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

Jeffrey A. Meyers  
Commissioner

Katja S. Fox  
Director

129 PLEASANT STREET, CONCORD, NH 03301  
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www.dhhs.nh.gov

August 28, 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 of Behavioral Health, Bureau of Mental Health Services, to enter into an agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, in an amount not to exceed \$197,164.41, to provide a training program for First Episode Psychosis, effective upon Governor and Executive Council approval, through September 30, 2018. 100% Federal Funds.

Funds are available in the following accounts 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.

**05-95-092-922010-4120-102 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, HHS: DIVISION OF BEHAVIORAL HEALTH, MENTAL HEALTH BLOCK GRANT**

| Fiscal Year | Class/Account | Class Title            | Job Number   | Total Amount        |
|-------------|---------------|------------------------|--------------|---------------------|
| SFY 2018    | 102/500731    | Contracts for Prog Svc | 92224120     | \$161,820.86        |
| SFY 2019    | 102/500731    | Contracts for Prog Svc | 92224120     | \$35,343.55         |
|             |               |                        | <b>Total</b> | <b>\$197,164.41</b> |

**EXPLANATION**

The purpose of this agreement is for the provision of a training program to the Community Mental Health Center System for First Episode Psychosis (FEP) patients. First Episode Psychosis is a comprehensive approach to treatment for individuals with first or early stage manifestation of a psychotic disorder. Early intervention services for First Episode Psychosis can improve symptoms and restore functioning in a manner superior to standard care services. First Episode Psychosis treatment services include Coordinated Specialty Care (CSC), delivered by a team of several professionals with different levels and areas of expertise.

Each year approximately 100,000 young people in the United States experience a first episode of mental illness. Long delays between the onset of mental illness and effective treatment are typical. A 2015 study of more than four-hundred (400) people in the United States with early symptoms found

that half experienced symptoms for nearly eighteen (18) months before beginning treatment. This is almost six times the World Health Organization's quality standard of a maximum twelve (12) weeks. Research shows that integrated coordinated specialty care effectively reduces symptoms and improves functioning.

Funds in this agreement will be used to continue a statewide training program, beginning with one Community Mental Health Center, using the NAVIGATE model, a team-based approach to specialized early intervention in mental illness. This treatment model emphasizes prompt detection, acute care during periods of crisis, and services to lead youth and young adults who are experiencing symptoms of mental illness for the first time, toward a continuation of healthy functioning.

Findings reported by the National Institute for Mental Health show that over two (2) years clients at the NAVIGATE clinics stayed in treatment longer; experienced greater improvement in their symptoms, in their interpersonal relationships, and in their quality of life; and were more involved in work or school compared to clients at typical-care sites.

Mary Hitchcock Memorial Hospital was selected for this project through a competitive bid process. A Request For Proposals for a trainer for First Episode Psychosis (FEP) Treatment Services was posted on The Department of Health and Human Services' web site from November 30, 2016 through January 30, 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 proposal. The Bid Summary is attached.

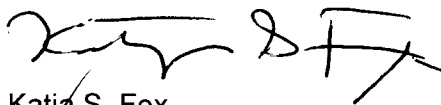
As referenced in the Request For Proposals and in Exhibit C-1 of this contract, this Agreement has the option to extend for up to two (2) additional years contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

Area served: Statewide.

Source of Funds: 100% Federal Funds. Catalog of Federal Domestic Assistance (CFDA) #93.958 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Federal Award Identification Number (FAIN) #SM010035-17.

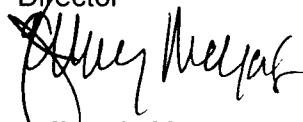
In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,



Katija 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**

**Trainer for First Episode Psychosis  
(FEP) Treatment Services**

RFP Name

**RFP-2017-DBH-05-FIRSTE**

RFP Number

**Bidder Name**

1. **Dartmouth-Hitchcock**

2. **0**

3. **0**

4. **0**

| Pass/Fail | Maximum Points | Actual Points |
|-----------|----------------|---------------|
|           | 180            | 140           |
|           | 180            | 0             |
|           | 180            | 0             |
|           | 180            | 0             |

**Reviewer Names**

1. Brian Huckins, NAMI Child & Family Liaison, Volunteer, Tech

2. Effie Malley, Mbr NH Mental Health Planning Advisy Council, Volunteer

3. Adele Gallant - Administrator, Bureau Children's Behavioral Health

4. Harry Cunningham, Training Director, Manchester Mental Health, Volunteer

5. Ann Driscoll, Administrator III, Ofc of Improvement & Integrity, Cost Team

6. Tanja Milic, DBH, Business Administrator II, Cost Team

Subject: Trainer for First Episode Psychosis (FEP) Treatment Services/RFP-2017-DBH-05-FIRSTE

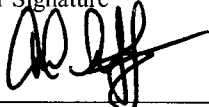
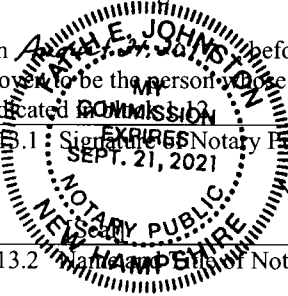
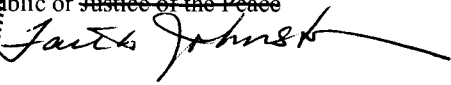
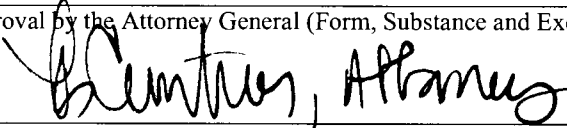
Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

**AGREEMENT**

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

**GENERAL PROVISIONS**

**1. IDENTIFICATION.**

|  |   |   |                                      |
|--|---|---|--------------------------------------|
| 1.1 State Agency Name<br>Department of Health and Human Services   |   | 1.2 State Agency Address<br>129 Pleasant Street<br>Concord NH 03301-3857                  |                                      |
| 1.3 Contractor Name<br>Mary Hitchcock Memorial Hospital  |   | 1.4 Contractor Address<br>One Medical Center Drive<br>Lebanon, NH 03756                   |                                      |
| 1.5 Contractor Phone Number<br>603-650-6404  | 1.6 Account Number<br>05-95-092-922010-4120-102 | 1.7 Completion Date<br>September 30, 2018   | 1.8 Price Limitation<br>\$197,164.41 |
| 1.9 Contracting Officer for State Agency<br>Jonathan V. Gallo, Esq. Interim Director of Contracts and Procurement  |   | 1.10 State Agency Telephone Number<br>603-271-9246  |                                      |
| 1.11 Contractor Signature<br>  |   | 1.12 Name and Title of Contractor Signatory<br>Daniel P. Jantzen, Chief Financial Officer |                                      |
| 1.13 Acknowledgement: State of <i>New Hampshire</i> , County of <i>Grafton</i><br>On <i>September 21, 2017</i> before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proved to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated. |   |   |                                      |
| 1.13.1 Signature of Notary Public or Justice of the Peace<br>    |   |   |                                      |
| 1.13.2 Name and Title of Notary or Justice of the Peace<br>Jacob Johnston  |   |   |                                      |
| 1.14 State Agency Signature<br>   |   | 1.15 Name and Title of State Agency Signatory<br>Katja S Fox, Director                    |                                      |
| Date: <i>9/30/17</i>   |   |   |                                      |
| 1.16 Approval by the N.H. Department of Administration, Division of Personnel (if applicable)<br>By: _____ Director, On: _____   |   |   |                                      |
| 1.17 Approval by the Attorney General (Form, Substance and Execution) (if applicable)<br>By:  On: <i>9/7/17</i>   |   |   |                                      |
| 1.18 Approval by the Governor and Executive Council (if applicable)<br>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

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 \$1,000,000 per 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.

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.



Exhibit A

**Scope of Services**

**1. Provisions Applicable to All Services**

- 1.1. The Contractor will 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 coordinate and establish a Coordinated Specialty Care (CSC) team for the Nashua Community Mental Health Center (CMHC).
- 2.2. The Contractor shall provide training to the Nashua CMHC on First Episode Psychosis Treatment Services used to treat individuals ages fifteen (15) to thirty-five (35) who present with symptoms of a psychotic disorder and meet State eligibility criteria for either a:
  - 2.2.1. Serious Emotional Disturbance (SED) or Serious Emotional Disturbance with Interagency Involvement (SED-IA) as determined through the use of the Child and Adolescent Needs and Strengths (CANS) assessment; or
  - 2.2.2. Serious Mental Illness (SMI) as determined through the use of the Adult Needs and Strengths Assessment (ANSA).
- 2.3. The Contractor shall provide a training program to ensure the Nashua Community Health Center can implement First Episode Psychosis (FEP) treatment services and continue those services beyond the training period, which shall include, but not be limited to:
  - 2.3.1. Initial Assessments.
  - 2.3.2. Clinical and Support Skills.
  - 2.3.3. Coordination of FEP treatment.
- 2.4. The Contractor shall ensure that all materials for trainings shall clearly indicate that no Protected Health Information (PHI), Personally Identifiable Information (PII), or other confidential information shall be revealed by trainees during training sessions or during any consultations with Contractor or Sub-Contractors.

*CH*  
8/21/17





**Exhibit A**

- 2.5. The Contractor shall train Nashua CMHC staff in the FEP NAVIGATE Model, which includes but is not limited to:
  - 2.5.1. Training FEP team members in fundamental information about FEP.
  - 2.5.2. Training on how to use joint decision-making with clients and natural supports.
  - 2.5.3. Specialty training for specific staff roles, which includes but is not limited to:
    - 2.5.3.1. Motivational interviewing strategies.
    - 2.5.3.2. Cognitive-behavioral strategies.
    - 2.5.3.3. Strategies for involving family members and other supporters.
  - 2.5.4. Clinical and support skills that will enable all team members to:
    - 2.5.4.1. Use shared decision-making with clients, family members and other supporters.
    - 2.5.4.2. Identify characteristics of individuals with first episode or early psychosis.
    - 2.5.4.3. Describe how clients with first episode schizophrenia differ from those who experience multi-episode schizophrenia.
    - 2.5.4.4. Identify the key needs of individuals with first or early psychosis.
    - 2.5.4.5. Contribute to the weekly FEP NAVIGATE team meetings.
    - 2.5.4.6. Identify key outcomes that can be improved by clients who participate in FEP treatment.
- 2.6. The Contractor shall ensure the Nashua CMHC FEP team includes, but are not limited to:
  - 2.6.1. A Program Director who is trained to:
    - 2.6.1.1. Educate the community on FEP in order to increase early recognition of psychosis.
    - 2.6.1.2. Recruit individuals who have begun to experience psychosis.
    - 2.6.1.3. Lead the FEP team.
  - 2.6.2. A Family Education (FE) Clinician (who may also be the Program Director) who is trained to:
    - 2.6.2.1. Assist natural supports in learning:



**Exhibit A**

- 2.6.2.1.1. General information about psychosis
- 2.6.2.1.2. How to manage psychosis.
- 2.6.2.1.3. How to support each other and build 'family resiliency.'
- 2.6.2.2. Conduct outreach and recruitment to community agencies.
- 2.6.2.3. Evaluate potential clients for the NAVIGATE program.
- 2.6.2.4. Use engagement strategies to involve clients in treatment.
- 2.6.2.5. Conduct weekly team meetings and collaborative treatment planning meetings.
- 2.6.2.6. Identify common reactions in family members of individuals with FEP.
- 2.6.2.7. Use engagement strategies to involve natural supports in treatment.
- 2.6.2.8. Conduct illness education sessions with natural supports of persons with early psychosis.
- 2.6.2.9. Identify and teach coping strategies for natural supports in order to assist them in responding to clients in a supportive manner.
- 2.6.2.10. Teach communication and problem solving skills to the client's natural supports.
- 2.6.2.11. Assist natural supports to identify and strengthen their own resiliency.
- 2.6.3. A Prescriber (psychiatrist, nurse practitioner or physician's assistant) who is trained to:
  - 2.6.3.1. Use low doses of medications to treat FEP.
  - 2.6.3.2. Understand special issues of relevance to individuals experiencing FEP, which may include but is not limited to:
    - 2.6.3.2.1. Avoiding authoritarian approaches.
    - 2.6.3.2.2. Using strategies for accommodating client ambivalence
  - 2.6.3.3. Identify early signs that an individual is developing symptom of psychosis.



**Exhibit A**

- 2.6.3.4. Describe the differences between recommended medication sequences for first episode and multi-episode schizophrenia.
- 2.6.3.5. Integrate the use of the Client Self-Questionnaire in client appointments.
- 2.6.3.6. Use strategies for joint decision-making as it applies to prescribing medication for clients.
- 2.6.3.7. Use strategies for retaining early phase psychosis clients in treatment.
- 2.6.3.8. Describe outcome differences between RAISE-ETP (FEP NAVIGATE) treatment programs and standard care for early phase psychosis.
- 2.6.4. An Individual Resiliency Trainer (IRT) who is trained to:
  - 2.6.4.1. Assist individuals identify and work towards their goals
  - 2.6.4.2. Teach individuals strategies and skills to build resiliency in coping with psychosis while staying on track with their lives.
  - 2.6.4.3. Focus on individual strengths and resiliency to assist with personal recovery goal setting.
  - 2.6.4.4. Identify strategies that individuals can use to cope with psychosis.
  - 2.6.4.5. Educate clients about the negative effects of substance use on psychosis and provide a message of hope and optimism for overcoming substance use problems.
  - 2.6.4.6. Assist clients with processing the experience of having a first episode of psychosis.
  - 2.6.4.7. Use cognitive behavioral therapy techniques such as cognitive restructuring.
  - 2.6.4.8. Use psychoeducational techniques to teach clients about psychosis and recover.
- 2.6.5. A Supported Employment And Education (SEE) Specialist) trained to:
  - 2.6.5.1. Assist individuals identify their educational and/or employment goals.
  - 2.6.5.2. Assist individuals with achieving their educational and/or employment goals.



Exhibit A


- 2.6.5.3. Identify key principles for supporting individuals in pursuing evaluation and employment goals.
- 2.6.5.4. Collaborative complete a Career Inventory.
- 2.6.5.5. Use strategies to assist individuals with identifying specific career goals.
- 2.6.5.6. Provide rapid job search and rapid school search to clients, based on client preference.
- 2.6.5.7. Develop job and school opportunities in the community for FEP clients.
- 2.6.5.8. Provide follow along supports for clients who have obtained a job or enrolled in school.
- 2.6.6. A specified FEP team member or a separate case manager trained to:
  - 2.6.6.1. Trained to assist individuals obtain needed services through community resources, such as housing and transportation.
- 2.6.7. A Peer Support who is either a specified FEP team member or and individual from an outside peer specialist program who is trained to:
  - 2.6.7.1. Assist clients by sharing experiences of recovery.
  - 2.6.7.2. Assist clients to get back on track with their lives, which may include, but is not limited to:
    - 2.6.7.2.1. Working.
    - 2.6.7.2.2. Attending school.
    - 2.6.7.2.3. Fostering positive relationships.
    - 2.6.7.2.4. Developing a strong support system.
- 2.7. The Contractor shall implement FEP NAVIGATE Training in four phases, as approved by the Department, which include:
  - 2.7.1. Phase 1- Refresher and Preparation to continue implementing the FEP team. The Contractor shall complete an assessment of and provide support for the Nashua CMHC to ensure the agency is prepared to continue implementing the NAVIGATE program. Phase 1 activities include, but are not limited to:
    - 2.7.1.1. Telephone consultations with the Nashua CMHC in order to assess readiness for receiving training. The Contractor shall ensure consultations are conducted in the presence of the CMHC administrative and



**Exhibit A**

clinical leadership and topics include, but are not limited to:

- 2.7.1.1.1. Discussion of the facility and its services, including but not limited to, any current early psychosis efforts; characteristics of the current population served; and plans for continuing the implementation of FEP NAVIGATE.
  - 2.7.1.1.2. Overview of Phase 2 and Phase 3 format requirements.
  - 2.7.1.1.3. Identification and formal 'buy-in' of local FEP leadership team and stakeholders.
  - 2.7.1.1.4. Identification of proposed FEP team members, with special attention to scope of practice; need for any additional training; optimal case size; and plans for release from current duties.
  - 2.7.1.1.5. Review of resources needed to implement the NAVIGATE program, with development of plans to access any resources currently not available at the agency.
  - 2.7.1.1.6. Development of funding streams and strategies.
  - 2.7.1.1.7. Discussion of plans for the prescriber regarding the time that shall be dedicated to regular meetings with clients, weekly team meetings and monthly consultation calls.
  - 2.7.1.1.8. Responses to administrative or clinical leadership questions regarding NAVIGATE.
- 2.7.1.2. Telephone consultations with the Nashua CMHC that will prepare the agency to implement FEP NAVIGATE, on topics that include but are not limited to:
- 2.7.1.2.1. Strategies for program development.
  - 2.7.1.2.2. Strategies for setting up the team.
  - 2.7.1.2.3. Establishment of enrollment criteria.

