment scheduling system and with the conversion to a new system several years later.

* Created and maintained master schedules for 65 providers.

* Negotiated and administered service contracts with outside facilities and agencies.

* Administered Training Affiliation Agreements for the Child and Adolescent Psychiatry Fellowship Training Program.

* Served as Department's Complaints Officer.

* Served as a resource to the Department on regulatory matters.

* Participated in the formation of a formal quality improvement program for the Department of Psychiatry

* Monitored day-to-day work flow and allocated resources to maximize productivity and insure timely task completion.

* Monitored and distributed monthly faculty productivity reports.

* Hired, trained, and managed department support staff.

* Assumed responsibility for UM program development, implementation, maintenance, evaluation, and improvement.

* Collaborated with clinicians in system-wide UM activities for those clients receiving services across the continuum of care in an integrated care delivery system.

* Collaborated with all involved individuals/departments to develop specific policies/guidelines for admission, utilization review, and care management processes.

* Developed and defined Access Office roles and functions.

* Established and maintained relationships with referral sources and third party payors.

* Managed intake and utilization review/case management functions for Inpatient, Partial Hospital, and Outpatient Psychiatry Services.

* In-serviced staff on utilization review process.

* Counseled and evaluated performance of professional nurses based on stated expectations and conducted annual appraisal interviews.

* Scheduled fifty staff to provide twenty-four hour coverage of Inpatient Psychiatry Services.

* Planned and coordinated assignments and activities to ensure safe patient care.

* Assumed responsibility for maintaining staffing budget demands while responding to widely fluctuating patient acuity and census.

* Participated in Nursing Department committees and task forces including the Acuity Steering Committee, Medication Process Task Force, Procedure Committee and Quality Assurance Committee.

* Functioned as liaison between Inpatient Psychiatry Services and Pharmacy.

* Monitored patient medication delivery as part of hospital quality assurance monitoring program.

* Consulted with architect and various hospital personnel to plan a psychiatric unit in a new facility and assisted with planning and coordinating Inpatient Psychiatry Services move to a new facility.

* Assisted with JCAHO reviews.

Clinical

* Provided initial and ongoing clinical review and authorization of services for all capitated clients.

* Conducted intake assessments on all inpatient psychiatry referrals.

* In-serviced and implemented a new multidisciplinary treatment plan.

* Counseled, supported and instructed psychiatric patients undergoing diagnostic evaluation and treatment on an acute psychiatric unit.

* Assessed, delivered and evaluated care provided to critically ill patients in an intensive care unit.

* Utilized sophisticated equipment in the evaluation and treatment of critically ill patients.

* Participated in multidisciplinary team approach to the development and evaluation of plans of care in the gerontological setting.

* Demonstrated clinical competence through use of the nursing process in medical-surgical nursing.

WORK HISTORY:

1/17 - present	Department of Medicine Dartmouth-Hitchcock Clinic Position: Interim Practice Manager Weight and Wellness Center and Sleep Medicine Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Sr. Practice Manager
10/16 - 1/17	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Sr. Practice Manager
7/16 - 10/16	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Practice Manager
7/01 - 6/16	Dartmouth-Hitchcock Psychiatric Associates, Department of Psychiatry, Geisel School of Medicine at Dartmouth Position: Administrative Director
7/98 - 6/01	Dartmouth Hitchcock Behavioral Healthcare Position: Care Management Coordinator
10/97 - 7/98	Dartmouth-Hitchcock Medical Center Position: Coordinator Inpatient Psychiatry Access Services
10/95 - 10/97	Dartmouth-Hitchcock Medical Center Position: Clinical Coordinator Inpatient Psychiatry Services Responsible for the management of Access Services, Psychiatry-Medicine Unit, and General Psychiatry Unit
7/93 - 9/95	Dartmouth-Hitchcock Medical Center Position: Coordinator Inpatient Psychiatry Access Services
9/89 - 6/93	Dartmouth-Hitchcock Medical Center Position: Clinical Coordinator Psychiatry-Medicine Unit/Short Term Unit

4/83 - 9/89	Dartmouth-Hitchcock Medical Center Position: Assistant Head Nurse General Psychiatry Unit Acting Head Nurse 11/87 - 7/88
5/81 - 4/83	Dartmouth-Hitchcock Medical Center Position: Staff Nurse General Psychiatry Unit
5/80 - 4/81	Hanover Terrace Health Care Position: Charge Nurse Skilled Care Unit
6/78 - 12/79	Dartmouth-Hitchcock Medical Center Position: Staff Nurse Intensive Care Unit
1/77 - 3/78	Frederick Memorial Hospital Position: Staff Nurse Medical-Surgical Unit
7/71 - 8/72	Dr. Herbert Glick Position: Medical Assistant Pediatric Office

EDUCATION;

1972 -1976	University of Maryland Bachelor of Science in Nursing Sigma Theta Tau and Phi Kapa Phi honor societies
1986	University of New Hampshire Course work toward Masters in Nursing Administration

LICENSURE:

Registered Nurse
License No. 021135-21
State of New Hampshire

COMMITTEE MEMBERSHIP:

Compliance Committee Coordinator, DHPA

Quality Improvement Committee, DHPA

CURRICULUM VITAE November, 2015

Steven Holmes Chapman, M.D.

Personal Information

Work Address:
Boyle Community Pediatrics Program
6L. General Pediatrics
Dartmouth Hitchcock Medical Center
One Medical Center Drive.
Lebanon. NH 03756
Phone: (603) 653-9605
E-mail: Steven.H.Chapman@Hitchcock.org

EDUCATION

DATES	INSTITUTION	DEGREE
2015	Value Institute. DHMC	Greenbelt
1990-1993	National Health Service Corp	Scholar
1989-1993	University of Pennsylvania	M.D.
1980-84	Brown University	A.B.

POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
1996-2000	National Health Service Corp. Lawrence MA	Pediatrics. Underserved Populations
1994-1996	University of Washington/Seattle Children's Medical Center	Pediatric Resident
1993-1994	University of Washington/Seattle Children's Medical Center	Pediatric Intern

PROFESSIONAL DEVELOPMENT ACTIVITES

DATE	INSTITUTION	TITLE/ACTIVITY
2009-Present (Annually)	Geisel/CHaD OCER Pediatric Training Retreat	Annual Residency Retreat for Rotation Directors

2013-Present (Annually)	Geisel/CHaD	Design and Direct Annual Faculty Development Sessions for Family Faculty – Boyle Program
2013-Present (Annually)	Geisel/CHaD	Design and Direct Annual Faculty Development Session for Community Faculty – Boyle Program
2015	AAP Community Pediatrics Training Initiative – Ben Hoffman MD Visiting Professor	Designed and Co-led 3 day Advocacy and Community Pediatrics Training Retreat
2000-2008 (4 sessions/year)	University of Washington	Visiting Professor Teaching Retreats
1999	University of Massachusetts	Teaching with GNOME – Goals, Needs Assessments, Objectives, Methods, Evaluation
1998	McGill School of Medicine	Effective and Efficient Teaching – Identifying Needs and Goals of Learners

ACADEMIC APPOINTMENTS

DATES	**INSTITUTION**	**TITLE**
2008- Present	Geisel/Dartmouth Medical School	Assistant Professor
2005-2008	University of Washington	Associate Clinical Professor
2001-2005	University of Washington	Assistant Clinical Professor
2000-2001	University of Washington	Instructor
1998-2000	University of Massachusetts	Assistant Clinical Professor
1996-2000	Tufts University	Assistant Clinical Professor

INSTITUTIONAL LEADERSHIP ROLES:

DATES	**INSTITUTION**	**TITLE**
2016-Present	Substance Use Mental Health Taskforce, DHMC	Lead, SBIRT Subgroup; Pediatric Lead, Perinatal Addiction Subgroup
2010- Present	Boyle Community Pediatrics Program, CHaD	Director
2010-Present	Family Advisory Board, CHaD	Lead Faculty Advisor and