  
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**Exhibit A**

- 2.7.1.2.4. Methods of working with private insurance and public assistance.
  - 2.7.1.2.5. Development of a referral network.
  - 2.7.1.2.6. Specific time that shall be set aside for staff to participate in team meetings and consultation calls.
  - 2.7.1.2.7. Identification of outcome measures.
  - 2.7.1.2.8. Establishment of materials and routines for outreach, referrals and engagement.
- 2.7.2. Phase 2 – Staff Training – The Contractor shall provide intensive ‘hands-on’ in-person training in the NAVIGATE components for the team(s). Intensive staff training shall include, but is not limited to:
- 2.7.2.1. Providing two (2) half-days of intensive Prescriber training.
  - 2.7.2.2. Providing one (1) full day refresher in-person training for the Director/Family Clinician, IRTs and SEE.
  - 2.7.2.3. Providing one (1) half-day of in-person Supervisor Training.
  - 2.7.2.4. Providing Consultation calls for the Nashua CMHC team in the following manner:
    - 2.7.2.4.1. Twelve (12) calls for the Prescriber.
    - 2.7.2.4.2. Eighteen (18) calls each for the Director/Family Clinician, IRT and SEE.
  - 2.7.2.5. Providing one (1) day of in-person SEE training and site visit in the Nashua community.
- 2.7.3. Phase 3 – Consultation and Fidelity Monitoring for Successful Implementation – The Contractor shall ensure NAVIGATE Trainer/Consultants conduct follow-up telephone consultation to the Nashua CMHC on actively using NAVIGATE components, including trouble-shooting the overall implementation of the model (beginning the first month following the in-person training and continuing for up to one year following the in-person training). The Contractor shall:
- 2.7.3.1. Provide monthly consulting calls to the prescriber for up to twelve (12) months after completing the initial training.

Handwritten initials of the contractor, appearing to be 'QJ'.

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**Exhibit A**

- 2.7.3.2. Ensure prescriber fidelity by documenting prescriber practices and reviewing practices post implementation.
- 2.7.3.3. Ensure clinical fidelity by reviewing case presentations and reviewing random cases post implementation.
- 2.7.3.4. Conduct consultation calls once every two weeks to the Director/Family Clinician, IRT Clinician and SEE Specialist.
- 2.7.3.5. Tape and rate Family Clinician and IRT Fidelity Sessions to establish clinical fidelity, based on the fidelity scales established during the RAISE research phase of NAVIGATE.
- 2.7.3.6. Observe; by tape, joining by telephone or by on-site visit; and rate a minimum of four (4) team meetings to ensure Director Fidelity
- 2.7.3.7. Review regular summaries of weekly team meetings conducted by the Director to ensure Director Fidelity.
- 2.7.3.8. Ensure SEE Fidelity through review of:
  - 2.7.3.8.1. Documentation of completed career inventories and community job development.
  - 2.7.3.8.2. Record keeping on contacts with clients and community resources.
  - 2.7.3.8.3. Case presentations.
- 2.7.3.9. Conduct a minimum of one (1) full day on-site observation of the SEE in the clinic and in the community.
- 2.7.4. Phase 4 – The Contractor shall evaluate procedures for the following seeking Clinical Certification:
  - 2.7.4.1. One (1) Prescriber;
  - 2.7.4.2. One (1) Director;
  - 2.7.4.3. One (1) Family Clinician;
  - 2.7.4.4. Two (2) IRTs; and
  - 2.7.4.5. One (1) SEE.
- 2.8. The Contractor shall ensure FEP NAVIGATE trainees in the Nashua CMHC receive reference materials that supplement the trainings provided, including but not limited to:



**Exhibit A**

- 2.8.1. Copies of the NAVIGATE Team Members' Guide for all team members.
- 2.8.2. Copies of the Director's Manuals, Family Education Manual, IRT manual, SEE manual and Prescriber's Manual, and links to Recovery Videos featuring clients and family members, for each Director receiving training.
- 2.8.3. Copies of the IRT Manual and links to the IRT videos for all IRT clinicians.
- 2.8.4. Copies of the Family Education Manual and links to Recovery videos featuring family members for all Family Education Clinicians.
- 2.8.5. Copies of the SEE manual and links to recovery videos featuring clients who are working and/or in school for all SEE Specialists.
- 2.8.6. Copies of the Prescriber's Manual and links to Recovery videos featuring clients talking about the role of medication in their recovery for all prescribers.
- 2.9. The Contractor shall evaluate certification requirements to FEP team members, which shall include, but not be limited to:
  - 2.9.1. Requirements for prescriber certification, that include but are not limited to:
    - 2.9.1.1. Participation in a minimum of ten (10) prescriber consultation calls.
    - 2.9.1.2. Meeting fidelity criteria that include, but are not limited to:
      - 2.9.1.2.1. Providing consultation data that indicates a minimum of 80% of clients served are being prescribed according to the NAVIGATE model.
      - 2.9.1.2.2. Providing consultation data regarding laboratory result and how those results have been addressed.
  - 2.9.2. Requirements for director certification, that include but are not limited to:
    - 2.9.2.1. Participation in a minimum of fourteen (14) consultation calls, of which are scheduled twice per month for the first six (6) months and once per month for the second six (6) months.
    - 2.9.2.2. Providing monthly written summary reports, in accordance with the Director Manual, to the Family





**Exhibit A**

- Clinician consultant, which shall include but not be limited to the number of following meetings that were held:
- 2.9.2.2.1. NAVIGATE team meetings.
  - 2.9.2.2.2. IRT supervision.
  - 2.9.2.2.3. Family supervision.
  - 2.9.2.2.4. SEE supervision.
  - 2.9.2.2.5. Collaborative treatment planning meetings.
  - 2.9.2.2.6. Accompaniments of SEE specialist community visits.
- 2.9.2.3. Arranging a minimum of four (4) team meetings (one per quarter) that include the NAVIGANT consultant by speaker phone.
- 2.9.2.4. Responding to the NAVIGATE consultant's feedback on team meetings.
- 2.9.2.5. Meeting fidelity criteria that includes, but is not limited to:
- 2.9.2.5.1. Conducting a minimum of 80% of the required meetings.
  - 2.9.2.5.2. Achieving an average of 3 on the Director Fidelity Scale for a minimum of three (3) team meetings that were observed.
  - 2.9.2.5.3. Achieving an average of 3 on the Team Fidelity Scale as assessed by the NAVIGATE Director/Family consultant.
- 2.9.3. Requirements for IRT Clinician certification, that include but are not limited to:
- 2.9.3.1. Participation in a minimum of forty-two (42) weekly clinical meetings about IRT.
  - 2.9.3.2. Audiotaping IRT sessions and completing IRT contact sheets.
  - 2.9.3.3. Submitting taped IRT sessions and completed IRT contact sheets to the NAVIGATE IRT Consultant.
  - 2.9.3.4. Responding to NAVIGATE consultant feedback on tapes and contact sheets providing in Section 2.7.3.3.



**Exhibit A**

- 2.9.3.5. Submitting tapes from a minimum of two (2) clients at different stages of IRT.
- 2.9.3.6. Meeting IRT fidelity criteria for both standard and individualized modules, which includes but are not limited to:
  - 2.9.3.6.1. Receiving a minimum rating of 3 on the IRT fidelity score for quality of session item on a minimum of four (4) consecutive sessions, as assessed by the NAVIGATE Consultant.
  - 2.9.3.6.2. Receiving a minimum rating of 3 on the RIRT fidelity score for the overall quality of session item on a minimum of four (4) consecutive sessions, as assessed by the NAVIGATE Consultant.
- 2.9.4. Requirements for Family Clinician certification, that include but are not limited to:
  - 2.9.4.1. Participation in a minimum of fourteen (14) consultation calls with the NAVIGATE Consultant.
  - 2.9.4.2. Audiotaping family sessions and completing family contact sheets in accordance with the Family Consultant Manual.
  - 2.9.4.3. Submitting taped family sessions and completed family contact sheets to the NAVIGATE Consultant.
  - 2.9.4.4. Responding to the NAVIGATE Consultant's feedback regarding the sessions in Section 2.7.4.2.
  - 2.9.4.5. Working with a minimum of two (2) families throughout the educational sessions to completion.
  - 2.9.4.6. Meeting family clinician fidelity criteria, which include but are not limited to:
    - 2.9.4.6.1. Receiving a rating of 3 on 'Overall quality of session' for 3 of the 4 rated sessions on a minimum of two (2) families, for a total of 8 rated sessions.
    - 2.9.4.6.2. Audiotaping and submitting a minimum of one consultation session for a minimum of two (2) families to the NAVIGATE consultant for rating and feedback.
- 2.9.5. Requirements for SEE Specialist certification, that include but are not limited to:



**Exhibit A**

- 2.9.5.1. Participating in a minimum of 42 meetings about SEE.
  - 2.9.5.2. Participating in a one-day site visit with SEE NAVIGATE Consultant while conducting business in the community.
  - 2.9.5.3. Providing sufficient information to the SEE NAVIGATE Consultant in order for the consultant to complete the NAVIGATE SEE Fidelity Scale, which may include role plays with the consultant in order to complete the entire assessment.
  - 2.9.5.4. Presenting a minimum of one (1) case to the consultant that indicates supports in progress to employment.
  - 2.9.5.5. Presenting a minimum of one (1) case to the consultant that indicates supports in progress to education.
  - 2.9.5.6. Meeting SEE Specialist Fidelity criteria, which include but are not limited to:
    - 2.9.5.6.1. Demonstration of satisfactory performance on job development skills, educational opportunity development skills and observed interactions with clients, natural supports, employers and educators.
    - 2.9.5.6.2. Demonstration of satisfactory ratings on the NAVIGATE SEE Fidelity Scale.
    - 2.9.5.6.3. Presentation of a minimum of two (2) cases to the consultant showing evidence of fulfilling a minimum of 80% of SEE principles.
- 2.10. The Contractor shall provide Team Fidelity and Clinical Provider certification requirements to the Nashua CMHC, which shall include, but not be limited to:
- 2.10.1. Information that indicates FEP teams must provide fully integrated NAVIGATE services to a minimum of five (5) clients for a period of not less than nine (9) months.
  - 2.10.2. Observation provided by NAVIGATE through consultation calls with the director, team meetings and reviews of records.



Exhibit A

**3. Reporting**

- 3.1. The Contractor shall provide quarterly reports that include, but are not limited to:
  - 3.1.1. A narrative summary of activities completed for the previous quarter that includes, but is not limited to:
    - 3.1.1.1. Specific contacts made to Nashua CMHC.
    - 3.1.1.2. Plan for the following quarter to overcome barriers experienced in the previous quarter.
  - 3.1.2. Assessment of agencies and support provided to agencies for the purpose of readiness to implement the NAVIGATE program.
  - 3.1.3. All reports provided pursuant to this contract will contain de-identified aggregate data only. No PHI, PII, or confidential information will be included. The Contractor shall not receive any PHI, PII or confidential information from any CMHC staff as a result of this contract.

**4. Deliverables**

- 4.1. The Contractor shall provide two (2) half-days of in-person training to the Prescribers from the Nashua CMHC to be completed within ninety (90) days of the contract effective date.
- 4.2. The Contractor shall provide one (1) day of refresher trainings, to be completed within ninety (90) days of the contract effective date, to the following positions:
  - 4.2.1. Director of the Nashua CMHC;
  - 4.2.2. Family clinician;
  - 4.2.3. Individual Resiliency Trainers; and
  - 4.2.4. Supported Employment and Education Specialist trainees.
- 4.3. The Contractor shall provide one (1) half-day of Supervisor training to be completed within ninety (90) days of the contract effective date.
- 4.4. The Contractor shall provide consultation calls within thirty (30) days of the completed training.
- 4.5. The Contractor shall begin the clinical certification process, which includes but may not be limited to:
  - 4.5.1. Taping IRT and family sessions.
  - 4.5.2. Reviewing SEE logs.
  - 4.5.3. Reviewing psychiatrists prescribing practices.

*[Handwritten Signature]*

8/21/17


**New Hampshire Department of Health and Human Services  
Trainer for First Episode Psychosis (FEP) Treatment Services**



**Exhibit A**

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- 4.6. The Contractor shall provide one (1) full day of SEE training and site visit in the Nashua community for Fidelity purposes as part of the clinical certification process by September 30, 2018.
- 4.7. The Contractor shall provide clinical certification for team members who meet clinical criteria by September 30, 2018.

  
8/20/17



## Exhibit B

### Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. This contract is funded with federal funds. Department access to supporting funding for this project is dependent upon the criteria set forth in the Catalog of Federal Domestic Assistance (CFDA) (<https://www.cfda.gov>) #93.958 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Federal Award Identification Number (FAIN) #SM010035-17.
3. The Contractor shall use and apply all contract funds for authorized direct and indirect costs to provide services in Exhibit A, Scope of Services, in accordance with Exhibit B-1, Budget through Exhibit B-2, Budget.
4. The Contractor shall not use or apply contract funds for capital additions or improvements, entertainment costs, or any other costs not approved by the Department.
5. Payment for services provided in accordance with Exhibit A, Scope of Services, shall be made as follows:
  - 5.1. Payments shall be made on cost reimbursement basis only, for allowable expenses and in accordance with Exhibits B-1, Budget through Exhibit B-2, Budget.
  - 5.2. Allowable costs and expenses shall include those expenses detailed in Exhibit B-1, Budget through Exhibit B-2, Budget.
  - 5.3. The Contractor shall submit monthly invoices using invoice forms provided by the Department, and will reference contract budget detail on each invoice.
  - 5.4. The Contractor shall submit supporting documentation and required reports in Exhibit A, Scope of Services, Section 4, that support evidence of actual expenditures, in accordance with Exhibit B-1, Budget through Exhibit B-2, Budget for the previous month by the tenth (10<sup>th</sup>) working of the current month.
  - 5.5. The invoices for services outlined in Exhibit B-1, Budget, through Exhibit B-2 Budget shall be submitted preferably by e-mail on Department approved invoices to:

State Planner or Designee  
Department of Health and Human Services  
Bureau of Mental Health Services  
105 Pleasant Street  
Concord, NH 03301



**Exhibit B**

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[beth.nichols@dhhs.nh.gov](mailto:beth.nichols@dhhs.nh.gov)

- 5.6. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement.
6. A final payment request shall be submitted no later than forty (40) days from the Form P37, General Provisions, Contract Completion Date, Block 1.7.
7. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this Contract may be withheld, in whole or in part, in the event of noncompliance with any State or Federal law, rule or regulation applicable to the services provided, or if the said services have not been completed in accordance with the terms and conditions of this Agreement.
8. Notwithstanding paragraph 18 of the Form P-37, General Provisions, an amendment limited to transfer the funds within the budgets in Exhibit B-1 and Exhibit B-2 and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

8/21/18

Exhibit B-1

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital, Department of Psychiatry

Budget Request for: RFP-2017-DBH-05-FIRST/Trainer for First Episode Psychosis  
 (Name of RFP)