		Member
2010-Present	Molly's Place Family Resource Center, CHaD	Medical Director
2012-Present	Pediatric Schwartz Rounds, DHMC, Geisel	Medical Director
2009-Present	Homeless Healthcare Project – Pediatric Residency, CHaD	Medical Director
2010-2016	Healthy Eating Active Living -- CHaD	Steering Committee Member
2008-Present	Pediatric Ambulatory Education Committee	Lead Preceptor
2009-2014	Pediatric Medical Home Implementation Committee, CHaD	Co-Founder and Chair
2012-2014	Primary Care Data and Measurement Committee, DHMC	Pediatric Lead
2012-2014	Center for Primary Care and Population Health, DHMC	Associate Director of Child Health
2012-2014	Primary Care Council, DHMC	Pediatric Lead
2009-2012	Regional Primary Care Council Leadership, DHMC	Steering Committee Member
2009-2011	Ambulatory Resource Quality Committee, CHaD	Pediatric Primary Care Director
2009-2011	Lebanon CHaD General Pediatrics Clinic, CHaD	Medical Director
2008-2011	Green Team, CHaD Primary Care	Team Leader
2009-2010	Pediatric Department Council, CHaD, Pediatric Residency	Primary Care Representative
2004-2008	Olympic Medical Center, Washington State	Chair, Olympic Quality Institute

SEARCH COMMITTEES CHAIRED

Date	Position	Department
2015-6	Child Abuse Pediatrician, M.D.	Pediatrics, Geisel/DHMC
2015	Primary Care Pediatrics, APRN	Primary Care Pediatrics, Geisel/DHMC
2014	Primary Care Pediatrics, APRN	Primary Care Pediatrics, Geisel/DHMC

LICENSURE AND CERTIFICATION

DATE	LICENSURE/CERTIFICATION
2015-Present	American Board of Pediatrics, Recertification
2005	American Board of Pediatrics, Recertification
1996	American Board of Pediatrics, Certification
2008-Present	New Hampshire Medical License
2000-2008, 1993-1996	Washington State Medical License
1996-2000	Massachusetts Medical License

Hospital Appointments

DATES	INSTITUTION	POSITION/TITLE
2011-Present	Dartmouth Hitchcock Medical Center	Senior Staff Membership
2008-Present	Dartmouth Hitchcock Medical Center	Staff Physician
2000-2008	Olympic Medical Center, Washington State	Senior Staff
2004-2008	Olympic Medical Center, Washington State	Chair, Olympic Quality Institute

TEACHING ACTIVITIES

UNDERGRADUATE EDUCATION

Not Applicable

GRADUATE EDUCATION

CLASSROOM TEACHING:

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2012-2014	TDI/Tuck Masters of Healthcare Delivery Science	Population Health: Vulnerable Populations and Workforce Reform	Pediatric Faculty	30

UNDERGRADUATE MEDICAL EDUCATION

CLASSROOM TEACHING

DATE	INSTITUTION	COURSE	ROLE	HOURS/YR
2010-Present	**Geisel Medical**	**From The Other Side Of The Stethoscope**	**Facilitator**	**12**
2010-Present	**Geisel Medical**	**Careers in Medicine**	**Pediatric Lecturer**	**2**
2012-2014	**Geisel Medical**	**Population Health Lecture**	**Lecturer, Family Medicine 3rd years**	**3**

CLERKSHIP TEACHING

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2008-Present	Geisel	Pediatrics	Lead Preceptor	60
2012-Present	Geisel	On Doctoring	Lead Preceptor	20

GRADUATE MEDICAL EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2008-Present	Geisel/DHMC/Pediatric Residency	Continuity Clinic	Lead Preceptor	220
2008-Present	Geisel/DHMC/Pediatric Residency	Ambulatory Rotation	Faculty Preceptor	80
2010-Present	Geisel/DHMC/Pediatric Residency	Community Pediatrics	Course Director	21 Resident Rotations each year
2010-Present	Geisel/DHMC Pediatric Residency	Adolescent Medicine	Faculty Preceptor	20
2009-Present	Geisel/DHMC/Pediatric Residency	Advocacy Elective	Course Director	30
2009-Present	Geisel	Schweitzer Fellowship	Advisor/Selection Committee	4
2011-Present	Geisel	From the Other Side of the Stethoscope (FOSS)	Co-Director, Facilitator	10
2010-Present	Geisel	Career Roadmap Series	Pediatrics Presenter	2

Curricular Programs Developed

DATES	INSTITUTION	COURSE TITLE	ROLE
2011-Present	Dartmouth Pediatric Residency Program	Windshield Survey—Social Determinants of Health Community Needs Assessment	Community Pediatrics Course Director, Content Developer
2011-Present	Dartmouth/Geisel School of Medicine	From the Other Side of the Stethoscope – Compassionate Care workshop with Family Faculty	Co-Developer of Content and Format, with Todd Poret and Toni Lamonica
1991-Present	University of	Bridging the Gap:	Co-Founder, Content

	Pennsylvania School of Medicine	Interdisciplinary Community Health Internship Program	and Format Developer

ADVISING/MENTORING

UNDERGRADUATES/GRADUATE STUDENTS

Not Applicable

MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME
6/2014- June 2017	Christina Jaramillo	Qualitative Research: FOSS (From the Other Side of The Stethoscope)
12/2014 – June 2017	Bianca Williams	Patient Voices – Qualitative Data on the Patient Experience
2016- Present	Simrun Bal	Neonatal Abstinence Syndrome (NAS) – Babies Born Addicted. and Supports for Parents After Nursery Discharge

RESIDENTS/FELLOWS

DATES	MENTEE'S NAME	SPECIALTY
7/15 - Present	Carrie Schulmeister	Pediatric Resident – Academic Advisor
7/14 - Present	Aimee Beaton	Pediatrics Oral Health Fluoride Varnish Project
4/15 – June 2017	Hallie Baucher	Pediatrics Homeless Healthcare Project
5/12-6/15	Sam McWilliams	Pediatrics – Homeless Healthcare Project
2011-13	Brendan Gilligan	Pediatrics
2010-2012	Diana Baker	Pediatric Advocacy

FACULTY

Date	Mentee's Name	Specialty
2015-2016	Susan Pullen MSW	Behavioral Health – SBIRT and Substance Abuse in

	Adolescents

RESEARCH TEACHING/MENTORING

UNDERGRADUATE, GRADUATE, FACULTY

Not Applicable

RESIDENTS -- Advocacy Projects as Scholarly Activity

DATE	MENTEE'S NAME	SPECIALTY
2014-2017	Aimee Beaton	Pediatrics - Oral Health in Underserved Children. SBIRT – Substance Abuse in Adolescents
2015-Present	Sam Ogden	Parents Together – Parents and Recovery Support in Families with Young Children
2015-2017	Hailee Baucher	Health Education and Parent Coaching in a Homeless Population
2013-2015	Sam McWilliams	Child Homeless Healthcare Project
2012	Ryan Johnson	It Happens Here Too: Rural Homelessness and Health in Northern New England
2010-2012	Diana Baker	Child Oral Health – The Opportunity of Fluoride Varnish in Medical Settings

COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT

DATES	INSTITUTION	COURSE TITLE/ACTIVITY	ROLE	HOURS/YEAR
2015-Present	CHaD/The Family Place/Second Growth	Parents Together. Parenting and Substance Misuse Support Course	Faculty Director	20
2011-Present	DHMC/Upper Valley Haven	Bridges Out of Poverty	Course Coordinator	8

2009-Present	Dresden School Board		School District Physician	30
2010-Present	Child Focus Forum		Physician Lead	4
2014- Present	NH Oral Health Coalition		Physician Lead	20
2013-Present	Community Pediatric Grand Rounds	Community agency-based seminar series	Medical Director	6
2013-Present	NH Children's Alliance/Kids Count	Pediatric Advisor	Board Member	15
2014-Present	Let's Grow Kids Vermont		Campaign Ambassador	4

RESEARCH FUNDING

Comment [PEP1]: Would be good to add in your new Planning Grant as of Aug 2017

DATES	PROJECT	ROLE	%EFFORT	SPONSOR	ANNUAL
September 2017 onward	Advancing the Standard of Care for Women and Children Affected by Substance Use Disorders (Planning Grant)	Co-PI	10%	NH Charitable Foundation	**PLANNING GRANT FOR 'CENTER OF EXCELLENCE' PERINATAL SUBSTANCE ABUSE CARE**
September 2017 Onward	Regional Consult Network – Perinatal Substance Abuse Care	Core Pediatric Lead	5%	NH Charitable Foundaton	
2015-Present	NIDA CTN Northeast Node	Core-Investigator	5%	NIDA CTN	
July 2017-Dec 2018	AAP Healthy People 2020 Chapter Grant "The Earlier the Better. Supporting Families in Early Opiate Recovery"	PI	10% (in kind; grant supports program expenses)	American Academy of Pediatrics	
July 2017-July 2018	Family Engagement Grant	Co-PI	In Kind, funds to support family advisory infrastructure	American Academy of Pediatrics Friends of Children Fund	
May 2014-May 2017	Adolescent Substance Abuse --	Co-Director	10%	NH Charitable Foundation –	