Budget Period: State Fiscal Year (SFY) 2018, July 1, 2017 - June 30, 2018

| Line Item                               | Total Program Cost |                | Contractor Share / Match |                | Funded by DHHS contract share |                | Total         |
|---|--------------------|----------------|--------------------------|----------------|-------------------------------|----------------|---------------|
|   | Direct Incremental | Indirect Fixed | Direct Incremental       | Indirect Fixed | Direct Incremental            | Indirect Fixed |               |
| 1. Total Salaries/Wages                 | \$ 1,625.00        | \$ 476.13      | \$ -                     | \$ -           | \$ 1,625.00                   | \$ 476.13      | \$ 2,101.13   |
| 2. Employee Benefits                    | \$ 568.75          | \$ 166.64      | \$ -                     | \$ -           | \$ 568.75                     | \$ 166.64      | \$ 735.39     |
| 3. Consultants                          | \$ 111,320.00      | \$ 32,616.76   | \$ -                     | \$ -           | \$ 111,320.00                 | \$ 32,616.76   | \$ 143,936.76 |
| 4. Equipment:                           | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Rental                                  | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Repair and Maintenance                  | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Purchase/Depreciation                   | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 5. Supplies:                            | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Educational                             | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Lab                                     | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Pharmacy                                | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Medical                                 | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Office                                  | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 6. Travel                               | \$ 1,350.00        | \$ 395.55      | \$ -                     | \$ -           | \$ 1,350.00                   | \$ 395.55      | \$ 1,745.55   |
| 7. Occupancy                            | \$ 6,287.73        | \$ 1,842.30    | \$ -                     | \$ -           | \$ 6,287.73                   | \$ 1,842.30    | \$ 8,130.03   |
| 8. Current Expenses                     | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Telephone                               | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Postage                                 | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Subscriptions                           | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Audit and Legal                         | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Insurance                               | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| Board Expenses                          | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 9. Software                             | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 10. Marketing/Communications            | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 11. Staff Education and Training        | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 12. Subcontracts/Agreements             | \$ -               | \$ -           | \$ -                     | \$ -           | \$ -                          | \$ -           | \$ -          |
| 13. Other (specific details mandatory): | \$ 4,000.00        | \$ 1,172.00    | \$ -                     | \$ -           | \$ 4,000.00                   | \$ 1,172.00    | \$ 5,172.00   |
| <b>TOTAL</b>                            | \$ 125,151.48      | \$ 36,669.38   | \$ -                     | \$ -           | \$ 125,151.48                 | \$ 36,669.38   | \$ 161,820.86 |

Indirect As A Percent of Direct 29.30%



8/12/18

**New Hampshire Department of Health and Human Services**

Bidder/Program Name: **Mary Hitchcock Memorial Hospital, Department of Psychiatry**

Budget Request for: **RFP-2017-DBH-05-FIRSTE/Trainer for First Episode Psychosis**  
(Name of RFP)

Budget Period: **State Fiscal Year (SFY) 2019, July 1, 2018 - September 30, 2018**

| Line Item                               | Total Program Cost |                |              | Contractor Share / Match |                |       | Funded by DHHS contract share |                |              | Total        |
|---|--------------------|----------------|--------------|--------------------------|----------------|-------|-------------------------------|----------------|--------------|--------------|
|   | Direct Incremental | Indirect Fixed | Total        | Direct Incremental       | Indirect Fixed | Total | Direct Incremental            | Indirect Fixed | Total        |              |
| 1. Total Salary/Wages                   | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 2. Employee Benefits                    | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 3. Consultants                          | \$ 26,774.00       | \$ 7,844.78    | \$ 34,618.78 | \$ -                     | \$ -           | \$ -  | \$ 26,774.00                  | \$ 7,844.78    | \$ 34,618.78 | \$ 34,618.78 |
| 4. Equipment:                           | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Rental                                  | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Repair and Maintenance                  | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Purchase/Depreciation                   | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 5. Supplies:                            | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Educational                             | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Lab                                     | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Pharmacy                                | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Medical                                 | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Office                                  | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 6. Travel                               | \$ 560.53          | \$ 164.24      | \$ 724.77    | \$ -                     | \$ -           | \$ -  | \$ 560.53                     | \$ 164.24      | \$ 724.77    | \$ 724.77    |
| 7. Occupancy                            | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 8. Current Expenses                     | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Telephone                               | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Postage                                 | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Subscriptions                           | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Audit and Legal                         | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Insurance                               | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| Board Expenses                          | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 9. Software                             | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 10. Marketing/Communications            | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 11. Staff Education and Training        | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 12. Subcontracts/Agreements             | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| 13. Other (specific details mandatory): | \$ -               | \$ -           | \$ -         | \$ -                     | \$ -           | \$ -  | \$ -                          | \$ -           | \$ -         | \$ -         |
| <b>TOTAL</b>                            | \$ 27,334.53       | \$ 8,009.02    | \$ 35,343.55 | \$ -                     | \$ -           | \$ -  | \$ 27,334.53                  | \$ 8,009.02    | \$ 35,343.55 | \$ 35,343.55 |

Indirect As A Percent of Direct 29.30%



**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.

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8/21/17



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 (EEO):** The Contractor will provide an Equal Employment Opportunity Plan (EEO) 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.



**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 9.2 of the General Provisions of this contract, is amended to read:

All materials developed by contractor or its subcontractors to provide the Services under this Agreement will remain the property of Contractor or its subcontractors.
3. Subparagraph 9.3 of the General Provisions of this contract, is amended to read:

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; provided, however, prior written approval of the State shall not be required for Contractor or its agents or subcontractors to disclose the data solely for purposes of providing Services in accordance with this Agreement.
4. 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.

*COJ*

*8/2/17*



- 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.
5. Subparagraph 14.1.2 of the General Provisions of this contract, Insurance, is deleted.
6. Subparagraph 15.2 of the General Provisions of this contract, is amended to read:

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 as required in N.H. RSA chapter 281-A. 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.
7. Paragraph 14, of the Special Provisions, Exhibit C, Prior Approval and Copyright Ownership is amended to read:

All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. Contractor grants to the State an irrevocable, non-exclusive, worldwide, royalty-free right and license to use, reproduce, display, and distribute copies of all original materials produced, including, but not limited to, brochures, resource directors, protocols or guidelines, posters or reports, in the provision of these Services. The Contractor shall, and shall require any subcontractor or assignee to, obtain prior written approval from DHHS before using any information or data provided by the State in any materials to be used for purposes other than providing Services under this Agreement.
8. 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.

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8/21/17





**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

New Hampshire Department of Health and Human Services  
Exhibit D



- 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:

8/21/17  
Date

  
Name: Daniel F. Jantzen  
Title: Chief Financial 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-1.)
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:

8/21/17  
Date

  
Name: Daniel Jantzen  
Title: Chief Financial Officer



**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**

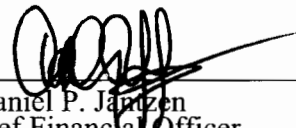
11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
  - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
  - 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:

8/21/17  
Date

  
Name: Daniel P. Jantzen  
Title: Chief Financial Officer



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

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

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

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;
- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;
- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);
- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;
- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;
- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;
- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;
- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;
- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

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

Exhibit G

Certification of Compliance with requirements pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower protections

Contractor Initials

New Hampshire Department of Health and Human Services  
Exhibit G



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

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

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

Contractor Name:

8/21/17  
Date

  
Name: Daniel J. Zantzen  
Title: Chief Financial Officer

Exhibit G

Certification of Compliance with requirements pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower protections

Contractor Initials

  
8/21/17  
Date



**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:

8/21/17  
Date

  
Name: Daniel P. Jantzen  
Title: Chief Financial Officer





Exhibit I

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**HEALTH INSURANCE PORTABILITY ACT**  
**BUSINESS ASSOCIATE AGREEMENT**

*Reserved*



**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:

8/21/17  
Date

  
Name: Daniel P. Jantzen  
Title: Chief Financial Officer



**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: _____ |

    
8/21/17

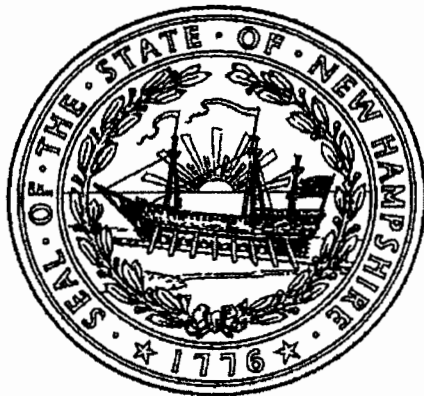
# State of New Hampshire

## Department of State

### CERTIFICATE

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

Business ID: 68517



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 May A.D. 2017.

A handwritten signature in black ink, appearing to read "William M. Gardner".

William M. Gardner  
Secretary of State

**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 7<sup>th</sup>, 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.”

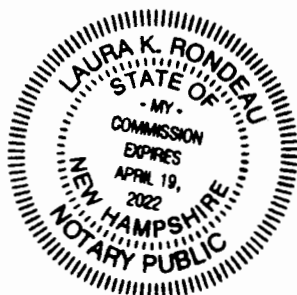
3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer and Chief Financial Officer, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Daniel P. Jantzen is the Chief Financial Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.


IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 21 day of August.

  
\_\_\_\_\_  
Anne-Lee Verville, Board Chair

STATE OF NHCOUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 21<sup>st</sup> day of August, by Anne-Lee Verville.



  
\_\_\_\_\_  
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

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.

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

**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                     |             |
|-------------------------------|--------------------|---------------|-----------------------|------------------------|----------------------------|-------------|
| <b>X</b>                      | <b>CLAIMS MADE</b> | 0002017-A     | 07/01/2017            | 06/30/2018             | EACH OCCURRENCE            | \$1,000,000 |
|                               |                    |               |                       |                        | PRODUCTS-COMP/OP AGGREGATE |             |
|                               |                    |               |                       |                        | PERSONAL ADV INJURY        |             |
|                               |                    |               |                       |                        | GENERAL AGGREGATE          | \$3,000,000 |
|                               |                    |               |                       |                        | FIRE DAMAGE                |             |
| <b>OTHER</b>                  |                    |               |                       |                        | MEDICAL EXPENSES           |             |
| <b>PROFESSIONAL LIABILITY</b> | EACH CLAIM         |               |                       |                        |                            |             |
|                               | CLAIMS MADE        |               |                       |                        | ANNUAL AGGREGATE           |             |
|                               | OCCURENCE          |               |                       |                        |                            |             |
| <b>OTHER</b>                  |                    |               |                       |                        |                            |             |


**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**





CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 08/10/2017

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.

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.

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: Safety National Casualty Corporation
NAIC #: 15105

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.

Table with columns: INSR LTR, TYPE OF INSURANCE, ADDL INSD, SUBR WVD, POLICY NUMBER, POLICY EFF (MM/DD/YYYY), POLICY EXP (MM/DD/YYYY), LIMITS. Includes sections for Commercial General Liability, Automobile Liability, Umbrella Liab, Excess Liab, and Workers Compensation and Employers' Liability.

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

CERTIFICATE HOLDER: NH DHHS, 129 Pleasant Street, Concord, NH 03301
CANCELLATION: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
AUTHORIZED REPRESENTATIVE: John Zawilinski



## **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.



***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**

| <i>(in thousands of dollars)</i>  | <b>2016</b>         | <b>2015</b>         |
|---|---------------------|---------------------|
| <b>Assets</b>   |                     |                     |
| 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  | <u>397,400</u>      | <u>343,767</u>      |
| 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  | <u>\$ 1,835,667</u> | <u>\$ 1,786,013</u> |
| <b>Liabilities and Net Assets</b>   |                     |                     |
| 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   | <u>299,681</u>      | <u>273,312</u>      |
| 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   | <u>1,346,163</u>    | <u>1,182,281</u>    |
| 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  | <u>489,504</u>      | <u>603,732</u>      |
| Total liabilities and net assets  | <u>\$ 1,835,667</u> | <u>\$ 1,786,013</u> |

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**

| <i>(in thousands of dollars)</i>  | <b>2016</b>        | <b>2015</b>      |
|---|--------------------|------------------|
| <b>Unrestricted revenue and other support</b>   |                    |                  |
| Net patient service revenue, net of provision for bad debt<br>(\$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  | <u>1,791,707</u>   | <u>1,560,024</u> |
| <b>Operating expenses</b>   |                    |                  |
| 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  | <u>1,830,687</u>   | <u>1,569,336</u> |
| Operating loss  | <u>(38,980)</u>    | <u>(9,312)</u>   |
| <b>Nonoperating gains (losses)</b>  |                    |                  |
| 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  | <u>(5,865)</u>     | <u>80,243</u>    |
| (Deficiency) excess of revenue over expenses  | <u>\$ (44,845)</u> | <u>\$ 70,931</u> |

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**

| <i>(in thousands of dollars)</i>   | <b>2016</b>       | <b>2015</b>       |
|--|-------------------|-------------------|
| <b>Unrestricted net assets</b>   |                   |                   |
| (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                                 | <u>(114,011)</u>  | <u>11,519</u>     |
| <b>Temporarily restricted net assets</b>                                       |                   |                   |
| 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                       | <u>(726)</u>      | <u>11,793</u>     |
| <b>Permanently restricted net assets</b>                                       |                   |                   |
| 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                                  | <u>509</u>        | <u>16,812</u>     |
| Change in net assets   | (114,228)         | 40,124            |
| <b>Net assets</b>  |                   |                   |
| Beginning of year  | <u>603,732</u>    | <u>563,608</u>    |
| End of year  | <u>\$ 489,504</u> | <u>\$ 603,732</u> |

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

| <i>(in thousands of dollars)</i>   | <b>2016</b>      | <b>2015</b>      |
|--|------------------|------------------|
| <b>Cash flows from operating activities</b>  |                  |                  |
| 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  | <u>(12,840)</u>  | <u>14,350</u>    |
| <b>Cash flows from investing activities</b>  |                  |                  |
| 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  | <u>(60,802)</u>  | <u>(26,388)</u>  |
| <b>Cash flows from financing activities</b>  |                  |                  |
| 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  | <u>75,325</u>    | <u>20</u>        |
| Increase (decrease) in cash and cash equivalents   | 1,683            | (12,018)         |
| <b>Cash and cash equivalents</b>   |                  |                  |
| Beginning of year  | 38,909           | 50,927           |
| End of year  | <u>\$ 40,592</u> | <u>\$ 38,909</u> |
| <b>Supplemental cash flow information</b>  |                  |                  |
| 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.



# Dartmouth-Hitchcock Health and Subsidiaries

## Consolidated Notes to Financial Statements

### June 30, 2016 and 2015

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#### 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.).

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2016 and 2015

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- *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.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2016 and 2015**

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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            | <u>\$ 337,160</u> |

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2016 and 2015**

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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.

# Dartmouth-Hitchcock Health and Subsidiaries

## Consolidated Notes to Financial Statements

### June 30, 2016 and 2015

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#### **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)

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Consolidated Notes to Financial Statements**

#### **June 30, 2016 and 2015**

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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.

# Dartmouth-Hitchcock Health and Subsidiaries

## Consolidated Notes to Financial Statements

### June 30, 2016 and 2015

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#### 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.

# **Dartmouth-Hitchcock Health and Subsidiaries**

## **Consolidated Notes to Financial Statements**

### **June 30, 2016 and 2015**

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#### **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



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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.