	SBIRT			Hilton Family Foundation
2013- 2015	Compassionate Care Initiative	Co-PI	10% (in kind)	Dolan Family Foundation
2015 – Present (Funded through 2020)	Adolescent Substance Abuse Research Node	Co-PI	5%	National Institute of Drug Abuse (NIDA)

CURRICULUM/PROGRAM DEVELOPMENT

DATES	Program	Description
2015-Present	Parents Together – Boyle Community Pediatrics Program, in partnership with 3 community agencies.	Three parenting/recovery groups in partnership with The Family Place, Second Growth, and Perinatal Addiction Treatment program. Pediatric residents involved in program evaluation as well as providing pediatric care to children in the program.
2013-Present	Faculty Development Seminars for Pediatric Family Faculty and Community Faculty	The Boyle Program uses non-traditional faculty for teaching medical students and residents. This series explores development of skills and pedagogical techniques for both Family Faculty (parents of children with special health care needs) and Community Faculty (community agencies and organizations that work with children).
2012-Present	Boyle Community Forum Series: "How Can We Be a Stronger, Healthier Community?"	Presentation and moderated panel discussion on population health issue, held 3 times a year. Topics include Gun Violence, Childhood Obesity, Adolescent Suicide, and Adolescent Opioid Addiction.
2012-Present	Bridges Out of Poverty	Co-Sponsored with The Upper Valley Haven; A joint DHMC –Community seminar on the culture of poverty, and approaches to compassionate care.
2011-Present	Boyle Fund Grant Program	$3-18K grants given to community partners for programs providing care and support to children with special healthcare needs. Past areas of focus have included childhood obesity, and supporting substance abuse recover in parents with young children. Pediatric Residents are involved in the execution of these programs.
2010-Present	Pediatric Resident Advocacy Elective	Defining advocacy as "speaking for those

		whose voice is not heard' this is a month long elective involving project work using an 8-step advocacy framework, including need assessment, attainable goals and objectives, working with collaborative partners, measurement, and evaluation.
2011-Present	Community Needs Assessment 'Windshield Survey'	Incoming pediatric interns are each assigned a town to visit and conduct a health needs assessment, and report back to the residency in written form, and conference presentation.
2009-Present	From the Other Side of The Stethoscope	All Third year Geisel pediatric clerkship students write a reflection on a case of theirs, share with other students and Family Faculty (Parents of children with special healthcare needs who are trained to teach medical learners), and participate in a group discussion on the elements of compassionate care.
1991-Present	Bridging the Gaps – Co-Founder	Developed at the University of Pennsylvania, this Interdisciplinary Community Health Summer Internship program has spread to all medical schools in Philadelphia and Pittsburgh, and has trained over 4000 medical, social work, nursing, and dental students, with all presenting posters at an Annual Symposium. **www.med.upenn.edu/*btg***

ENTREPRENEURIAL ACTIVITIES

Not Applicable

MAJOR COMMITTEE ASSIGNMENTS

NATIONAL/INTERNATIONAL

DATES	COMMITTEE	ROLE	INSTITUTION
2017-2020	AAP District I Executive Committee	NH President	American Academy of Pediatrics

2009-Present	Committee on Oral Health	NH State Champion	American Academy of Pediatrics
2014-2017	AAP National Leadership Forum	NH Vice President	American Academy of Pediatrics
2013-Present	Community Pediatrics Training Initiative	NH AAP/Geisel Representative	American Academy of Pediatrics
2014-Present	NHSC Alumni Recruitment	NHSC Ambassador	National Health Service Corp

REGIONAL

2017	Senators Shaheen and Hassan NH Health Leaders Advisory Group	NH AAP Representative	U.S. Senate
2012-Present	Region I District Leadership Council	NH Representative	American Academy of Pediatrics
2014-Present	NH Pediatric Improvement Partnership	Steering Committee	CHaD/University of New Hampshire
2012-Present	NH Oral Health Coalition	Physician Liaison	AAP, NH Oral Health Coalition, NH Dental Society

LOCAL/INSTITUTIONAL

2016-2017	Substance Misuse Initiate	Lead, Adolescent SBIRT, Member Perinatal Addiction	DHMC
2011-Present	Child Focus Forum	Pediatric Lead	DHMC – 12 Community Organizations/Govt Agencies
2014-Present	Bridges Out of Poverty Collaborative	Boyle Director	Boyle Program, United Way, Upper Valley Haven,
2017-Present	NH Pediatric Society Executive Committee	Chair	American Academy of Pediatrics

MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

DATES	**SOCIETY**	**ROLE**
2017-2020	NH Pediatric Society	President

2014-Present	NH Pediatric Society	Vice President
2008-Present	NH Pediatric Society	Executive Committee Member
2009-Present	Community Pediatrics SIG- AAP	Faculty Member

EDITORIAL BOARDS/JOURNAL REFEREE ACTIVITIES

Not Applicable

AWARDS AND HONORS:

DATE	AWARD
2016	American Academy of Pediatrics Special Achievement Award for "His valuable work educating residents and medical students on substance misuse in children, and addressing poverty in children"
2016	First Place Award. Value Institute DHMC Patient Safety and Quality Award: Adolescent SBIRT
2015	University of Pennsylvania Bridging The Gaps 25th Anniversary -- Community Health Lifetime Recognition
2014	Pediatric Residency Teaching Award
2005	Hero of Health Award – Washington State Department of Health
2003	Bridging The GAP Founders Award – University of Pennsylvania
2000	Faculty Excellence Award – Teacher of the Year (Lawrence Family Medicine Residency)
1991-2000	Public Health Service National Health Service Corp Scholarship
1993	CIBA-Geigy Award for Outstanding Community Service
1993	Alpha Omega Alpha Honor Society
1992	Paul Stolley International Clinical Epidemiology Travel Award

INVITED PRESENTATIONS:

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION

NATIONAL

*^ 2017 June	"SBIRT in Adolescence"	Substance Abuse Mental Health Services Administration (SAMHSA)	Providence, RI
*^ 2017 May	"SBIRT in Primary Care Pediatrics: Lessons and Opportunities Beyond Implementation"	National Drug Abuse Treatment Clinical Trials Network Science Series	Bethesda, MD Lebanon, NH (Webex Talk, live and archived)
*^ 2017 April	"The Earlier the Better: Developing a System of Integrated Care for Childbearing Families with Substance Use Disorders"	Pediatric Academic Society Annual Meeting	San Francisco, CA
*^ 2017 April	"SBIRT Implementation in Primary Care: What Happens After Screening?" With Ardis Olson	Pediatric Academic Society Annual Meeting Poster	San Francisco, CA
*^ 2017 April	"Systematic Tablet-Based Adolescent Screening Improves Practice" Susanne Tanski MD Presenter	Pediatric Academic Society Annual Meeting Platform Presentation	San Francisco, CA
*^ 2017 March	"Management of Adolescent Substance Use Disorder: An Overview and Next Steps"	National Institute on Drug Abuse, Clinical Trials Network Annual Scientific Meeting	Bethesda, MD
*^2016 December	"Beyond Screening and Brief Intervention with Adolescents"	National Drug Abuse Treatment Clinical Trials Network (CTN) Youth Special Interest Group	Bethesda, MD (WebEx)
*^2016 October	"SBIRT in Pediatric Primary Care"	Hilton Foundation Annual Retreat	Washington D.C.
*^2016 October	"Parenting and Substance Abuse: Preventing Adverse Childhood Experiences"	The Northeast Node of the National Drug Abuse Treatment Clinical Trials Network (CTN) Annual Meeting	Hanover, NH
*^2016	Families as Teachers: From the Other Side of the Stethoscope in Third Year Medical Student Clerkships	Pediatric Academic Society, Workshop	Baltimore, MD
*^2016	Addressing Substance Misuse in Adolescents: the SBIRT Model in Primary Care	Academic Pediatric Association, Platform Presentation	Baltimore, MD
*^2016	Tooth or Consequences: Fluoride Varnish Medical Settings	Dartmouth Annual Mount Washington Pediatric Conference, Lecture and Workshop	Mount Washington Lodge, NH
#^2015	Family Faculty Teaching Compassionate Care: From	Academic Pediatric Association	San Diego, CA