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

*(in thousands of dollars)*

|   |                  |
|---|------------------|
| <b>Assets</b>                             |                  |
| 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                     | <u>\$ 46,826</u> |
| <b>Liabilities</b>                        |                  |
| 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                 | <u>28,044</u>    |
| <b>Net Assets</b>                         |                  |
| Unrestricted                              | 18,083           |
| Temporarily restricted                    | 670              |
| Permanently restricted                    | 29               |
| Total net assets                          | <u>18,782</u>    |
| Total liabilities and net assets          | <u>\$ 46,826</u> |

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                                    | <u>(401)</u>     |
| Nonoperating gains                                | 235              |
| Excess of revenue over expenses                   | <u>(166)</u>     |
| Net assets transferred to affiliate               | 18,782           |
| Changes in temporarily and permanently net assets | 24               |
| Increase in net assets                            | <u>\$ 18,640</u> |

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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):

| <i>(in thousands of dollars)</i>                                      | <b>2016</b>         | <b>2015</b>      |
|---|---------------------|------------------|
| Total operating revenues  | \$ 1,835,177        | \$ 1,658,250     |
| Total operating expenses  | <u>1,872,167</u>    | <u>1,671,124</u> |
| Operating loss  | (36,990)            | (12,874)         |
| Nonoperating gains  | <u>(6,045)</u>      | <u>81,277</u>    |
| (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                           | <u>(5,873)</u>      | <u>(931)</u>     |
| (Decrease) increase in unrestricted net assets                        | <u>\$ (112,201)</u> | <u>\$ 4,755</u>  |

**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:

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

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.

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

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

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:

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

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-

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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.

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**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.

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**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              |
|--|-------------------|-------------------|
| <b>Assets limited as to use</b>                                  |                   |                   |
| 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            |
|  | <u>513,525</u>    | <u>533,479</u>    |
| <b>Investments held by captive insurance companies (Note 12)</b> |                   |                   |
| 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            |
|  | <u>76,993</u>     | <u>85,168</u>     |
| <b>Held by trustee under indenture agreement (Note 10)</b>       |                   |                   |
| Cash and short-term investments                                  | 1,950             | 1,778             |
|  | <u>1,950</u>      | <u>1,778</u>      |
| Total assets limited as to use                                   | <u>\$ 592,468</u> | <u>\$ 620,425</u> |

*(in thousands of dollars)*

|  | 2016              | 2015              |
|--|-------------------|-------------------|
| <b>Other investments for restricted activities</b> |                   |                   |
| 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                |
|  | <u>142,036</u>    | <u>132,016</u>    |
| Total other investments for restricted activities  | <u>\$ 142,036</u> | <u>\$ 132,016</u> |

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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)*

|                                    | <b>2016</b>       |                   |                   |
|------------------------------------|-------------------|-------------------|-------------------|
|                                    | <b>Fair Value</b> | <b>Equity</b>     | <b>Total</b>      |
| 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                |
|                                    | <u>\$ 384,858</u> | <u>\$ 349,646</u> | <u>\$ 734,504</u> |

*(in thousands of dollars)*

|                                    | <b>2015</b>       |                   |                   |
|------------------------------------|-------------------|-------------------|-------------------|
|                                    | <b>Fair Value</b> | <b>Equity</b>     | <b>Total</b>      |
| 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                |
|                                    | <u>\$ 415,482</u> | <u>\$ 336,959</u> | <u>\$ 752,441</u> |



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

| <i>(in thousands of dollars)</i>                                | <b>2016</b>        | <b>2015</b>       |
|---|--------------------|-------------------|
| <b>Unrestricted</b>   |                    |                   |
| 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                   | <u>(22,980)</u>    | <u>(28,824)</u>   |
|   | <u>(19,115)</u>    | <u>(8,465)</u>    |
| <b>Temporarily restricted</b>                                   |                    |                   |
| Interest and dividend income, net                               | 536                | 1,151             |
| Net realized gains on sales of securities                       | (18)               | 646               |
| Change in net unrealized gains on investments                   | <u>(1,674)</u>     | <u>(1,619)</u>    |
|   | <u>(1,156)</u>     | <u>178</u>        |
| <b>Permanently restricted</b>                                   |                    |                   |
| Change in net unrealized losses on beneficial interest in trust | <u>(219)</u>       | <u>(187)</u>      |
|   | <u>(219)</u>       | <u>(187)</u>      |
|   | <u>\$ (20,490)</u> | <u>\$ (8,474)</u> |

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.

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**6. Property, Plant, and Equipment**

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

| <i>(in thousands of dollars)</i>                | <b>2016</b>       | <b>2015</b>       |
|---|-------------------|-------------------|
| 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            |
|   | <u>1,637,009</u>  | <u>1,384,322</u>  |
| Less: Accumulated depreciation and amortization | <u>1,046,617</u>  | <u>818,816</u>    |
| Total depreciable assets, net                   | 590,392           | 565,506           |
| Construction in progress                        | <u>22,172</u>     | <u>35,849</u>     |
|   | <u>\$ 612,564</u> | <u>\$ 601,355</u> |

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

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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:

| <i>(in thousands of dollars)</i>         | 2016       |           |          |            | Redemption<br>or Liquidation | Days'<br>Notice |
|--|------------|-----------|----------|------------|------------------------------|-----------------|
|  | Level 1    | Level 2   | Level 3  | Total      |                              |                 |
| <b>Assets</b>                            |            |           |          |            |                              |                 |
| <b>Investments</b>                       |            |           |          |            |                              |                 |
| 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    |                              |                 |
| <b>Deferred compensation plan assets</b> |            |           |          |            |                              |                 |
| 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  |
| <b>Beneficial interest in trusts</b>     |            |           |          |            |                              |                 |
| Total assets                             | \$ 349,421 | \$ 90,928 | \$ 9,087 | \$ 449,516 | Not applicable               | Not applicable  |
| <b>Liabilities</b>                       |            |           |          |            |                              |                 |
| Interest rate swaps                      | \$ -       | \$ 28,917 | \$ -     | \$ 28,917  | Not applicable               | Not applicable  |
| Total liabilities                        | \$ -       | \$ 28,917 | \$ -     | \$ 28,917  |                              |                 |

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| <i>(in thousands of dollars)</i>               | 2015              |                  |                 |                   | Redemption<br>or Liquidation | Days'<br>Notice |
|--|-------------------|------------------|-----------------|-------------------|------------------------------|-----------------|
|  | Level 1           | Level 2          | Level 3         | Total             |                              |                 |
| <b>Assets</b>                                  |                   |                  |                 |                   |                              |                 |
| <b>Investments</b>                             |                   |                  |                 |                   |                              |                 |
| 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  |
| <b>Total investments</b>                       | <b>324,341</b>    | <b>91,141</b>    | <b>-</b>        | <b>415,482</b>    |                              |                 |
| <b>Deferred compensation plan assets</b>       |                   |                  |                 |                   |                              |                 |
| 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                |                              |                 |
| <b>Total deferred compensation plan assets</b> | <b>52,477</b>     | <b>-</b>         | <b>78</b>       | <b>52,555</b>     | Not applicable               | Not applicable  |
| Beneficial interest in trusts                  | -                 | -                | 9,345           | 9,345             | Not applicable               | Not applicable  |
| <b>Total assets</b>                            | <b>\$ 376,818</b> | <b>\$ 91,141</b> | <b>\$ 9,423</b> | <b>\$ 477,382</b> |                              |                 |
| <b>Liabilities</b>                             |                   |                  |                 |                   |                              |                 |
| Interest rate swaps                            | \$ -              | \$ 24,740        | \$ -            | \$ 24,740         | Not applicable               | Not applicable  |
| <b>Total liabilities</b>                       | <b>\$ -</b>       | <b>\$ 24,740</b> | <b>\$ -</b>     | <b>\$ 24,740</b>  |                              |                 |

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.

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

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|                                      | 2015  |   |                        |                 |
|--------------------------------------|---|---|------------------------|-----------------|
|                                      | Beneficial<br>Interest in<br>Perpetual<br>Trust | Contribution<br>Receivable<br>From Charitable<br>Remainder<br>Trust | Guaranteed<br>Contract | Total           |
| <i>(in thousands of dollars)</i>     |   |   |                        |                 |
| <b>Balances at beginning of year</b> | \$ 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           |
| <b>Balances at end of year</b>       | <b>\$ 9,345</b>                                 | <b>\$ -</b>   | <b>\$ 78</b>           | <b>\$ 9,423</b> |

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:

| <i>(in thousands of dollars)</i> | 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            |
|                                  | <b>\$ 75,731</b> | <b>\$ 76,457</b> |

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

| <i>(in thousands of dollars)</i> | 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               |
|                                  | <b>\$ 53,590</b> | <b>\$ 53,081</b> |

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

# Dartmouth-Hitchcock Health and Subsidiaries

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#### 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.

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

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

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

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

| <i>(in thousands of dollars)</i>       | <b>2016</b>         |                               |                               | <b>Total</b>     |
|--|---------------------|-------------------------------|-------------------------------|------------------|
|  | <b>Unrestricted</b> | <b>Temporarily Restricted</b> | <b>Permanently Restricted</b> |                  |
| <b>Balances at beginning of year</b>   | \$ 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            |
| <b>Balances at end of year</b>         | <b>\$ 26,205</b>    | <b>\$ 25,780</b>              | <b>45,402</b>                 | <b>\$ 97,387</b> |
| <b>Balances at end of year</b>         |                     |                               | 45,402                        |                  |
| Beneficial interest in perpetual trust |                     |                               | 8,188                         |                  |
| Permanently restricted net assets      |                     |                               | <b>\$ 53,590</b>              |                  |

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| <i>(in thousands of dollars)</i>       | 2015             |                           |                           |                  |
|--|------------------|---------------------------|---------------------------|------------------|
|  | Unrestricted     | Temporarily<br>Restricted | Permanently<br>Restricted | Total            |
| <b>Balances at beginning of year</b>   | \$ 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           |
| <b>Balances at end of year</b>         | <u>\$ 26,405</u> | <u>\$ 28,296</u>          | <u>44,491</u>             | <u>\$ 99,192</u> |
| <b>Balances at end of year</b>         |                  |                           | 44,491                    |                  |
| Beneficial interest in perpetual trust |                  |                           | <u>8,590</u>              |                  |
| Permanently restricted net assets      |                  |                           | <u>\$ 53,081</u>          |                  |



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**10. Long-Term Debt**

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

| <i>(in thousands of dollars)</i>  | <b>2016</b>       | <b>2015</b>       |
|---|-------------------|-------------------|
| <b>Variable rate issues</b>   |                   |                   |
| 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             |
| <b>Fixed rate issues</b>  |                   |                   |
| 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  |                   |                   |
| <b>Other</b>  |                   |                   |
| 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  | <u>4,875</u>      | <u>3,369</u>      |
|   | 648,462           | 594,156           |
| Less  |                   |                   |
| Original issue discount, net  | 881               | 1,493             |
| Current portion   | <u>18,307</u>     | <u>17,179</u>     |
|   | <u>\$ 629,274</u> | <u>\$ 575,484</u> |

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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:

| <i>(in thousands of dollars)</i> | <b>2016</b>       |
|----------------------------------|-------------------|
| 2017                             | \$ 18,307         |
| 2018                             | 19,117            |
| 2019                             | 69,159            |
| 2020                             | 20,262            |
| 2021                             | 20,290            |
| Thereafter                       | 501,327           |
|                                  | <u>\$ 648,462</u> |

**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.

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**(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.

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#### **(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.

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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 defined 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.

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**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:

| <i>(in thousands of dollars)</i>                 | <b>2016</b>      | <b>2015</b>      |
|--|------------------|------------------|
| 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/contractual termination benefits         | 300              | 56               |
|  | <u>\$ 22,887</u> | <u>\$ 15,644</u> |

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

|  | <b>2016</b>                | <b>2015</b>                |
|--|----------------------------|----------------------------|
| 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 %            |

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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:

| <i>(in thousands of dollars)</i>  | <b>2016</b>         | <b>2015</b>         |
|---|---------------------|---------------------|
| <b>Change in benefit obligation</b>                                     |                     |                     |
| Benefit obligation at beginning of year                                 | \$ 988,143          | \$ 877,082          |
| Additional benefit obligation<br>resulting from new affiliations        | -                   | 95,314              |
| Total benefit obligation at beginning of year                           | <u>988,143</u>      | <u>972,396</u>      |
| 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                                       | <u>1,096,619</u>    | <u>988,143</u>      |
| <b>Change in plan assets</b>  |                     |                     |
| Fair value of plan assets at beginning of year                          | 845,052             | 783,890             |
| Additional plan assets at fair value<br>resulting from new affiliations | -                   | 77,608              |
| Total fair value of plan assets at beginning of year                    | <u>845,052</u>      | <u>861,498</u>      |
| 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                                | <u>872,320</u>      | <u>845,052</u>      |
| Funded status of the plans  | (224,299)           | (143,091)           |
| Current portion of liability for pension                                | (46)                | (46)                |
| Long term portion of liability for pension                              | <u>(224,253)</u>    | <u>(143,045)</u>    |
| Liability for pension   | <u>\$ (224,299)</u> | <u>\$ (143,091)</u> |

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.

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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:

| <i>(in thousands of dollars)</i> | <b>2016</b>       | <b>2015</b>       |
|----------------------------------|-------------------|-------------------|
| Net actuarial loss               | \$ 423,640        | \$ 368,959        |
| Prior service cost               | 228               | 608               |
|                                  | <u>\$ 423,868</u> | <u>\$ 369,567</u> |

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

| <i>(in thousands of dollars)</i> |                  |
|----------------------------------|------------------|
| Unrecognized prior service cost  | \$ 182           |
| Net actuarial loss               | 30,515           |
|                                  | <u>\$ 30,697</u> |

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 2015, respectively.

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

|  | <b>2016</b>                | <b>2015</b>                |
|--|----------------------------|----------------------------|
| 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.



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

|                                 | <b>Range of<br/>Target<br/>Allocations</b> | <b>Target<br/>Allocations</b> |
|---------------------------------|--|-------------------------------|
| 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.

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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                             |                   |                   |                  |                   |                              |                 |
|----------------------------------|-------------------|-------------------|------------------|-------------------|------------------------------|-----------------|
| <i>(in thousands of dollars)</i> | Level 1           | Level 2           | Level 3          | Total             | Redemption<br>or Liquidation | Days'<br>Notice |
| <b>Investments</b>               |                   |                   |                  |                   |                              |                 |
| 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                | <u>\$ 267,734</u> | <u>\$ 565,343</u> | <u>\$ 39,243</u> | <u>\$ 872,320</u> |                              |                 |

| 2015                             |                   |                   |                  |                   |                              |                 |
|----------------------------------|-------------------|-------------------|------------------|-------------------|------------------------------|-----------------|
| <i>(in thousands of dollars)</i> | Level 1           | Level 2           | Level 3          | Total             | Redemption<br>or Liquidation | Days'<br>Notice |
| <b>Investments</b>               |                   |                   |                  |                   |                              |                 |
| 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                | <u>\$ 303,026</u> | <u>\$ 499,513</u> | <u>\$ 42,513</u> | <u>\$ 845,052</u> |                              |                 |

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:

| <i>(in thousands of dollars)</i>     | 2016             |                         |                  |
|--------------------------------------|------------------|-------------------------|------------------|
|                                      | Hedge Funds      | Private<br>Equity Funds | Total            |
| <b>Balances at beginning of year</b> | \$ 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)          |
| <b>Balances at end of year</b>       | <u>\$ 38,988</u> | <u>\$ 255</u>           | <u>\$ 39,243</u> |

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| <i>(in thousands of dollars)</i>          | <b>2015</b>        |                                 |                  |
|---|--------------------|---------------------------------|------------------|
|   | <b>Hedge Funds</b> | <b>Private<br/>Equity Funds</b> | <b>Total</b>     |
| <b>Balances at beginning of year</b>      | \$ 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            |
| <b>Balances at end of year</b>            | <b>\$ 42,076</b>   | <b>\$ 437</b>                   | <b>\$ 42,513</b> |

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:

|                                 | <b>2016</b>  | <b>2015</b>  |
|---------------------------------|--------------|--------------|
| 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           |
|                                 | <u>100 %</u> | <u>100 %</u> |

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.

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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:

| <i>(in thousands of dollars)</i> | <b>Pension Plans</b> |
|----------------------------------|----------------------|
| 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:

| <i>(in thousands of dollars)</i>      | <b>2016</b>       | <b>2015</b>     |
|---------------------------------------|-------------------|-----------------|
| Service cost                          | \$ 544            | \$ 527          |
| Interest cost                         | 2,295             | 2,347           |
| Amortization net prior service income | (5,974)           | -               |
| Amortization net loss                 | 610               | -               |
|                                       | <u>\$ (2,525)</u> | <u>\$ 2,874</u> |

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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:

| <i>(in thousands of dollars)</i>  | <b>2016</b>        | <b>2015</b>        |
|---|--------------------|--------------------|
| <b>Change in benefit obligation</b>   |                    |                    |
| Benefit obligation at beginning of year                                     | \$ 50,438          | \$ 51,006          |
| Additional benefit obligation resulting from new affiliations               | -                  | 471                |
|   | <u>50,438</u>      | <u>51,477</u>      |
| 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   | <u>51,370</u>      | <u>50,438</u>      |
| Funded status of the plans  | <u>(51,370)</u>    | <u>(50,438)</u>    |
| Current portion of liability for postretirement medical and life benefits   | <u>(3,130)</u>     | <u>(3,203)</u>     |
| Long term portion of liability for postretirement medical and life benefits | <u>(48,240)</u>    | <u>(47,235)</u>    |
| Liability for postretirement medical and life benefits                      | <u>\$ (51,370)</u> | <u>\$ (50,438)</u> |

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:

| <i>(in thousands of dollars)</i> | <b>2016</b>        | <b>2015</b>        |
|----------------------------------|--------------------|--------------------|
| Net prior service income         | \$ (27,478)        | \$ (33,452)        |
| Net actuarial loss               | 11,080             | 10,260             |
|                                  | <u>\$ (16,398)</u> | <u>\$ (23,192)</u> |

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

| <i>(in thousands of dollars)</i> | <b>2016</b>       | <b>2015</b>       |
|----------------------------------|-------------------|-------------------|
| Net prior service income         | \$ (5,974)        | \$ (5,974)        |
| Net loss                         | <u>689</u>        | <u>610</u>        |
|                                  | <u>\$ (5,285)</u> | <u>\$ (5,364)</u> |

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.

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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:

|                                  | <b>2016</b>                    |                                  |              |
|----------------------------------|--------------------------------|----------------------------------|--------------|
|                                  | <b>HAC</b><br><i>(audited)</i> | <b>RRG</b><br><i>(unaudited)</i> | <b>Total</b> |
| <i>(in thousands of dollars)</i> |                                |                                  |              |
| Assets                           | \$ 86,101                      | \$ 2,237                         | \$ 88,338    |
| Shareholders' equity             | 13,620                         | 806                              | 14,426       |
| Net income                       | -                              | 50                               | 50           |

|                                  | <b>2015</b>                    |                                  |              |
|----------------------------------|--------------------------------|----------------------------------|--------------|
|                                  | <b>HAC</b><br><i>(audited)</i> | <b>RRG</b><br><i>(unaudited)</i> | <b>Total</b> |
| <i>(in thousands of dollars)</i> |                                |                                  |              |
| 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:

|                                  |                  |
|----------------------------------|------------------|
| <i>(in thousands of dollars)</i> |                  |
| 2017                             | \$ 8,441         |
| 2018                             | 6,210            |
| 2019                             | 4,062            |
| 2020                             | 2,663            |
| 2021                             | 2,009            |
| Thereafter                       | 274              |
|                                  | <u>\$ 23,659</u> |

**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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2016 and 2015**

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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:

| <i>(in thousands of dollars)</i> | <b>2016</b>         | <b>2015</b>         |
|----------------------------------|---------------------|---------------------|
| Program services                 | \$ 1,553,377        | \$ 1,335,316        |
| Management and general           | 271,409             | 225,983             |
| Fundraising                      | 5,901               | 8,037               |
|                                  | <u>\$ 1,830,687</u> | <u>\$ 1,569,336</u> |

**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<br>(Parent) | D-H and<br>Subsidiaries | Cheshire and<br>Subsidiaries | NLH and<br>Subsidiaries | MAHHC and<br>Subsidiaries | APD              | Eliminations       | Health<br>System<br>Consolidated |
|---|------------------|-------------------------|------------------------------|-------------------------|---------------------------|------------------|--------------------|----------------------------------|
| <b>Assets</b>   |                  |                         |                              |                         |                           |                  |                    |                                  |
| 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  | <u>8,070</u>     | <u>317,977</u>          | <u>39,934</u>                | <u>17,285</u>           | <u>12,757</u>             | <u>24,310</u>    | <u>(22,933)</u>    | <u>397,400</u>                   |
| 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                  | 19,559                    | 16,464           | -                  | 612,564                          |
| Other assets  | 17,950           | 68,921                  | 9,794                        | 5,409                   | 3,943                     | 111              | (14,929)           | 91,199                           |
| Total assets  | <u>\$ 26,313</u> | <u>\$ 1,510,911</u>     | <u>\$ 161,330</u>            | <u>\$ 79,086</u>        | <u>\$ 50,361</u>          | <u>\$ 45,528</u> | <u>\$ (37,862)</u> | <u>\$ 1,835,667</u>              |
| <b>Liabilities and Net Assets</b>   |                  |                         |                              |                         |                           |                  |                    |                                  |
| 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   | <u>9,857</u>     | <u>250,802</u>          | <u>25,918</u>                | <u>14,990</u>           | <u>10,650</u>             | <u>10,397</u>    | <u>(22,933)</u>    | <u>299,681</u>                   |
| 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   | <u>9,857</u>     | <u>1,186,100</u>        | <u>75,385</u>                | <u>41,919</u>           | <u>28,947</u>             | <u>26,888</u>    | <u>(22,933)</u>    | <u>1,346,163</u>                 |
| Commitments and contingencies   |                  |                         |                              |                         |                           |                  |                    |                                  |
| <b>Net assets</b>   |                  |                         |                              |                         |                           |                  |                    |                                  |
| Unrestricted  | 16,456           | 234,609                 | 58,978                       | 32,706                  | 14,099                    | 18,264           | (14,929)           | 360,183                          |
| Temporarily restricted  | -                | 57,091                  | 1,454                        | 345                     | 1,496                     | 345              | -                  | 75,731                           |
| Permanently restricted  | -                | 33,111                  | 10,513                       | 4,116                   | 5,819                     | 31               | -                  | 53,590                           |
| Total net assets  | <u>16,456</u>    | <u>324,811</u>          | <u>85,945</u>                | <u>37,167</u>           | <u>21,414</u>             | <u>18,640</u>    | <u>(14,929)</u>    | <u>489,504</u>                   |
| Total liabilities and net assets  | <u>\$ 26,313</u> | <u>\$ 1,510,911</u>     | <u>\$ 161,330</u>            | <u>\$ 79,086</u>        | <u>\$ 50,361</u>          | <u>\$ 45,528</u> | <u>\$ (37,862)</u> | <u>\$ 1,835,667</u>              |

# Dartmouth-Hitchcock Health and Subsidiaries

## Consolidating Balance Sheets

### June 30, 2016

| (in thousands of dollars)   | D-H<br>Obligated<br>Group | THF       | DHMC     | Eliminations | D-H and<br>Subsidiaries |
|---|---------------------------|-----------|----------|--------------|-------------------------|
| <b>Assets</b>   |                           |           |          |              |                         |
| 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  |                           |           |          |              |                         |
| Other investments for restricted activities   | 551,724                   | -         | -        | -            | 551,724                 |
| Property, plant, and equipment, net   | 91,879                    | 22,840    | -        | -            | 114,719                 |
| Other assets  | 454,894                   | 1         | 2,675    | -            | 457,570                 |
|   | 68,752                    | 4         | 165      | -            | 68,921                  |
| Total assets  | \$ 1,484,115              | \$ 23,508 | \$ 3,288 | \$ -         | \$ 1,510,911            |
| <b>Liabilities and Net Assets</b>   |                           |           |          |              |                         |
| 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

| <i>(in thousands of dollars)</i>  | D-HH<br>(Parent) | D-H and<br>Subsidiaries | Cheshire and<br>Subsidiaries | NLH and<br>Subsidiaries | MAHHC and<br>Subsidiaries | Eliminations | Health<br>System<br>Consolidated |
|---|------------------|-------------------------|------------------------------|-------------------------|---------------------------|--------------|----------------------------------|
| <b>Assets</b>   |                  |                         |                              |                         |                           |              |                                  |
| 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                     |
| <b>Liabilities and Net Assets</b>   |                  |                         |                              |                         |                           |              |                                  |
| 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                     | -            | 94,854                           |
| 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   |                  |                         |                              |                         |                           |              |                                  |
| <b>Net assets</b>   |                  |                         |                              |                         |                           |              |                                  |
| 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

|   | D-H<br>Obligated<br>Group | THF       | DHMC     | Eliminations | D-H and<br>Subsidiaries |
|---|---------------------------|-----------|----------|--------------|-------------------------|
| <i>(In thousands of dollars)</i>  |                           |           |          |              |                         |
| <b>Assets</b>   |                           |           |          |              |                         |
| 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  |                           |           |          |              |                         |
| Other investments for restricted activities   | 570,057                   | -         | -        | -            | 570,057                 |
| Property, plant, and equipment, net   | 89,176                    | 23,941    | -        | -            | 113,117                 |
| Other assets  | 458,368                   | 1         | 2,675    | -            | 461,044                 |
|   | 66,675                    | 3         | 159      | -            | 66,837                  |
| Total assets  | \$ 1,472,240              | \$ 24,465 | \$ 4,117 | \$ (247)     | \$ 1,500,575            |
| <b>Liabilities and Net Assets</b>   |                           |           |          |              |                         |
| 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               |
| <b>Commitments and contingencies</b>  |                           |           |          |              |                         |
| 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**

| <i>(in thousands of dollars)</i>                                     | D-HH<br>(Parent) | D-H and<br>Subsidiaries | Cheshire and<br>Subsidiaries | NLH and<br>Subsidiaries | MAHHC and<br>Subsidiaries | APD              | Eliminations       | Health<br>System<br>Consolidated |
|--|------------------|-------------------------|------------------------------|-------------------------|---------------------------|------------------|--------------------|----------------------------------|
| <b>Unrestricted revenue and other support</b>                        |                  |                         |                              |                         |                           |                  |                    |                                  |
| 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                         | <u>4,996</u>     | <u>1,491,079</u>        | <u>165,296</u>               | <u>63,363</u>           | <u>51,105</u>             | <u>20,973</u>    | <u>(5,105)</u>     | <u>1,791,707</u>                 |
| <b>Operating expenses</b>  |                  |                         |                              |                         |                           |                  |                    |                                  |
| 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   | <u>23,470</u>    | <u>1,503,334</u>        | <u>172,070</u>               | <u>64,475</u>           | <u>50,999</u>             | <u>21,374</u>    | <u>(5,035)</u>     | <u>1,830,687</u>                 |
| Operating (loss) margin  | <u>(18,474)</u>  | <u>(12,255)</u>         | <u>(6,774)</u>               | <u>(1,112)</u>          | <u>106</u>                | <u>(401)</u>     | <u>(70)</u>        | <u>(38,980)</u>                  |
| <b>Nonoperating gains (losses)</b>                                   |                  |                         |                              |                         |                           |                  |                    |                                  |
| 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                               | <u>16,527</u>    | <u>(22,495)</u>         | <u>(1,075)</u>               | <u>684</u>              | <u>190</u>                | <u>235</u>       | <u>69</u>          | <u>(5,865)</u>                   |
| (Deficiency) excess of revenue over expenses                         | <u>(1,947)</u>   | <u>(34,750)</u>         | <u>(7,849)</u>               | <u>(428)</u>            | <u>296</u>                | <u>(166)</u>     | <u>(1)</u>         | <u>(44,845)</u>                  |
| <b>Unrestricted net assets</b>                                       |                  |                         |                              |                         |                           |                  |                    |                                  |
| 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                       | <u>\$ 15,321</u> | <u>\$ (112,292)</u>     | <u>\$ (20,724)</u>           | <u>\$ (1,520)</u>       | <u>\$ (266)</u>           | <u>\$ 18,264</u> | <u>\$ (12,794)</u> | <u>\$ (114,011)</u>              |

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

| <i>(in thousands of dollars)</i>                                     | D-H<br>Obligated<br>Group | THF          | DHMC        | Eliminations   | D-H and<br>Subsidiaries |
|--|---------------------------|--------------|-------------|----------------|-------------------------|
| <b>Unrestricted revenue and other support</b>                        |                           |              |             |                |                         |
| 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                         | <u>1,487,623</u>          | <u>4,320</u> | <u>550</u>  | <u>(1,414)</u> | <u>1,491,079</u>        |
| <b>Operating expenses</b>  |                           |              |             |                |                         |
| 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   | <u>1,499,699</u>          | <u>4,261</u> | <u>646</u>  | <u>(1,272)</u> | <u>1,503,334</u>        |
| Operating (loss) margin  | <u>(12,076)</u>           | <u>59</u>    | <u>(96)</u> | <u>(142)</u>   | <u>(12,255)</u>         |
| <b>Nonoperating gains (losses)</b>                                   |                           |              |             |                |                         |
| Investment losses  | (18,537)                  | (311)        | -           | -              | (18,848)                |
| Other, net   | (3,789)                   | -            | -           | 142            | (3,647)                 |
| Total nonoperating (losses) gains, net                               | <u>(22,326)</u>           | <u>(311)</u> | <u>-</u>    | <u>142</u>     | <u>(22,495)</u>         |
| Deficiency of revenue over expenses                                  | <u>(34,402)</u>           | <u>(252)</u> | <u>(96)</u> | <u>-</u>       | <u>(34,750)</u>         |
| <b>Unrestricted net assets</b>                                       |                           |              |             |                |                         |
| 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                                  | <u>(112,135)</u>          | <u>(61)</u>  | <u>(96)</u> | <u>-</u>       | <u>(112,292)</u>        |

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

| <i>(in thousands of dollars)</i>                                     | D-HH<br>(Parent) | D-H and<br>Subsidiaries | NLH and<br>Subsidiaries | Cheshire and<br>Subsidiaries | MAHHC and<br>Subsidiaries | Eliminations   | Health<br>System<br>Consolidated |
|--|------------------|-------------------------|-------------------------|------------------------------|---------------------------|----------------|----------------------------------|
| <b>Unrestricted revenue and other support</b>                        |                  |                         |                         |                              |                           |                |                                  |
| 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                         | <u>12,203</u>    | <u>1,392,940</u>        | <u>59,530</u>           | <u>53,824</u>                | <u>49,628</u>             | <u>(8,101)</u> | <u>1,560,024</u>                 |
| <b>Operating expenses</b>  |                  |                         |                         |                              |                           |                |                                  |
| 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   | <u>18,885</u>    | <u>1,393,055</u>        | <u>59,418</u>           | <u>55,288</u>                | <u>51,098</u>             | <u>(8,408)</u> | <u>1,569,336</u>                 |
| Operating (loss) margin  | <u>(6,682)</u>   | <u>(115)</u>            | <u>112</u>              | <u>(1,464)</u>               | <u>(1,470)</u>            | <u>307</u>     | <u>(9,312)</u>                   |
| <b>Nonoperating gains (losses)</b>                                   |                  |                         |                         |                              |                           |                |                                  |
| 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                               | <u>92,838</u>    | <u>(14,891)</u>         | <u>2,034</u>            | <u>452</u>                   | <u>117</u>                | <u>(307)</u>   | <u>80,243</u>                    |
| Excess (deficiency) of revenue over expenses                         | <u>86,156</u>    | <u>(15,006)</u>         | <u>2,146</u>            | <u>(1,012)</u>               | <u>(1,353)</u>            | <u>-</u>       | <u>70,931</u>                    |
| <b>Unrestricted net assets</b>                                       |                  |                         |                         |                              |                           |                |                                  |
| 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                    | (600)          | -                                |
| Additional paid in capital   | 600              | -                       | -                       | -                            | -                         | -              | -                                |
| Change in fair value on interest rate swaps                          | -                | (869)                   | (221)                   | -                            | 159                       | -              | (931)                            |
| Increase (decrease) in unrestricted net assets                       | <u>2,130</u>     | <u>(86,008)</u>         | <u>1,930</u>            | <u>79,700</u>                | <u>14,367</u>             | <u>(600)</u>   | <u>11,519</u>                    |
|  | <u>\$</u>        | <u>\$</u>               | <u>\$</u>               | <u>\$</u>                    | <u>\$</u>                 | <u>\$</u>      | <u>\$</u>                        |