	The Other Side of The Stethoscope		
*2015	From The Other Side of The Stethoscope: Compassion Care in Pediatric Clerkship	Counsel on Medical Student Education in Pediatrics	New Orleans, LA
*2012	"Bringing Compassionate Care to Life with Schwartz Center Rounds"	Schwartz Center: Press Ganey	Washington DC
*^2008	Overcoming Fluorophobia In a Rural Western Town By Building Strong Community Partnerships	AAP National Conference	Washington, DC
*^2000	Searching For the Evidence – Use Of Electronic Databases & Internet In Research & Clinical Decision Making Workshop	Academic Pediatric Association National Conference	Boston, MA
*1995	Creating A Road Map For The Future: Workshop	National Health Service Corp	Washington, DC
*^1991	"The West Philadelphia Improvement Corp (WEPIC) Community Health Watch: A School Based Education and Screening Initiative"	Prevention 91: Buiilding an Economic Framework	Baltimore, MD

REGIONAL/LOCAL

*^ 2017 June	"Parents Together: An Integrated System of Support for Parents of Young Children in Early Recovery"	DHMC APRN CME Retreat	Lebanon, NH
*^ 2017 June	"SBIRT in Pediatric Primary Care"	DHMC "No Health Without Mental Health" Evening CME Symposium	Lebanon, NH
*^10/2015	"Ripples in the Pond: Implementing Substance Abuse Screening in NH"	NH Center for Excellent, Region SBIRT Summit	Concord, NH
*^10/2015	"Fluoride Varnish in Medical Office Settings"	NH Oral Health Coalition Annual Summit	Concord, NH
*9/2015	The Raising of America -- Moderator	Boyle Community Forum Series	Lebanon, NH
*7/2015	Brief Intervention: Effective Response To a Positive Substance Abuse Screen	Family Medicine Faculty	Lebanon, NH
*7/2015	Community Needs Assessment: Conducting a Windshield Survey	Pediatric Residency	Lebanon, NH

*6/2015	Third Year Medical Student Clerkship Reflections with Family Faculty: From the Other Side of The Stethoscope	Pediatric Academic Society Meeting, Platform Presentation	San Diego, CA
*6/2015	Brief Intervention: Effective Response To a Positive Substance Abuse Screen	Pediatrics Primary Care Faculty	Lebanon, NH
*5/2015	SBIRT in Primary Care	DHMC Value Institute	Manchester, NH
* 4/2015	Addressing Substance Misuse: Lessons from the NH Youth SBIRT Initiative	Dartmouth Seminar Series	Dartmouth College, Hanover NH
* ^ 2/2015	Adolescent Substance Abuse Screening and Intervention	Dartmouth Research Cooperative	Annual Retreat, North Conway, NH
*^ 10/2014	Implementing a Tablet Based Substance Abuse Screener	NH Center For Excellence	Concord, NH
*10/2014	Healthy Eating Active Living: Community Translation	Boyle Community Forum Series	Lebanon, NH
*9/2014	Barrel To The Head: Firearms and Suicide Risk -- Moderator	Boyle Community Forum Series	Lebanon, NH
*3/2014	The Hungry Heart – Adolescent Substance Abuse	Boyle Community Forum Series	Lebanon, NH
*6/2013	Medical Dental Partnerships: Risk Assessment and Fluoride Varnish	NH Oral Health Coalition	Concord, NH
*2/2013	Working Toward The Sandy Hook Promise" -- Moderator	Boyle Community Forum Series	Lebanon, NH
*1/2013	Testimony, Oral Health Access	NH Senate Bill 284	Concord, NH
1/2012	Testimony, Fluoride Regulation	NH House Bill 186	Concord, NH

PUBLICATIONS

ARTICLES

Aimee Beaton, MD, Catherine Shubkin, MD, **Steven Chapman, MD** Addressing Substance Misuse in Adolescents: A Review of the Literature on the SBIRT (Screening, Brief Intervention, and Referral to Treatment) Model. *Current Opinions In Pediatrics* 2016 Apr;28(2):258-65 PMID: 26867164

Robert D. Newman MD, **Steven H. Chapman MD**, Catherine D. Shubkin MD, Douglas Diekema MD A Wilderness Medicine Curriculum for Pediatric Residents. . *Pediatric Emergency Care*, Vol 14, No. 1, 1998

Mitchell P. LaPlante Ph.D., **Steven H. Chapman**, Gail R. Wilensky Ph.D., Life Expectancy and Health Status of the Aged, Social Security Administration, 1986

Glinda S. Cooper, **Steven H. Chapman**, Gail R. Wilensky Ph.D., An Evaluation of The Eastern Caribbean Regional Training Program for Allied Health Professionals US Agency for International Development, 1985

Louis Garrison, Jr. Ph.D., **Steven H. Chapman**, The Potential Revenue of A State Run Lottery in Jamaica, Report to the Jamaican Ministry of Health, 1985

BOOK CHAPTERS

Gail R. Wilensky Ph.D., **Steven H. Chapman,** in Indicators and Trends of Health and Healthcare, D. Schwefel M.D. *Demographic Indicator Systems of Health Care Needs ed*. Springer Press (1986) pp. 34-40.

ON LINE PUBLICATIONS

Andrew Aligne MD, Deborah Best MD, **Steven H. Chapman** MD, Cappy Collins MD, Lisa Ayoub-Rodriguez MD, Julie Linton MD, Michele Lossius MD, Jerri Rose MD, Benjamin Hoffman The Community Pediatrics Training Initiative Project Planning Tool: A Practical Approach to MD .Community-Based Advocacy *MedEdPortal*, Accepted for Publication in August, 2017

Journal Guest Editor

Gail R. Wilensky Ph.D., **Steven H. Chapman** (Guest Editors) Medicare Physician Payment Alternatives: Assessing the Options. *Medical Care Review* Vol 43, No 1, 1986

Letters to the editor:

Op-Ed: Don't Harm Children and Call It Reform – Co-Authored with Senator Jean Shaheen	Concord Monitor, Portsmouth Gazette, Keene Sentinel, Valley News	June, 2017
Op-Ed Community Water Fluoridation and Ethics	Peninsula Daily News	October, 2015
Op-Ed – Charleston SC – Race and Violence	Valley News	July, 2015
Letter -- Fluoridation as public health	Valley News	September, 2014
Letter -- Sandy Hook and Gun Violence	Valley News	January, 2012

CURRICULUM VITAE

Date Prepared: September 7, 2017

NAME: Julia Renee Frew, MD

ADDRESS: Office: Department of Psychiatry
Geisel School of Medicine at Dartmouth
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756
Julia.R.Frew@hitchcock.org
603-650-4564 office

[redacted]

EDUCATION:

DATE	INSTITUTION	DEGREE
1992-1996	Kenyon College	B.A., summa cum laude
1998-1999	New York University	Postbaccalaureate Premedical Program
2000-2005	Brown Medical School (Brown-Dartmouth Program in Medical Education)	M.D.

POST-DOCTORAL TRAINING:

DATE	SPECIALTY	INSTITUTION
2006-2010	Psychiatry	Geisel School of Medicine at Dartmouth
2009-2010	Psychiatry- Chief Resident	Geisel School of Medicine at Dartmouth

LICENSURE AND CERTIFICATION:

DATE	LICENSURE/CERTIFICATION
2010-	New Hampshire Board of Medicine #14795
2010-	Vermont Board of Medical Practice #042-0011941
2011-	Diplomate, American Board of Psychiatry and Neurology (Psychiatry)

ACADEMIC APPOINTMENTS:

DATE	ACADEMIC TITLE	INSTITUTION
2009-2011	Instructor in Psychiatry	Geisel School of Medicine at Dartmouth
2011-	Assistant Professor of Psychiatry	Geisel School of Medicine at Dartmouth
2016-	Assistant Professor of Obstetrics and Gynecology	Geisel School of Medicine at Dartmouth
2017-	Assistant Professor of Medical Education	Geisel School of Medicine at Dartmouth

HOSPITAL APPOINTMENTS:

DATE	HOSPITAL TITLE	INSTITUTION
2010	Inpatient Psychiatrist (per diem)	Central Vermont Medical Center
2010-	Attending Psychiatrist	Dartmouth-Hitchcock Medical Center
2010-	Director, Women's Mental Health Program	Dartmouth-Hitchcock Medical Center
2010-2015	Consulting Psychiatrist, Live Well/ Work Well Employee Wellness Program	Dartmouth-Hitchcock Medical Center
2016-	Medical Director, Perinatal Addiction Treatment Program	Dartmouth-Hitchcock Medical Center

COMMITTEE ASSIGNMENTS:

DATE	COMMITTEE	INSTITUTION
2008-	Education Policy Committee	Geisel Department of Psychiatry
2009-2010	Residency Curriculum Committee	Geisel Department of Psychiatry
2009-2010	Quality Improvement Committee	Dartmouth-Hitchcock Psychiatric Associates
2009-2010	Psychiatry Grand Rounds Committee	Geisel Department of Psychiatry
2010-2011	Guardianship Policy Committee	Dartmouth-Hitchcock Medical Center
2011-2016	Faculty Council (Psychiatry representative)	Geisel School of Medicine at Dartmouth
2012-	Clinical Education Course Director Committee	Geisel School of Medicine at Dartmouth
2012-	Psychiatry Residency Selection Committee	Geisel Department of Psychiatry
2013-	Graduate Medical Education Committee	Dartmouth-Hitchcock Medical Center
2013-	Chair, Residency Program Clinical Competency Committee	Geisel Department of Psychiatry
2014-	Residency Program Evaluation Committee	Geisel Department of Psychiatry
2015-	Graduate Medical Education Curriculum Committee	Dartmouth-Hitchcock Medical Center

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

DATE	SOCIETY	ROLE
2008-2010	American Psychiatric Association	Member-in-Training
2009-	North American Society for Psycho-Social Obstetrics & Gynecology	Member
2010-2015	Academy of Psychosomatic Medicine	Member, Founding Member of Women's Mental Health Special Interest Group
2012-	International Association for Women's Mental Health	Member
2013-	Association of Directors of Medical Student Education in Psychiatry	Member

2013-	American Association of Directors of Psychiatry Residency Training	Member
2014-	Postpartum Support International	Member

AWARDS AND HONORS:

DATE	AWARD
1992-1996	National Merit Scholarship
1992-1996	Kenyon College Honors Scholarship
1996	Phi Beta Kappa
2000	Volunteer of the Year, St. Vincent's Hospital and Medical Center, NYC
2004	"Best Platform Research Presentation", Academy of Breastfeeding Medicine Annual Meeting
2005	Patricia McCormick Prize, given to the outstanding female student in the graduating class of Brown Medical School
2016	Inducted into Geisel Academy of Master Educators

CLINICAL AND RESEARCH INTERESTS

Women's mental health, perinatal addiction treatment, psychosomatic medicine, physician and medical student health and wellness, psychiatric education of medical students and residents

TEACHING EXPERIENCE/CURRENT TEACHING RESPONSIBILITIES

Geisel School of Medicine at Dartmouth:

DATE	TEACHING
2010-	OB/Gyn Residency Program: Teach on perinatal psychiatry topics
2012	Created and implemented Frontiers in Brain and Behavior preclinical elective for first and second year medical students
2012-	Co-director, Psychiatry Clerkship - Didactic and small group teaching since 2008 - Assumed Co-directorship in 2012: assist with administration of the course including attending weekly clerkship oversight meetings, grading student write-ups, overseeing residents involved in teaching in the clerkship, and assigning final grades
2012-	Residency/Career Advisor for Geisel students interested in pursuing careers in psychiatry
2013-	SBM- Psychiatry Course Director - Facilitate small group sessions to teach 2nd year medical students psychiatric interviewing skills since 2006. - Teach topics such as psychiatric interviewing, delirium, psychiatric ethics since 2010 - Assumed Directorship of course in 2013: oversee all aspects of the course including faculty recruitment, curriculum oversight, final examination, and small group interviewing component
2013-	Associate Director, Psychiatry Residency Program - Teach and directly supervise residents since 2010

- Assumed Associate Directorship in 2013: assist with administration of Adult Psychiatry Residency Program including participating in recruitment, designing and implementing evaluation methods for residents, overseeing teaching activities of senior residents, and meeting regularly with residents regarding their progress

2013- SBM Reproduction Course: Teach session on perinatal psychiatry

2013- Travel yearly to Providence, RI to provide mock oral board exams for Brown Psychiatry Residents

2014-2017 Co-Director, Scientific Basis of Medicine Program (2nd year medical school curriculum at Geisel School of Medicine)

- Oversee Scientific Basis of Medicine Program, including course review, recruitment and evaluation of PBL tutors, review of examinations, determination of final grades, advising for students, and strategic planning

West Central Behavioral Health:

DATE	TEACHING
2009	Led inservice training sessions for case managers at community mental health center on psychopharmacology and substance abuse
2009	Provided psychoeducation about psychopharmacology to clients in Illness Management and Recovery Program

INVITED PRESENTATIONS

Local/Regional

DATE	TOPIC	ORGANIZATION	LOCATION
2011	Depression 101: Treatment of Depression	DHMC Live Well/Work Well Program	Lebanon, NH
2011	Effective Treatment of Anxiety	DHMC Live Well/Work Well Program	Lebanon, NH
2011	Women's Mental Health	DHMC Live Well/Work Well Program	Lebanon, NH
2012	Postpartum Depression	Geisel OB/Gyn Interest Group	Hanover, NH
2012	Access to Mental Health Care for Perinatal Women	Northern New England Perinatal Quality Improvement Network	Lebanon, NH
2012	Access to Mental Health Care for Perinatal Women	OB/Gyn Grand Rounds	Lebanon, NH
2012-14	Women's Mental Health In Primary Care	"What's New in Psychiatry for Non-Psychiatric Providers" CME event	Lebanon & Manchester, NH
2013	Perinatal Psychiatry	Geisel OB/Gyn and Psychiatry Interest Groups	Hanover, NH
2014	Management of Bipolar Disorder in Pregnancy and Lactation	Psychiatry Grand Rounds Dartmouth-Hitchcock	Lebanon, NH

2014	Management of Bipolar Disorder in Pregnancy and Lactation	Psychiatry Grand Rounds University of Vermont	Burlington, VT
2015	Assessment and Management of Depression and Anxiety in Primary Care Patients: Management of Stressful Encounters and Difficult Patients in Primary Care	"What's New in Psychiatry for Non-Psychiatric Providers" CME event	Lebanon, NH
2016	Perinatal Psychiatric Illness	Mental Health Center Of Greater Manchester Grand Rounds	Manchester, NH
2017	Building a Life Worth Living: Treating Moms With Opioid Use Disorders	New Hampshire Association for Infant Mental Health	Concord, NH
2017	Moms in Recovery: Treatment for Pregnant and Parenting Women with Substance Use Disorders: Typical Treatment Dilemmas	Dartmouth-Hitchcock Pediatric Schwartz Rounds	Lebanon, NH
2017	Co-occurring Disorders In Perinatal Women with Substance Use Disorders	Perinatal Opioid Use Disorders Learning Collaborative	Lebanon, NH/Webinar
2017	Tackling the New Hampshire Opioid Crisis (Perinatal Addiction Treatment)	Northeast Node/NIDA Clinical Trials Node/ Center for Technology and Behavioral Health	Hanover, NH
2017	No Health without Mental Health (Perinatal Addiction Treatment)	Dartmouth-Hitchcock Departments of Psychiatry and Population Health	Lebanon, NH
2017	Opiate Crisis: Stories and Solutions (panel discussion)	VT PBS	Rutland, VT

National/International

DATE	TOPIC	ORGANIZATION	LOCATION

2004	First Steps Breastfeeding Education Project	Academy of Breastfeeding Medicine Annual Meeting	Orlando, FL
2016	Moms and Moms-to-Be in Recovery: a Perinatal Addiction Treatment Program	North American Society for Psychosocial Obstetrics and Gynecology	New York, NY
2016	The Earlier the Better: Developing a system of integrated care for child-bearing families with substance use disorders	National Drug Abuse Treatment Clinical Trials Network/ Center for Substance Abuse Treatment	Webinar
2017	Pregnancy and Psychiatric Medication	Recovery Library by Pat Deegan	Online resource

BIBLIOGRAPHY

Original Articles:

Frew, J & Taylor, J. First Steps: A program for medical students to teach high school students about breastfeeding. *Medicine and Health / Rhode Island.* 2005; 88:48-50.