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

| <i>(in thousands of dollars)</i>  | D-H<br>Obligated<br>Group | THF           | DHMC          | Eliminations   | D-H and<br>Subsidiaries |
|---|---------------------------|---------------|---------------|----------------|-------------------------|
| <b>Unrestricted revenue and other support</b>                           |                           |               |               |                |                         |
| 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                            | <u>1,386,886</u>          | <u>3,907</u>  | <u>6,482</u>  | <u>(4,335)</u> | <u>1,392,940</u>        |
| <b>Operating expenses</b>   |                           |               |               |                |                         |
| 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  | <u>1,383,299</u>          | <u>4,079</u>  | <u>6,484</u>  | <u>(807)</u>   | <u>1,393,055</u>        |
| Operating margin (loss)   | <u>3,587</u>              | <u>(172)</u>  | <u>(2)</u>    | <u>(3,528)</u> | <u>(115)</u>            |
| <b>Nonoperating gains (losses)</b>                                      |                           |               |               |                |                         |
| Investment (losses) gains   | (12,079)                  | 68            | -             | -              | (12,011)                |
| Other, net  | (6,408)                   | -             | -             | 3,528          | (2,880)                 |
| Total nonoperating (losses) gains, net                                  | <u>(18,487)</u>           | <u>68</u>     | <u>-</u>      | <u>3,528</u>   | <u>(14,891)</u>         |
| Deficiency of revenue over expenses                                     | <u>(14,900)</u>           | <u>(104)</u>  | <u>(2)</u>    | <u>-</u>       | <u>(15,006)</u>         |
| <b>Unrestricted net assets</b>  |                           |               |               |                |                         |
| Net assets released from restrictions (Note 8)                          | 454                       | 263           | -             | -              | 717                     |
| Change in funded status of pension and other<br>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                          | <u>\$ (86,165)</u>        | <u>\$ 159</u> | <u>\$ (2)</u> | <u>\$ -</u>    | <u>\$ (86,008)</u>      |

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

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**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**

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

**CURRICULUM VITAE**

**Name:** Alan Ivan Green, M.D.

**Office Address:** Department of Psychiatry, Geisel School of Medicine at Dartmouth  
Dartmouth Hitchcock Medical Center  
One Medical Center Drive  
Lebanon, NH 03756 **Phone:** 603-650-7549

**Email:** [alan.i.green@dartmouth.edu](mailto:alan.i.green@dartmouth.edu) **Fax:** 603-650-8415

**Place of Birth:** Norwalk, Connecticut

**Education:** 1965 A.B., Columbia College  
1969 M.D., The Johns Hopkins University School of Medicine

**Postdoctoral Training**Internship and Residencies

1969-1970 Intern in Medicine, Beth Israel Hospital, Boston  
1972-1973 Junior Resident in Psychiatry, Boston City Hospital, Boston  
1973-1975 Resident in Psychiatry, Massachusetts Mental Health Center, Boston  
1975-1981 On medical leave due to systemic cytomegalovirus infection  
1981-1982 Resident in Psychiatry, Massachusetts Mental Health Center, Boston

Research Fellowships

1970-1971 Staff Associate, National Institute of Mental Health,  
Laboratory of Pre-Clinical Pharmacology, Washington, D.C.  
1971-1972 On assignment from NIMH to Special Action Office for Drug Abuse Prevention,  
Executive Office of the President  
1982-1984 Clinical Research Training Fellow, Massachusetts Mental Health Center, Boston

**Licensure and Certification**

1974-2012 California, Board of Medical Quality Assurance  
1975 Massachusetts, Board of Registration in Medicine, # 38430  
1984 Certification by American Board of Psychiatry and Neurology, #26343  
2003 New Hampshire, Board of Medicine, #11912

**Faculty Academic Appointments**

1969-1970 Clinical Fellow in Medicine, Harvard Medical School  
1972-1982 Clinical Fellow in Psychiatry, Harvard Medical School  
1982-1984 Senior Research Fellow in Psychiatry, Harvard Medical School  
1984 Lecturer in Psychiatry, Harvard Medical School  
1984-1994 Assistant Professor of Psychiatry, Harvard Medical School  
1994- 2002 Associate Professor of Psychiatry, Harvard Medical School  
2002- Lecturer in Psychiatry, Harvard Medical School  
2002- Raymond Sobel Professor of Psychiatry, Geisel School of Medicine at Dartmouth  
2002- Chairman, Department of Psychiatry, Geisel School of Medicine at Dartmouth  
2005-2016 Professor of Pharmacology and Toxicology, Geisel School of Medicine at Dartmouth  
2010- Associate Dean for Clinical and Translational Science,  
Geisel School of Medicine at Dartmouth  
2010- Director, SYNERGY: The Dartmouth Clinical and Translational Science Institute  
2016- Professor of Molecular and Systems Biology, Geisel School of Medicine at Dartmouth

**Hospital Appointments**

- 1981-1984 Assistant Clinical Director, Southard Clinic, Massachusetts Mental Health Center
- 1982-2008 Staff Psychiatrist, Massachusetts Mental Health Center
- 1983-2004 Medical Staff, New England Deaconess Hospital
- 1984-1993 Associate Director of Psychopharmacology, Massachusetts Mental Health Center
- 1983-1993 Program Director, Psychopharmacology Extramural Training Program, Massachusetts Mental Health Center
- 1984-2001 Attending Physician, Brockton VA Medical Center
- 1987-1999 Administrative Director to Director, Commonwealth Research Center, Massachusetts Mental Health Center
- 1993-2002 Medical Staff, Brigham & Women's Hospital
- 1999-2002 Director, Commonwealth Research Center, Massachusetts Mental Health Center, Harvard Medical School
- 1996-2002 Director, Office of Research Administration, Massachusetts Mental Health Center
- 1998-2002 Director, Neuropsychopharmacology Laboratory, Massachusetts Mental Health Center
- 2002- Mary Hitchcock Memorial Hospital, Lebanon, NH
- 2004- Consulting Staff, Beth Israel Deaconess Medical Center, Boston, MA
- 2002- Chairman, Department of Psychiatry, Dartmouth-Hitchcock Medical Center

**Other Professional Positions and Major Visiting Appointments**

- 1971 Special Assistant to Director, Special Action Office for Drug Abuse Prevention, Executive Office of the President, Washington, D.C.
- 1971-1972 Acting Director of Research, Special Action Office for Drug Abuse Prevention, Executive Office of the President
- 1972-1973 Director of Biomedical Research, Special Action Office for Drug Abuse Prevention, Executive Office of the President
- 1973-1975 Consultant, Special Action Office for Drug Abuse Prevention, Executive Office of the President
- 2001-2002 Vice-President, Massachusetts Mental Health Institute
- 2001-2005 Member, Board of Directors, Massachusetts Mental Health Institute
- 2002- Member, Board of Directors, West Central Behavioral Health
- 2002- Member, Board of Governors, Dartmouth Hitchcock Medical Center
- 2002- Director, Psychopharmacology Research Group, Department of Psychiatry, Geisel School of Medicine at Dartmouth

**Major Administrative Leadership Appointments**

- 1999-2002 Director, Commonwealth Research Center, Harvard Medical School Department of Psychiatry
- 2002- Chairman, Department of Psychiatry, Geisel School of Medicine at Dartmouth
- 2010- Director, SYNERGY: The Dartmouth Clinical and Translational Science Institute, Dartmouth College

**Committee Service**

|           |   |
|-----------|---|
| 1983-1984 | Vice President, Clinical Staff Organization, Massachusetts Mental Health Center |
| 1984      | President, Clinical Staff Organization, Massachusetts Mental Health Center      |
| 1984-1985 | Chairman, Task Force on Neuroleptic Agents, MA Department of Mental Health      |
| 1989-1991 | Member, Clozapine Task Force, MA Department of Mental Health                    |
| 1989-1990 | Member, Committee on AIDS and Drugs, Harvard AIDS Institute                     |
| 1991-2002 | Member, Research Committee, Dept of Psychiatry, Harvard Medical School          |
| 1991-2002 | Member, Research Committee, Massachusetts Mental Health Center                  |
| 1993-1999 | Member, MA Department of Mental Health, Research Advisory Committee             |
| 1995-1996 | Member, Task Force on Informed Consent, MA Department of Mental Health          |
| 1998-2002 | Member, Promotions Committee, Massachusetts Mental Health Center                |
| 2001-2005 | Member, Board of Directors, Massachusetts Mental Health Institute               |
| 2002-     | Advisory Board, Neuroscience Center, Geisel School of Medicine at Dartmouth     |
| 2002-     | Member, Board of Governors, Dartmouth Hitchcock Medical Center                  |
| 2002-     | Member, Board of Directors, West Central Behavioral Health, Lebanon, NH         |
| 2013-     | Member, National CTSA Steering Committee, NCATS, NIH                            |

**Professional Societies**

|           |  |
|-----------|--|
| 1975-     | Member, American Psychiatric Association                           |
| 1982-     | General Member, Massachusetts Psychiatric Society                  |
| 1983-     | Program Committee, Massachusetts Psychiatric Society               |
| 1983-1986 | Newsletter Editor, Massachusetts Psychiatric Society               |
| 1996-     | Member, Massachusetts Medical Society                              |
| 1998-     | Member, American Association for the Advancement of Science        |
| 1999-2003 | Fellow, American Psychiatric Association                           |
| 2001-     | Member, American College of Neuropsychopharmacology                |
| 2003-     | Distinguished Fellow, American Psychiatric Association             |
| 2007-     | Distinguished Life Fellow of the American Psychiatric Association  |
| 2009-     | Member, Collegium Internationale Neuro-Psychopharmacologicum       |
| 2011-     | Fellow, American College of Neuropsychopharmacology                |
| 2012-     | Member, Committee on Dual Disorders, World Psychiatric Association |

**Grant Review Activities**

|      |  |
|------|--|
| 2002 | Member, ZMHI/NRB w -13R Study Section (NIMH)                             |
| 2002 | Chairman, ZAAI BB22 Study Section (NIAAA)                                |
| 2004 | Member, Peer Review of RFA-DA-04-016 (NIDA)                              |
| 2006 | Member, Peer Review Panel of RFA DA06-002 (Pilot Clinical Trials) (NIDA) |
| 2009 | Member, NIDA "L" Review Committee  |
| 2010 | Member, ZMH1 ERB-F (08) S Study Section (NIMH)                           |
| 2010 | Member, ZMH1 ERB-F (02) S Study Section (NIMH)                           |
| 2011 | Member, ZRG1 BDCN-C (02) M Study Section (NIH)                           |
| 2014 | Member, ZAA1 DD 10 1, NIAAA Concept Review - Human Lab Paradigms         |

**Editorial Activities**

|           |  |
|-----------|--|
| 1995-2013 | Member, Editorial Board, Harvard Mental Health Letter  |
| 2003-     | Member, Editorial Board, Schizophrenia Research        |
| 2003-     | Member, Editorial Board, The Journal of Dual Diagnosis |
| 2008-     | Associate Editor, The Journal of Dual Diagnosis        |

2008-2010 Member, Physician Editorial Board, Neuropsychiatry Reviews  
 2009- Assistant Editor, Addiction  
 2010-2013 Member, Editorial Board, Schizophrenia Bulletin  
 2010- Co-Editor, The Journal of Dual Diagnosis

**Honors and Prizes**

1982 Ethel Dupont-Warren Award, Department of Psychiatry, Harvard Medical School  
 1988 William F. Milton Fund Award, Harvard Medical School  
 1990 Outstanding Teacher Award, Brockton VA Medical Center, Dept. of Psychiatry  
 1997 Best Doctors in Boston: Boston Magazine  
 1998 Outstanding Psychiatrist Award for Research, Massachusetts Psychiatric Society  
 1998 NARSAD Independent Investigator Award  
 1998 Best Doctors in America  
 1999- Who's Who in America  
 2000 Peter Curran Lecturer, Mater Hospital Trust, Belfast, N. Ireland  
 2003 Distinguished Fellow, American Psychiatric Association  
 2004 Master of Arts (Hon.), Dartmouth College  
 2005 Best Doctors in America  
 2006 Turner Lecturer, Dartmouth Medical School  
 2007 Joseph J. Schildkraut Memorial Lecturer, University of Massachusetts  
 2007- Distinguished Life Fellow of the American Psychiatric Association  
 2007- Best Doctors in America  
 2011- Fellow, American College of Neuropsychopharmacology  
 2013 Member of Honour, Spanish Society of Dual Pathology

**Major Research Interests**

1. Schizophrenia and comorbid substance use disorder: neuropharmacology, neuroimaging and treatment development
2. Medication development for addiction
3. Brain reward circuitry
4. Animal models
5. Early intervention in schizophrenia

**Research Funding**

Current Federal Grants

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| 2012-2017<br>NIDA R01DA032533<br>PI: Green                                 | Clozapine for cannabis use disorder in schizophrenia                             |
| 2013-2020<br>NIDA R01DA034699<br>PI: Green                                 | Cannabis, schizophrenia and reward: self-medication and agonist treatment?       |
| 2013-2018<br>NCATS 1 UL1 TR001086-03<br>NCATS 1KL2TR001088-03<br>PI: Green | Dartmouth SYNERGY <br>The Dartmouth Clinical and Translational Science Institute |

2015- 2017  
 NIAAA/Fast-Track Drugs & Biologics  
 PI: Green  
 Randomized, Double Blind, Placebo-Controlled Trial of the Safety and Efficacy of HORIZANT® (Gabapentin Enacarbil) Extended-Release Tablets for the Treatment of Alcohol Use Disorder

2015-2020  
 NIH/NIDA  
 PI: Marsch/Poldrack  
 Applying Novel Technologies and Methods to Inform the Ontology of Self-Regulation

Current Clinical Trials:

Current Investigator Initiated Grants from Industry:

2015-2016  
 Alkermes  
 PI: Green  
 Olanzapine-Samidorphan in Alcohol-Preferring Rodents

Past NARSAD Grant:

1998-2002  
 NARSAD  
 Independent Investigator Award  
 PI: Green  
 Toward the prevention of schizophrenia: treatment of negative symptoms and neurocognitive deficits in first degree relatives

Past Federal Grants

1993-2001  
 NIMH RO1MH49891  
 PI: Green  
 Clozapine response and biogenic amines in schizophrenia

1994-1999  
 NIMH RO1MH52376  
 PI: Green  
 Clozapine vs. haloperidol in first episode schizophrenia

1995-2001  
 NIMH RO1MH49891-Supp.  
 PI: Green  
 Clozapine vs. olanzapine: an effectiveness study. Clinical Services Supplement to Grant #RO1MH49891

1995-1998  
 NIMH RO1MH49891-Supp.  
 PI: Green  
 Minority Supplement to Grant #RO1MH49891

1999-2004  
 NIAAA RO1AA11904  
 PI: Green  
 Alcoholism and schizophrenia: Effects of clozapine

1999-2004  
 NIAAA RO1AA11904  
 PI: Green  
 Minority Supplement to NIAAA Grant #RO1AA11904

2004-2007  
 NIAAA R03AA014644  
 PI: Green  
 Antipsychotics and alcohol drinking in rodents

2000-2008  
 NIDA R01DA 13196  
 Cannabis and schizophrenia: Effects of clozapine



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| PI: Green   |   |
| 2001-2009<br>NIMH R21MH62157<br>PI: Green                   | Clozapine, cannabis and first episode schizophrenia   |
| 2004-2009<br>NIDA R21DA019215-01<br>PI: Green               | Cannabis and schizophrenia: fMRI Reward Circuit Biomarker   |
| 2007-2009<br>NIAAA CSP-1027<br>PI: Green                    | Efficacy of quetiapine fumarate sustained release for the treatment of alcohol dependency in very heavy drinkers                                |
| 2007-2010<br>NIMH 5R03MH075833-02<br>PI: Chau; Co-PI: Green | Toward a Rat Model of Alcohol Abuse in Schizophrenia  |
| 2009-2011<br>NIAAA/Fast Track NCIG-002<br>PI: Green         | Efficacy of Levetiracetam Extended Release for the treatment of alcohol dependency in very heavy drinkers                                       |
| 2009-2011<br>NIAAA R13AA018603<br>PI: Green                 | Conference: Integrating Etiologic Models and Optimizing Treatment for Alcohol Disorders in Schizophrenia Patients                               |
| 2010-2012<br>NIDA R21 DA029131<br>PI: Sevy                  | Improving Substance Use and Clinical Outcomes in Heavy Cannabis Users   |
| 2011-2012<br>NIAAA/Fast Track NCIG-003<br>PI: Green         | A Phase 2, Double-Blind, Placebo Controlled Trial to Assess the Efficacy of Varenicline Tartrate for Alcohol Dependence in Very Heavy Drinkers. |
| 2009-2012<br>NIDA R01DA026799<br>PI: Green                  | Cannabis and Schizophrenia: Self-Medication and Agonist Treatment? (No Cost Extension)  |
| 2010-2013<br>NIAAA R01AA018151<br>PI: Green                 | Deconstructing Clozapine: Toward Medication for Alcoholism in Schizophrenia (No Cost Extension)   |
| 2011-2014<br>NIAAA R21AA019534<br>PI: Green                 | Alcoholism and Schizophrenia: A Translational Approach to Treatment (No Cost Extension)   |
| 2014-2015<br>NCATS 3UL1TR001086-02S1<br>PI: Green           | Enhancing Clinical Research Professionals' Training and Qualifications  |
| 2014-2015<br>NCATS 3UL1TR001086-02S2<br>PI: Green           | Development of a Cross-CTSA IRB Reliance Program (National IRB Reliance Initiative)   |

Past Investigator Initiated Grants

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| 1989-1990<br>Milton Fund<br>Harvard Medical School<br>PI: Green        | Subgroups of psychotic patients:<br>pharmacologic, biochemical and<br>clinical differences |
| 1991-1994<br>Sandoz Research Institute<br>PI: Green                    | Clozapine in psychotic patients  |
| 1993-1994<br>Eli Lilly & Co.<br>PI: Green                              | Biochemical predictors and correlates<br>of response to olanzapine                         |
| 1994-1996<br>Otsuka America Pharm., Inc.<br>PI: Green                  | Biochemical predictors and correlates<br>of response to OPC-14597                          |
| 1997-1999<br>Eli Lilly & Co.<br>PI: Green                              | Olanzapine vs. typical neuroleptics:<br>prolactin level and ovarian function               |
| 1997-1999<br>Novartis Pharmaceuticals<br>PI: Green                     | Clozapine's effect on prolactin level<br>and ovarian function                              |
| 1997-2000<br>Janssen Research Foundation<br>PI: Green (with MT Tsuang) | Risperidone in relatives of patients<br>with schizophrenia                                 |
| 1997-2001<br>Eli Lilly & Co.<br>PI: Green                              | Olanzapine vs. haloperidol in first<br>episode schizophrenia: an addendum study            |
| 1999-1999<br>Novartis Pharmaceuticals<br>PI: Green                     | Clozapine in patients with<br>schizophrenia and substance abuse                            |
| 1999-2003<br>Eli Lilly & Co.<br>PI: Green                              | Clozapine vs. olanzapine:<br>an effectiveness study  |
| 2000-2001<br>Eli Lilly & Co.<br>PI: Green                              | Preventing weight gain from novel antipsychotics<br>(feasibility study)                    |
| 2001-2002<br>Novartis Pharmaceuticals<br>PI: Green                     | Does clozapine limit alcohol<br>drinking in Syrian Golden Hamsters?                        |
| 2002-2006<br>AstraZeneca<br>PI: Green                                  | Comparison of atypical antipsychotics<br>in first episode schizophrenia                    |

2004-2006  
Bristol-Myers Squibb/Otsuka  
PI: Green

Aripiprazole in alcohol drinking rodents

2000-2007  
AstraZeneca  
PI: Green

Quetiapine in schizophrenia and comorbid  
substance use disorder (retrospective)

2000-2007  
Eli Lilly & Co.  
PI: Green

Olanzapine in patients with comorbid substance  
use disorder and schizophrenia (retrospective)

2003-2008  
AstraZeneca  
PI: Green

Efficacy of quetiapine in treating patients with active  
substance use disorder and schizophrenia

2006-2008  
Cyberonics Inc.  
PI: Green

Does vagus nerve stimulation limit alcohol drinking in  
the alcohol-preferring Syrian golden hamster?

2004-2008  
Janssen Research Foundation  
PI: Green

Risperidone and alcohol drinking in the Syrian golden hamster  
and in the alcohol-preferring "P" rat.

2004-2010  
Janssen Research Foundation  
PI: Green

Risperidone long-acting for alcohol and schizophrenia treatment  
(R-LAST).

2007-2011  
Janssen Research Foundation  
PI: Green

Paliperidone in alcohol drinking rodents

2013-2014  
Novartis  
PI: Green

Iloperidone for alcohol use disorder in schizophrenia

Past Clinical Trials

1989-1991  
Janssen Research Foundation  
PI: Green

Risperidone in the treatment of schizophrenia

1989-1990  
Sandoz Research Institute  
PI: Green

SDZ HDC-912 in the treatment of  
schizophrenia

1991-1994  
Merck, Sharp & Dome  
PI: Green

Remoxipride vs. haloperidol in  
schizophrenic outpatients

1993-1997  
Eli Lilly & Co.

Fixed-dose olanzapine vs. placebo  
in the treatment of schizophrenia

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| PI: Green   |  |
| 1994-1996<br>Otsuka America Pharm., Inc.<br>PI: Green | OPC-14597 vs. haloperidol and placebo<br>in the treatments of schizophrenia  |
| 1994-1996<br>Pfizer, Inc.<br>PI: Green                | Inpatient study of ziprasidone and haloperidol in the acute<br>exacerbation of schizophrenia and schizoaffective disorder  |
| 1994-1996<br>Pfizer, Inc.<br>PI: Green                | Evaluating the safety and efficacy of two dose regimens of oral<br>ziprasidone and haloperidol in the maintenance treatment<br>of outpatients with schizophrenia or schizoaffective disorder |
| 1994-2000<br>Pfizer, Inc.<br>PI: Green                | Evaluating the safety and outcome of oral ziprasidone in subjects<br>who have participated in previous clinical trials of ziprasidone  |
| 1995-1996<br>Otsuka America Pharm., Inc.<br>PI: Green | A dose ranging study of OPC-14597<br>in patients with schizophrenia  |
| 1995-2002<br>Otsuka America Pharm., Inc.<br>PI: Green | An open-label tolerability study of OPC 14597<br>in schizophrenic patients   |
| 1996-1997<br>Zeneca Pharmaceuticals<br>PI: Green      | Health outcomes study of Seroquel and usual care in<br>schizophrenia and schizoaffective disorder  |
| 1996-1998<br>Janssen Research Foundation<br>PI: Green | A comparison of risperidone and haloperidol for prevention of<br>relapse in subjects with schizophrenia and schizoaffective<br>disorders   |
| 1997<br>ICON Clinical Research, Inc.<br>PI: Green     | A phase III randomized study comparing 2 doses of intramuscular<br>ziprasidone (2 mg and 20 mg) in subjects with psychosis and<br>acute agitation  |
| 1997-1998<br>Hoescht Marion Rousel, Inc.<br>PI: Green | A multicenter, randomized, double-blind, placebo and active<br>controlled study of MDL 100,907 in schizophrenic and<br>schizoaffective patients  |
| 1997-1999<br>Hoescht Marion Rousel, Inc.<br>PI: Green | A multicenter, open-label, long-term follow-up, safety study<br>of MDL 100,907 in schizophrenic and schizoaffective patients   |
| 1997-1999<br>Otsuka America Pharm., Inc.<br>PI: Green | A study of aripiprazole in schizophrenia   |
| 1997-2001<br>Eli Lilly & Co.<br>PI: Green             | The acute and long-term efficacy of<br>olanzapine in first-episode psychotic disorders   |

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| 1998-2001<br>Novartis Pharmaceuticals<br>PI: Green | Clozapine vs. olanzapine in patients with schizophrenia and suicidality                                   |
| 2000-2002<br>Bristol-Myers Squibb<br>PI: Green     | A multicenter study of aripiprazole in the treatment of patients with acute schizophrenia                 |
| 2000-2002<br>Novartis Pharmaceuticals<br>PI: Green | A multicenter trial of iloperidone in patients with schizophrenia   |
| 2003-2005<br>Eli Lilly & Co.<br>PI: Green          | Atomoxetine plus olanzapine for cognitive dysfunction in schizophrenia                                    |
| 2004-2006<br>Forest Laboratories<br>PI: Green      | Memantine in psychosis  |
| 2008-2010<br>H. Lundbeck A/S<br>PI: Green          | Neurocognitive effect of sertindole versus quetiapine in patients with schizophrenia.                     |
| 2008-2010<br>Eli Lilly and Co.<br>PI: Green        | A phase 2 study of LY2196044 compared with naltrexone and placebo in the treatment of alcohol dependence. |

## Teaching

### 1. Medical School Courses

|           |  |
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| 1981-1985 | Psychiatry 700a, Harvard Medical School  |
| 1982-1985 | William James Seminar, Harvard Medical School  |
| 1983-1986 | William James Seminar II, Harvard Medical School   |
| 1984-1985 | Pathophysiology 905.0, Harvard Medical School  |
| 1984-1986 | Psychiatry 700b, Harvard Medical School  |
| 1986-1989 | Psychiatry 700, Harvard Medical School   |
| 1989-1997 | Psychiatry 700mj, Harvard Medical School   |
| 2003-     | Medical Neuropharmacology: Antipsychotics, Geisel School of Medicine at Dartmouth                  |
| 2004-2009 | Psych 606: Adolescent Alcohol Abuse, Dartmouth College   |
| 2005-     | Neurobiology of Psychosis, Geisel School of Medicine at Dartmouth                                  |
| 2006      | Pharmacology 131: Neuropharmacology and Imaging Biomarkers, Geisel School of Medicine at Dartmouth |
| 2006-     | Schizophrenia and Substance Abuse, Neuroscience Center, Geisel School of Medicine at Dartmouth     |
| 2007-     | PEMM 131: Neuropharmacology and Imaging Biomarkers, Geisel School of Medicine at Dartmouth         |
| 2007-     | PEMM 102: Neurotransmitter Transporters, Geisel School of Medicine at Dartmouth                    |
| 2008-     | PEMM 211: Neurobiology of Schizophrenia, Geisel School of Medicine at Dartmouth                    |

### 2. Hospital Courses and Teaching Presentations

- 1982- Psychopharmacology Lecture Series (Annual), Massachusetts Mental Health Center  
 1982-2002 Board Review Course (CME), Massachusetts Mental Health Center  
 1983-1993 Psychopharmacology Extramural Training Program (CME),  
 Massachusetts Mental Health Center  
 1984 Lecturer: Psychoneuroendocrinology, Brockton VA Medical Center  
 1985-1986 Topics in Psychopharmacology (CME), Lenox, MA  
 1986-1991 Psychopharmacology Update (CME), Aruba  
 1986-1994 Psychopharmacology Case Conference and Seminar, Brockton VA Medical Center  
 1987-1988 Psychopharmacology Update (CME), Massachusetts Department of Mental Health  
 1989-1994 Psychosis Seminar, Massachusetts Mental Health Center  
 1989-1992 Affective Disorders Seminar, Massachusetts Mental Health Center  
 1990-1993 Anxiety Disorders Seminars, Massachusetts Mental Health Center  
 1991- Harvard Medical School CME, Essential Psychopharmacology  
 1993-1994 Harvard Medical School CME, Psychopharmacology for the Family Physician  
 1993 Brockton VA Medical Center, Typical and Atypical Neuroleptic Drugs  
 1994 Harvard Longwood Psychiatry Residency, Pharmacological Approach to Schizophrenia  
 1994 MMHC CME, Psychopharmacology for the internist  
 1994-2002 Anxiety Disorders Courses, Harvard Longwood Psychiatry Residency  
 1996-2002 Psychosis Seminar, Harvard Longwood Psychiatry Residency  
 1997- Course Director, Essential Psychopharmacology, Harvard CME  
 2000-2002 Harvard Longwood Psychiatry Residency: lectures on psychopharmacology of psychosis  
 2003- Research Seminar, Dartmouth Psychiatry Residency Program  
 2003- Psychopharmacology, Pharmacology Course, Year Two,  
 Geisel School of Medicine at Dartmouth  
 2003- Psychiatry Grand Rounds, Dartmouth Hitchcock Medical Center  
 2003 Lecturer, Neuroscience Center at Dartmouth  
 2003 Psychiatry Grand Rounds, New Hampshire Hospital  
 2004 Lecturer, Addiction Symposium, Dartmouth Center on Addiction, Recovery and Education  
 2005 Psychiatry Grand Rounds, New Hampshire Hospital  
 2005 Pharmacology and Toxicology Seminar Series, Dartmouth Medical School:  
 "Brain Reward Circuit Dysfunction in Schizophrenia: A Target for Therapeutic  
 Intervention?"  
 2006 Pharmacology 131 Spring Lecture, Dartmouth Medical School. Modern Approaches in  
 Experimental Therapeutics: Neuropharmacology/Brain Imaging  
 2006 Neuroscience Center at Dartmouth, Pathophysiological Basis of Brain Disease Course:  
 "Neurobiology of Schizophrenia."  
 2007- Neuroscience Center at Dartmouth, Pathophysiological Basis of Brain Disease  
 Course: "Neurobiology of Schizophrenia and Substance Abuse."  
 2011 Dartmouth Community Medical School  
 "Alcohol and Drug Abuse: Is it all about reward?"