Frew, J. Psychopharmacology of Bipolar I Disorder During Lactation: a case report of use of lithium and aripiprazole in a nursing mother. *Archives of Women's Mental Health.* 2015; 18(1):135-136.

Posters:

Frew, J & Taylor, J. First Steps Breastfeeding Education Project. Society of Teachers of Family Medicine Predoctoral Education National Conference, New Orleans, LA. 2004.

Larusso, E, Frew, J & Krishnan, N. Integrating Mental Health Care into Obstetrics & Gynecology: Results from an embedded psychiatry consultation clinic and implications for quality improvement. North American Society for Psychosocial Obstetrics & Gynecology Annual Meeting, Providence, RI. 2012.

Frew, J & LaRusso, E. Psychiatric consultation in obstetrics/gynecology (OB/GYN): Updated results from a reproductive psychiatry consultation clinic and implications for quality improvement. Perinatal Mental Health Meeting, Chicago, IL. 2013.

Frew, J. Psychopharmacology of bipolar I disorder during lactation: A case report of use of lithium and aripiprazole in a nursing mother. Perinatal Mental Health Meeting, Chicago, IL. 2013.

Goodman, D & Frew, J. Dismantling Barriers to Addiction Treatment and Maternity Care: Results from an Integrated Program. American Society of Addiction Medicine, New Orleans, LA. 2017.

KATRIN TCHANA, LICSW

2 Breck Hill Road
Lyme, NH 03768
phone: (603) 738-9479/(603) 795-2180 email: Katrin.H.Tchana@hitchcock.org

SUMMARY OF SOCIAL SERVICE EXPERIENCE:

DARTMOUTH HITCHCOCK DEPARTMENT OF PSYCHIATRY
Lebanon, NH 2/2015 - Current
Behavioral Health Coordinator
Provide counseling services and substance abuse treatment to patients in the OB/Gyn Clinic and Addiction Treatment Program at Dartmouth Hitchcock Medical Center. As embedded clinician in the OB/Gyn clinic provide care coordination for patients with mental health disorders and consult to providers regarding behavioral health management strategies. As Behavioral Health Coordinator for the Perinatal Addiction Treatment Program provide clinical leadership and oversight of addiction treatment services to pregnant and parenting women with substance use disorders.

MT. ASCUTNEY HOSPITAL AND HEALTHCARE CENTER
Windsor, VT 6/2012-1/2015
Community Care Coordinator/Community Social Worker
As part of the Vermont Blueprint for Health initiative, provided support, advocacy, health coaching and resource and referral services to patients and their families with complex needs. Worked with community groups and local agencies to identify and provide outreach services to vulnerable community members.

GRAFTON COUNTY SENIOR CITIZEN'S COUNCIL (GCSSC)
SERVICELINK
Lebanon, NH 8/2011-5/2012
MSW Intern
Researched, designed and implemented pilot program to provide care coordination to older citizens of Grafton County in order to promote health and safety for aging in place. Provided support accessing services, short-term case management, information and referral for elderly and disabled adults and their caregivers. Led Aging Well and Caregiver Support groups.

CHILD ADVOCACY AND PROTECTION PROGRAM
DARTMOUTH-HITCHCOCK MEDICAL CENTER Lebanon, NH 9/2010-5/2011
MSW Intern
Provided support to families of children where there is concern that cause of hospitalization was deliberately inflicted injury. Served as a member of the Child Advocacy Center's multidisciplinary team and participated in case reviews. Received training in conducting forensic interviews of children who were suspected to be victims of sexual abuse.

WEST CENTRAL BEHAVIORAL HEALTH
Lebanon, NH 2004-2010
DBT Clinician
Provided individual psychotherapy and group therapy as staff clinician for West Central's Enhanced Care Program, serving individuals who suffer from mood disorders, substance abuse disorders, personality disorders and post-traumatic stress disorder. All services provided were informed by the principles of Dialectical Behavioral Therapy, an evidenced-based therapy mode that uses coaching and motivational interviewing to help clients develop effective emotion regulation strategies.

CLARA MARTIN CENTER
Randolph, VT 2000-2004
Site Director, Bradford Office 2003-2004
Responsible for general oversight of satellite office for a Community Mental Health Center. Provided support for clinical staff and supervision of front office. Served as agency representative to the local community and provided communication with senior management team in main office in Randolph, VT.
Intake Coordinator, Bradford Office 2001-2004
Provided access to care for satellite office of a Community Mental Health Center. Provided first contact with potential mental health care consumers and matched them with appropriate services. Supervised the Adult Outpatient Program and provided oversight of emergency services program, staffing and supervision of walk-in clinic, and leadership for the DBT skills training group.
Emergency Clinician 2000-2001
Provided 24-hour emergency mental health care for Orange County, VT. Assessed individuals and families in crisis for risk of suicide or violence towards others, arranged admission for psychiatric hospitalization (including involuntary admission), made referrals to appropriate mental health care providers and social welfare agencies.

HEADREST
Lebanon, NH 1998-2000
Clinician
Responsible for staffing a 24-hour hotline and drop-in center providing support and suicide intervention for individuals throughout Vermont and New Hampshire. Staffed the after-hours emergency lines for community agencies providing crisis support. Provided case management and supportive counseling services.

SUMMARY OF TEACHING EXPERIENCE

- UNIVERSITY of VERMONT DEPARTMENT of SOCIAL WORK Burlington, VT
  Graduate Research/Teaching Assistant 2010-2012
- BERNICE A. RAY SCHOOL Hanover, NH 1996-1998
  English as a Second Language Tutor
- VERMONT REFUGEE ASSISTANCE PROGRAM Burlington, VT
  English as a Second Language Teacher 1991-1993
- GEORGE WASHINGTON HIGH SCHOOL New York, NY 1990 - 1991
  English as a Second Language Teacher
- BOYS AND GIRLS HIGH SCHOOL, Brooklyn, NY 1988 - 1990
  English Teacher
- U.S. PEACE CORPS Cameroon, West Africa 1985 - 1988
  English Teacher 1985 - 1988

EDUCATION:

M.S.W. University of Vermont, Burlington, VT 2012
Transformative Social Work with a focus in Contemplative Practice (Selected as a Graduate Assistant)

M.A. Teaching English as a Second Language, Teachers College, Columbia University, New York, NY 1990 (Selected as a Peace Corps Fellow)

B.A. Human Ecology, College of the Atlantic, Bar Harbor, ME 1983

LICENSURE:

LICSW, State of NH, license number: 1822

CURRICULUM VITAE

NAME: Daisy J. Goodman, CNM, WHNP, DNP, MPH

EMAIL:
daisy.j.goodman@dartmouth.edu
daisy.j.goodman@hitchcock.org

LICENSURE and CERTIFICATION
NH - APRN 045116-23
NH - RN 045116-21
ACNM certificate #10710
NCC certificate # GOO104259401

EDUCATION

Institution	Degree/Certification	Date
Geisel School of Medicine at Dartmouth	MPH	2014
Massachusetts General Hospital (MGH) Institute of Health Professions	DNP	2010
State University of New York at Stony Brook	MS	2004
Frontier School of Midwifery and Family Nursing	CNM WHNP	2002 2002
N.H. Community Technical College	AD-RN	1998
Yale University	BA	1985
College of the Atlantic	—	1982

TEACHING EXPERIENCE

Institution	Title	Date
Colby-Sawyer College, Clinical Nurse Leader Program	Adjunct Professor of Nursing *Applied Healthcare Improvement*	2017
The Dartmouth Institute for Health Policy and Clinical Practice	Clinical Assistant Professor Instructor *Continual Improvement of Health Care* *MPH Practicum* *Coproducing Healthcare Service in Systems*	2016-present 2015-2016
	Teaching Assistant: *Epidemiology/Biostatistics* *Statistical Methods for Quality Improvement* *Continual Improvement of Health Care (2013-2104)*	2013-2015
Masters in Healthcare Delivery Science Program at Dartmouth	Curriculum Specialist	2015
Geisel School of Medicine at Dartmouth	Clinical Assistant Professor Instructor Obstetrics and Gynecology Community and Family Medicine	2016 2013-2016
	Co-facilitator: *History, Society and the Physician*	2016
Frontier Nursing University	Teaching Associate: *Professional Role Development* *Health Promotion* *Community Assessment* *Health Policy: the Birth Center as Case Study*	2013- 2014
Philadelphia University, Continuing Medical/Professional Education	Adjunct Faculty *Pharmacology in Women's Health*	2011-2013
Tufts School of Medicine	Clinical Instructor	2011-2012

CLINICAL EXPERIENCE

Dartmouth Hitchcock Medical Center Department of Obstetrics and Gynecology Perinatal Addiction Treatment Program	Certified Nurse Midwife	2013-present
Franklin Health Women's Care Franklin Memorial Hospital	Certified Nurse Midwife	2006- 2013
Swift River Health Care Rumford Hospital	Certified Nurse Midwife	2002-2006
Maine General Medical Center	Registered Nurse, MCH	2002
Weeks Memorial Hospital	Staff Nurse, Maternity	2000
Weeks Medical Center	Office Nurse, Primary Care	1999- 2000
Coos County Nursing Hospital	Staff/Charge Nurse	1997-2000
Weeks Memorial Hospital	Staff Nurse, Medical Surgical	1998-1999

FELLOWSHIPS

Veterans Health Administration	Quality Scholars Fellow	2012- 2015

HONORS AND AWARDS

2015 Blatman Scholar's Award: Dept. of Obstetrics and Gynecology, Dartmouth Hitchcock Medical Center

2014 The Dartmouth Institute for Health Policy and Clinical Practice: Leadership Award

2012 Maine Affiliate, American College of Nurse -Midwives: Midwife of the Year Award

2010 MGH Institute of Health Professions: Lavinia Dock Scholarly Writing Award

2008 MGH Institute of Health Professions: Clapham Merit Scholarship

2001 Frontier School of Midwifery and Family Nursing: Mardi Perry Scholarship

1998 New Hampshire Technical College: Nursing Faculty Award Scholarship

1997 Androscoggin Valley Hospital Scholarship Award

PUBLICATIONS

Murphy, J, **Goodman, D**, Johnson, T, Terplan, M. The Comprehensive Addiction Treatment Recovery Act (CARA): No one called the midwife *(under review).*

Goodman, D, Bowden, K, O'Connor, A. Substance abuse during pregnancy. In Engstrom, J, Marfel, J, Jordan, R. *Prenatal and Postnatal Care: A Guide for Nurse Practitioners and Midwives, 2nd ed.* New Jersey: Wiley-Blackwell *(under review).*

Goodman, D, Ogrinc, G, Davies, L, et al. Explanation and Elaboration of the SQUIRE [Standards for Quality Improvement Reporting Excellence] Guidelines, version 2.0: Examples of SQUIRE elements in the healthcare improvement literature. *BMJ Quality and Safety*. 2016;0: 1–24.

Goodman, D. Substance use disorders. In Thorpe, N, Farley, C, Jordan, R. *Clinical Practice Guidelines for Midwifery and Women's Health (5th ed).* 2016. Jones and Bartlett.

Goodman, D. Improving access to maternity care for pregnant women with opioid use disorders: co-location of midwifery services in the Dartmouth-Hitchcock Perinatal Addiction Treatment Program. *Journal of Midwifery and Women's Health,* 2015:60:6:706-712.

Goodman, D, Milliken, C, Theiler, R, Nordstrom, B, Akerman, S. A Multidisciplinary Approach to the Treatment of Co-occurring Opioid Use Disorder and Posttraumatic Stress Disorder in Pregnancy: A Case Report. *Journal of Dual Diagnosis* 2015 (ePub ahead of print).

Akerman, S, Brunette, M, Green, A., **Goodman, D**, Blunt, Heil, S. Treating tobacco use disorder in pregnant women on opioid substitution therapy: A systematic review. *Journal of Substance Abuse Treatment* 2015; 52:40-7.

Ogrinc, G, Davies, L, **Goodman, D**, Batalden, P, Davidoff, F, Stevens, D. SQUIRE 2.0: (Standards for Quality Improvement Reporting Excellence): Revised Publication Guidelines from a Detailed Consensus Process. *The Joint Commission Journal on Quality and Safety* 2015;41;10:471-479.

Davies, L, Donnelly, K, **Goodman, D**, Ogrinc, G. Findings from a novel approach to publication guideline revision: User road testing of a draft version of SQUIRE 2.0. *BMJ Quality and Safety* 2015 (ePub ahead of print).

Bowden, K., **Goodman, D**. Barriers to employment for postpartum women with substance use disorders. *Work: A Journal of Assessment, Prevention & Rehabilitation* 2015; 50; 3: 425-31

Akerman, S, **Goodman, D**. Treating Opioid Use Disorders in Pregnant Women: Are We Doing Enough? *Newsletter of the American Association of Addiction Psychiatry* June, 2014.

Goodman, D, Wolff, K. Screening for substance abuse in women's health: a public health imperative. *Journal of Midwifery and Women's Health* 2013;58;3:278-287.

Goodman, D, O'Connor, A, Bowden, K. Substance abuse during pregnancy. In Engstrom, J, Marfel, J, Jordan, R. *Prenatal and Postnatal Care: A Guide for Nurse Practitioners and Midwives.* 2013. New Jersey: Wiley-Blackwell.

Goodman, D. (contributor). The Capstone Project: Students' Experience. (2012). In Ahmed, S, Andrist, L, Davis, S, Fuller, V. (Eds). *The DNP – Redesigning Advance Practice Roles for the 21st Century: Education, Practice, and Policy*. 2012. New York: Springer.

Goodman, D. Buprenorphine for the treatment of perinatal opioid dependence: pharmacology and implications for antepartum, intrapartum, and postpartum care. *Journal of Midwifery and Women's Health,* 2010;56;3: 240-247.

Technical Reports:

Snuggle ME Workgroup (2013). *Embracing Drug Affected Babies and their Families in the First Year of Life to Improve Medical Care and Outcomes in Maine.* (Contributing author).

MPH Capstone:

An Integrated Care Model for Treating Perinatal Substance Use Disorders: A Public Health Program Intervention Proposal. (2014). *Fulfillment of the Masters in Public Health degree. Geisel School of Medicine at Dartmouth.*

DNP Capstone:
Managing Perinatal Opioid Dependency in the Rural Community Setting: Clinical Guideline Development and Validation. (2009). *Fulfillment of the Doctor of Nursing Practice degree, Massachusetts General Hospital Institute for Healthcare Professionals.*

PRESENTATIONS

2017 American College of Nurse Midwives National Convention: "Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders: Expanding the Role of Midwives." (5/2017)

2017 American Society for Addiction Medicine National Conference (poster presentation): "Dismantling Barriers to Addiction Treatment and Maternity Care: Results from an Integrated Program (Co-author: Julia Frew, MD)

2017 Institute for Healthcare Improvement Virtual Expedition: "Nurturing Trust." (3/2017)

2016 Institute for Healthcare Improvement National Forum: "Can Improvement Cause Harm?" (Co-presenters Greg Ogrinc and William Nelson). (12/2016)

2016 Institute for Healthcare Improvement Scientific Symposium: "The SQUIRE Guidelines." (Co-presenters Greg Ogrinc and Louise Davies). (12/2016)

2016 Northern New England Perinatal Quality Improvement Network: "A Collaborative Project to Improve Quality and Safety for Pregnant and Parenting Women with Opioid Use Disorders: Project update." (11/2016)

2016 American Association of Colleges of Nursing: "The Nation's Opioid Crisis: Your Practice, Your Responsibility." Webinar (10/2016)

2016 ACNM/AWHONN Maine: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders. (10/2016)

2016 NIDA Clinical Trials Network, Northeast Node: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders (10/2016)

2016 Institute for Healthcare Improvement: WIHI program on integrated care models for treatment of perinatal substance use (6/2016)

2016 Quality and Safety in Nursing Education: Demystifying the SQUIRE guidelines. (5/2106)

2016 Northeast Medical Association (NEMA) annual meeting: "Moms and Moms-to-be in Recovery: Perinatal Addiction Treatment Programs" (3/2016)

2016 NNEPQIN Winter Conference: "A collaborative project to improve safety and quality of care for pregnant and postpartum women with opioid use disorders" (1/2016)

2015 Institute for Healthcare Improvement (IHI) 27th National Forum: faculty, SQUIRE writing workshop (12/2015)

2015 International SQUIRE writing conference: faculty, 11/2015

2015 "Revising the SQUIRE Guidelines for quality improvement reporting excellence: a case study in improvement" Oral presentation at the Academy for Healthcare Improvement (AHI) National Conference, 10/2015

2015 "Treatment of Perinatal Opioid Use Disorders" Oral presentation at American College of Nurse Midwives' National Conference, 6/2015

2015 "Double Jeopardy: The intersection of PTSD, substance use disorders, and pregnancy" Poster presentation at American College of Nurse Midwives' National Conference, 6/2015

2015 SQUIRE publication guidelines (with Greg Ogrinc, MD). Grand Rounds presentation, Center for Clinical Research and Technology, University Hospitals Case Medical Center, 5/2015

2015 SBIRT in Healthcare: focus on perinatal care. 11th Annual Dartmouth Symposium "Taking Action to Reduce Opioid-related Harm," 5/2015

2015 "In their own words: a qualitative study of the experience of prenatal care for women with opioid use disorders." Grand Rounds presentation, Department of Obstetrics and Gynecology, Dartmouth Hitchcock Medical Center, 3/2015.

2014 "SBIRT in Everyday Practice." Oral presentation at ChaD regional conference: Optimizing Our Interactions with Families with Substance Use Disorders, 11/2014.

2014 "Caring for Mothers with Opioid Use Disorders: A Collaborative Model." Oral presentation at Joint ACOG/AWHONN Regional Conference, 10/2014

2014 "Improving Quality of Care for Pregnant Women with Substance Use Disorders" Guest lecture for Quality Improvement course, MGH Institute for Health Professions, 7/2014

2014 "Integrating Substance Abuse Screening, Brief Intervention and Referral for Treatment in Maternity Care." Poster presentation for Academy for Healthcare Improvement, 5/2014

2014 "Screening for Substance Use Disorders in Women's Health." Oral presentation at American College of Nurse Midwives' National Conference, 5/2014

2013 "Screening, Brief Intervention and Referral for Treatment in Maternity Care" Webinar, sponsored by Maine Quality Counts

2013 Panelist, Advanced Practice Nursing Leadership Panel for University of Southern Maine (USM), Graduate Nursing Program, Portland, ME

2012 "Screening for Substance Abuse in Pregnancy" Oral presentation, Joint AWHONN/ACOG Regional Perinatal Conference, Freeport, ME 5/2012

2011 Education session, ACNM National Convention. "A collaborative approach for treating perinatal opioid addiction in the community setting," San Antonio, TX 5/2011

2011 ACNM Regional Conference. "Treating perinatal opioid dependence with buprenorphine," Portsmouth, NH, 10/2011

2010 Central Maine Medical Center Clinical Grand Rounds, "A collaborative model for treatment of perinatal opioid dependence in the rural community setting," Lewiston, ME

2010 Guest lecture, MGH Institute for Health Professions, Women's Health Nurse Practitioner Program: "Supporting women's addiction recovery: the role of the WHNP," Boston, MA

2010 New England Regional Perinatal Conference: "Treating perinatal opioid dependence in the rural community," Waterville, ME

2010 Maine AWHONN Supper Club presentation, "Managing perinatal opioid dependence in the community setting," Farmington, ME

OTHER SCHOLARLY ACTIVITIES:

2013-2017 SQUIRE 2.0 Revision Leadership Group

2015-2017 Abstract Review, QSEN (Quality & Safety in Nursing Education) Institute

2013-2016 Abstract Review, International Forum on Quality and Safety in Healthcare

2016 Reviewer, Journal of Substance Abuse Treatment

2011-2017 Reviewer, Journal of Midwifery and Women's Health

RESEARCH AND QUALITY IMPROVEMENT ACTIVITIES

2017 Empowering pregnant mothers with opioid use disorders to create and implement a Plan of Safe Care for their infants using technology *(Co-Principal Investigator with Sarah Lord, PhD).* SYNERGY Community Engagement Pilot Grant.

2016 HERIZONT: National Institute for Alcohol Abuse and Alcoholism clinical trial. *(Sub-investigator; Principal Investigators: Alan Green,MD; Sarah Akerman, MD).*

2015-2016 Improving Safety and Quality in the Care of Pregnant Women with Substance Use Disorders. A quality improvement project. *(Principal Investigator).* March of Dimes, New England Chapter

2014 In their own words: Perceived barriers to care for pregnant women with opioid dependence. A qualitative study of barriers and facilitators to care for prenatal and postpartum women with opioid dependence *(Principal Investigator).* Dartmouth-Hitchcock Medical Center, Department of Obstetrics and Gynecology: Blatman Scholars Fund

2014 Reward responsiveness in pregnant cigarette smokers treated with buprenorphine. Co-investigator. *(Principal Investigator: Sarah Akerman, MD)*

2009 Managing Perinatal Opioid Dependency in the Rural Community Setting: Clinical Guideline Development and Validation *(DNP Capstone).* MGH Institute for Health Professions

Clinical Improvement Work

2014 Perinatal Outcomes, Dartmouth Hitchcock Perinatal Addiction Treatment Program (data analysis, reporting). Funded by New Hampshire Charitable Foundation.

2013-2017 Project Coordinator, Dartmouth Hitchcock Medical Center, Department of Obstetrics and Gynecology, SBIRT Implementation Project. Funded by New Hampshire Charitable Foundation.

2011-2012 Project Director, Franklin Health Women's Care, 4Ps Plus Screening Project.

OTHER PROFESSIONAL ACTIVITIES

Professional Organizations

2002-current Member, American College of Nurse-Midwives

2014-current Member, American Society for Addiction Medicine

Policy and Advisory Board Memberships

2016- ACNM representative to Alliance for Innovation in Maternal Health (AIM) workgroup, bundle development workgroup for the Care of Women with Opioid Use Disorders

2013-2016 NH Statewide Partnership on Prenatal Substance Exposure/Alcohol Exposure

2011-2013 Maine Drug-Affected Babies Project- multidisciplinary work group on perinatal substance abuse

2009 Maine State Board of Nursing- APRN Advisory Board

PRECEPTORSHIPS:

2014 Clinical Preceptor, Nurse-Midwifery students, Yale University Nurse-Midwifery Program

2012 Clinical Preceptor, Women's Health, MGH Institute of Health Professions

2010 Clinical Preceptor, University of Vermont, Family Nurse Practitioner Program

2009 Clinical Preceptor, Hussein College, Family Nurse Practitioner Program

2009-2012 Clinical Instructor, Maine Sexual Assault Forensic Nurse Examiner Program

Mary Hitchcock Memorial Hospital

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Julia Frew, MD	Medical Director	$251,170	20%	$50,234
Daisy Goodman, APRN	Women's Health Director	$126,000	20%	$25,200
Steve Chapman, MD	Pediatric Director	$240,000	20%	$48,000
Katrin Tchana, LICSW	Clinical Director	$87,000	40%	$34,800
Suzy Catalona	Program Manager	$105,664	100%	$105,664

These are the key personnel on the leadership team, critical to the successful implementation and management of this program.

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Julia Frew, MD	Medical Director	$251,170	20%	
Daisy Goodman, APRN	Women's Health Director	$126,000	20%	
Steve Chapman, MD	Pediatric Director	$240,000	20%	
Katrin Tchana, LICSW	Clinical Director	$87,000	40%	
Suzy Catalona	Program Manager	$105,664	100%	
To Be Hired	Administrative Assistant/Coordinator		100%	
To Be Hired	Program Implementation Specialist/Evaluator		50%	
To Be Hired	Data Manager/Analyst		40%	
To Be Hired	Research Assistant		100%	

These are the key personnel on the leadership team, critical to the successful implementation and management of this program. The remaining positions listed on the submitted program staff list are critical to the delivery of services at each of the practice sites. Many of these employees will be hired directly by the 'host' practice, funded through a subcontract between D-H and the 'host' practice. For the MD positions, current contract median salaries have been used for this as their salaries are reviewed and adjusted twice per year (January & July).