### 3. Invited Presentations

- 1972 How Basic Science Might Solve Social Problems in Substance Abuse,  
 Society of Neurosciences, Houston, Texas  
 1986 New Research in Affective Disorders, Psychiatry Grand Rounds,  
 University of Massachusetts  
 1989 Psychopharmacologic Probes in Psychotic Disorders, Psychiatry Grand Rounds,  
 Dartmouth Medical School

- 1989 New Treatments for Psychosis, Grand Rounds, Fuller Memorial Hospital
- 1989 Psychopharmacology in the Substance Abusing Patient, Dual Diagnosis Conference, Fuller Memorial Hospital
- 1989 Treatment of Depression, Massachusetts Medical Society
- 1991 New Research in Psychosis, Medical Grand Rounds, Mt. Auburn Hospital, Harvard Medical School
- 1991 Psychopharmacologic Probes in Research on Psychosis, Psychiatry Grand Rounds, Beth Israel Hospital, Harvard Medical School
- 1991 New Anti-Psychotic Drugs, Massachusetts Psychiatry Society Scientific Meeting
- 1991 Seminar Leader, Biologic Basis of Schizophrenia, Psychosis Seminar, Beth Israel Hospital, Boston, MA
- 1991 Treatment-Resistant Psychosis, Psychiatry Grand Rounds, Boston University School of Medicine
- 1992 Biology of Psychosis, Psychosis Seminar, University of Massachusetts
- 1993 Seminar Leader, Interface of Psychopharmacology and Psychotherapy, Boston Psychoanalytic Institute
- 1993 Treatment-Resistant Psychosis, Brighton Marine Public Health Center, Brighton, MA
- 1993 Treatment-Resistant Psychosis, Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
- 1992 New Atypical Neuroleptic Drugs, Neurology Grand Rounds, West Roxbury VA Medical Center
- 1992 Endocrine Aspects of Psychiatric Disorders, Endocrine Grand Rounds, Brigham & Women's Hospital, Boston, MA
- 1992 Treatment-Resistant Depression, Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
- 1994 Massachusetts Alliance for the Mentally Ill, Brookline Affiliate, Brookline, MA
- 1994 The New Pharmacology of Schizophrenia, Grand Rounds, Hartford Hospital, CT
- 1994 The Neurodevelopmental Basis of Schizophrenia, MA Department of Mental Health, Schizophrenia: State-of-the-Art Review Conference, Boston, MA
- 1994 The New Pharmacology of Schizophrenia, Dartmouth-Hitchcock Medical Center, Dartmouth Medical School, Grand Rounds, Lebanon, NH
- 1994 New Antipsychotic Medications, Alliance for the Mentally Ill of Cape Cod and the Islands, Hyannis, MA
- 1995 The New Pharmacology of Schizophrenia, Harvard-Longwood Behavioral Neurology Seminar, Brigham & Women's Hospital, Boston, MA
- 1995 Should the role of clozapine be expanded? American College of Neuropsychopharmacology, San Juan, PR
- 1995 New Antipsychotic Drugs, Psychiatry Grand Rounds, Stanford Medical Center
- 1996 Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
- 1996 An expanded role for clozapine? New Clinical Drug Evaluation Unit Annual Meeting, FL
- 1996 Psychopharmacology Grand Rounds, McLean Hospital, Belmont, MA
- 1996 Response to Typical and Atypical Neuroleptics: Clinical Symptoms and Plasma HVA, Schizophrenia and Genetics Conference, Bilbao, Spain
- 1996 Psychiatry Grand Rounds, Dartmouth Medical School
- 1997 Psychiatry Grand Rounds, University of Massachusetts Medical Center
- 1997 Psychiatry Grand Rounds, Beth Israel Deaconess Medical Center, Boston
- 1997 Psychopharmacology Rounds, Brigham and Women's Hospital, Boston

- 1997 Psychopharmacology Rounds, McLean Hospital, Belmont, MA
- 1997 Atypical Antipsychotics in Mood and Other Disorders,  
Stanford University School of Medicine
- 1998 Psychopharmacology Rounds, Cambridge Hospital, Cambridge, MA
- 1998 Psychiatry Grand Rounds, University of Rochester
- 1998 Novel antipsychotics in psychosis: changing expectations, Program Chair,  
Industry Symposium, APA annual meeting, Toronto
- 1998 Substance use disorder and schizophrenia: the role of antipsychotics,  
APA annual meeting, Toronto
- 1998 Psychiatry Grand Rounds, University of Vermont
- 1998 Early Intervention in Psychosis, Neurobiologic Basis. MA Department of Mental  
Health, Early Interventions in Psychosis Conference, Boston, MA
- 1999 Psychiatry Research Conference, University of Chicago
- 1999 Psychopharmacology of Schizophrenia, McLean Hospital
- 1999 Redefining Treatment-Resistant Schizophrenia, Program Chair and Lecturer,  
Industry Symposium, APA Annual Meeting, Washington, D.C.
- 1999 Effects of Antipsychotic-induced Prolactin Elevation,  
XI World Congress of Psychiatry, Hamburg, Germany
- 1999 Science Series, Tufts University School of Medicine, Department of Psychiatry
- 2000 Psychiatry Grand Rounds, University of Toronto.
- 2000 Psychiatry Grand Rounds, Downstate Medical Center, State University of New York
- 2000 Peter Curran Lecture, Mater Hospital Trust, Belfast, Northern Ireland
- 2000 Grand Rounds, Creedmore Psychiatric Center, Queens, New York.
- 2000 Chair, Gender, Schizophrenia and Antipsychotic Therapy. Second International  
Conference on Hormones, Brain and Neuropsychopharmacology. Rhodes, Greece
- 2000 Psychiatry Grand Rounds, Brown University School of Medicine.
- 2000 Lecturer, Arthur Noyes Schizophrenia Conference, Norristown State Hospital, PA
- 2000 Lecturer, Schizophrenia and Substance Abuse. Chile Psychiatric Association,  
La Serena, Chile (via videoconferencing).
- 2000 Massachusetts Psychiatric Society: Schizophrenia and comorbid substance use disorder.
- 2000 Treatments for Schizophrenia. Alliance for the Mentally Ill. Framingham, MA
- 2000 Psychiatry Grand Rounds, University of New Mexico, Albuquerque, NM
- 2000 Psychiatry Grand Rounds, Brockton VA Medical Center, Harvard Medical School
- 2001 Meeting the Challenge of Schizophrenia and Co-occurring Addictions,  
Program Chair. Industry Symposium, APA Annual Meeting
- 2001 Psychopharmacology of Comorbid Substance Use Disorders, Industry Symposium,  
APA Annual Meeting
- 2001 Substance Abuse and Schizophrenia, Satellite Symposium of 7<sup>th</sup> World Congress  
on Biological Psychiatry, Berlin, Germany
- 2001 Psychiatry Grand Rounds, Boston University Medical Center
- 2001 Psychiatry Grand Rounds, Harvard Longwood Program in Psychiatry
- 2001 Psychiatry Grand Rounds, University of Massachusetts Medical Center
- 2002 Psychiatry Grand Rounds, Wayne State School of Medicine, Detroit, MI
- 2002 Psychiatry Grand Rounds, University of Texas Southwestern, Dallas, Texas
- 2002 Psychopharmacology Conference, Silver Hill Hospital, New Canaan, Connecticut
- 2002 Research Seminar, Department of Psychiatry, Indiana University Mercer University
- 2003 Psychiatry Rounds, Harvard University Health Service, Cambridge, MA
- 2003 Schizophrenia and Substance Abuse, Thresholds Clinic, Chicago, Illinois



- 2003 Schizophrenia: Past, Present and Future, Central Vermont Medical Center
- 2003 Addiction Psychiatry Conference, SUNY Upstate Medical University, Syracuse, NY
- 2003 "Psychiatry and Neuroscience," Brattleboro Retreat Board of Directors, Grafton, VT
- 2004 Psychiatry Grand Rounds, Harvard Longwood Program in Psychiatry, Boston, MA
- 2004 Psychiatry Grand Rounds, University of Miami, Miami, Florida
- 2004 Psychiatry Grand Rounds, University of Pennsylvania, Philadelphia, PA
- 2004 Cannabis, Schizophrenia and Clozapine. Medications Development in Cannabis Dependence, NIDA, Rockville, MD
- 2004 Schizophrenia and Substance Abuse. Scandinavian College of Neuropsychopharmacology – Annual Meeting. Juan les Pins, France
- 2004 Can You Change the Course of Schizophrenia? Scandinavian College of Neuropsychopharmacology – Annual Meeting. Juan les Pins, France
- 2004 Psychiatry Grand Rounds, Yale Medical School, New Haven, CT
- 2004 Neuroscience Rounds, McLean Hospital, Harvard Medical School, Belmont, MA
- 2004 Neuropharmacology Seminar, Albany Medical College, Albany, NY
- 2004 Special Lecture: "What is Evidence?" McGill Dept of Psychiatry, Montreal, Canada
- 2004 Keynote Address: "Drugs and the Developing Brain: Adolescent Drug Use." Vermont Substance Abuse Conference, Fairlee, VT
- 2004 "Neurobiology of Addiction." Annual Scientific Convention, New Hampshire Medical Society, Bretton Woods, NH
- 2005 Keynote Address: "Early Intervention in Psychosis." NH Chapter of the Psychiatric Nursing Association, Stowe, VT
- 2005 "Substance Abuse and Psychosis." XII International Symposium about Current Issues and Controversies in Psychiatry, Barcelona, Spain
- 2005 Pharmacotherapy. Substance Abuse and Schizophrenia. Symposium, American Psychiatric Association Annual Meeting, Atlanta, GA
- 2005 "Drugs and the Developing Brain." Dartmouth Center for Addiction, Research and Education Symposium
- 2005 "Cannabis and Psychosis." Symposium at American Psychiatric Association Annual Meeting, Atlanta, GA
- 2005 "Novel Medications Development for Cannabis Dependence Targeting Brain Reward Circuitry." Symposium: Advancing Treatment for Marijuana Dependence. College on Problems of Drug Dependence Annual Meeting, Orlando, FL
- 2005 "Schizophrenia and Substance Abuse: A Reward Deficiency Syndrome?" Neurology Grand Rounds, Dartmouth Hitchcock Medical Center, Lebanon, NH
- 2005 "Schizophrenia and Co-occurring Substance Abuse: A Brain Reward Circuit Deficiency?" Dartmouth Symposium for the Life Science: Mechanisms of Brain Disorders. Dartmouth Hitchcock Medical Center, Lebanon, NH
- 2005 "Pharmacotherapy for Schizophrenia and Co-occurring Substance Use Disorders." International Meeting on Implications of Comorbidity for Etiology and Treatment of Neuropsychiatric Disorders. Mazagón, Spain
- 2005 "Current and Emerging Roles for Antipsychotic Therapy," Neuroscience Grand Rounds, University of Arizona, Tucson, AZ
- 2005 "Substance Abuse and the Vulnerable Brain," Great Issues in Medicine and Global Health Symposium, Dartmouth Hitchcock Medical Center, Lebanon, NH
- 2006 "Schizophrenia and Substance Abuse." NIDA Symposium on Models of Co-occurring Disorders, Bethesda, MD
- 2006 "Pharmacologic Approaches to Co-occurring Disorders." NIAAA, NIMH, and NIDA

- Joint Comorbidity Conference, Bethesda, MD
- 2006 “Substance Abuse and Schizophrenia.” National Conference on Co-occurring Disorders, Indiana University, Indianapolis
- 2006 “Drugs, Alcohol and Teens.” Turner Lecture Series. Sponsored by West Central Behavioral Health, Department of Psychiatry, Dartmouth Medical School, National Alliance for the Mentally Ill.
- 2006 “The Clinician’s Dilemma: When to Use Two Antipsychotics?” 3<sup>rd</sup> In Teleconference, Atlanta, GA.
- 2006 “Substance Abuse and the Onset, Severity and Treatment of Schizophrenia.” International Society of Addiction Medicine (VIII ISAM Meeting), Oporto, Portugal.
- 2006 “Schizophrenia and Substance Abuse: Is it all about Reward?” New Frontiers in Psychiatry, Stowe, VT.
- 2006 Vermont State Substance Abuse Conference, Lake Morey, VT.
- 2006 “Treatment of Comorbid Cannabis Use and Schizophrenia.” American Academy of Child and Adolescent Psychiatry Annual Meeting, San Diego, CA.
- 2007 Joseph J. Schildkraut Memorial Lecture, University of Massachusetts
- 2007 Psychiatry Grand Rounds, Vanderbilt University, Nashville, TN.
- 2008 “Schizophrenia and Substance Abuse: Is it all about rewards?” Psychiatry Grand Rounds, Maine Medical Center, Portland, ME.
- 2008 “Deconstructing Clozapine: Toward New Medications for Alcoholism.” NIAAA, Washington, DC.
- 2008 “Schizophrenia and Substance Abuse: Is it all about rewards?” Psychiatry Grand Rounds, Tufts Medical Center, Boston, MA.
- 2008 “Lifting the Veil on Mental Illness: Science in Psychiatry.” Dartmouth Community Medical School
- 2008 “Targeting Reward Circuitry: Medication Development for Schizophrenia and Substance Abuse.” 1<sup>st</sup> Annual Chairs Summit, Hilton Head Island, SC. June 27-29.
- 2009 “Schizophrenia and Substance Abuse: Approaching Pharmacotherapy.” Plenary Session, CINP Thematic Conference, Edinburgh, UK. April 25-27.
- 2009 “A Translational Perspective on Clozapine: Clinical Utility.” CINP Thematic Conference, Edinburgh, UK. April 25-27.
- 2009 “Update on the Pharmacologic Treatment of Schizophrenia.” American Psychiatric Association Annual Meeting, San Francisco, CA. May 16-21.
- 2009 “Treatment of Schizophrenia and Co-Occurring Alcoholism.” American Psychiatric Association Annual Meeting, San Francisco, CA. May 16-21.
- 2009 “Cannabis and Psychosis.” Australian National Cannabis Conference, Sydney, Australia. September 7-8.
- 2009 “Deconstructing Clozapine: Toward Medication for Alcoholism in Schizophrenia.” Psychiatry Grand Rounds, McMaster University, Hamilton, ON, Canada. September 16.
- 2009 “Cannabis and Schizophrenia” October 27-November 1. American Association of Child and Adolescent Psychiatry Annual Meeting. Honolulu, HI.
- 2010 “Concurrent Treatment of Cannabis Dependence in Patients with Schizophrenia.” American Psychiatric Association Annual Meeting, New Orleans, LA. May 22-26.
- 2010 “Non-Psychotic Issues of Schizophrenic Patients: Schizophrenia and Substance Abuse.” American Psychiatric Association Annual Meeting, New Orleans, LA. May 22-26.
- 2010 “Treatment of Schizophrenia and Co-Occurring Alcoholism” Research Society on Alcoholism Annual Meeting, San Antonio, TX. June 26-30.
- 2010 “Essential Psychopharmacology, 2010: Practice and Update”

- 2011 Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). August 2-6.  
 “Essential Psychopharmacology, 2011: Practice and Update”
- 2011 Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). August 1-5.  
 “Deconstructing Clozapine: Toward Medications for Schizophrenia and Substance Abuse.”  
 CINP (Collegium Internationale Neuro-Psychopharmacologicum)  
 International Congress on Dual Disorders. Barcelona, Spain. October 4.
- 2011 “Does Use of Cannabis Increase Risk or Speed the Onset of Psychosis?”  
 2011 Course on the State of the Art in Addiction Medicine. October 27-29.  
 American Society of Addiction Medicine, Washington, DC
- 2012 “Double Trouble: Co-occurrence of Alcoholism and Psychiatric Disorders.”  
 American Psychiatric Association. Philadelphia, PA. May 7, 2012.
- 2012 “Essential Psychopharmacology, 2012: Practice and Update”  
 Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). Jul 31-Aug 3.
- 2013 “Schizophrenia and Co-Occurring Substance Use Disorders: Exploring Common  
 Neurocircuits and Effective Treatments: NIAAA Panel Session.”  
 New clinical Drug Evaluation Unit of NIMH. Hollywood Beach, FL, May 29.
- 2013 “Deconstructing Clozapine: Toward Medications for Schizophrenia and Substance Abuse.”  
 Penn State Medical Center. Hershey, PA, September 19.
- 2013 “Use of Antipsychotics and Dual Pathology.” International Congress. Spanish Society of  
 Dual Pathology. Barcelona, Spain, October 25.
- 2014 “Substance Abuse in Schizophrenia: Targeting the Brain Reward Circuit” Neuroscience Day  
 at Dartmouth. Lebanon, NH, February 21.
- 2014 “Brain Reward Circuit Activity: An Indicator of Therapeutic Efficacy?” Neurology  
 Grand Rounds, Dartmouth Hitchcock Medical Center, Lebanon, NH, May 9.
- 2014 “Cannabis Use Disorder in Schizophrenia: Is this really self-medication?” 8<sup>th</sup>  
 ALBATROS Congress, International Congress of Addictology. Paris, France, June 5.
- 2014 “Psychosis and Co-occurring Substance Use Disorder: Neural Circuitry, Models and New  
 Treatment Development.” International Society for Biomedical Research on  
 Alcoholism/Research Society on Alcoholism Joint Congress, Bellevue, WA, June 24.
- 2014 “Antipsychotics, Biology and Treatment of Schizophrenia”  
 Harvard Medical School Summer Seminar, July 28
- 2015 “Journal of Dual Diagnosis”  
 “Substance Use and Schizophrenia: Risk and Reward”  
 “Cannabis Use in Schizophrenia”  
 “Clozapine for Substance Use Disorders in Schizophrenia: A Unifying Hypothesis?”  
 International Congress of Dual Disorders, Addictions and Other Mental Disorders.  
 Barcelona, Spain. April 17-20.
- 2015 “Alcohol Use Disorder and Schizophrenia: Approaches to Pharmacologic Interventions”  
 American Psychiatric Association. Toronto, Ontario. May 16.
- 2017 “Schizophrenia and Co-occurring Substance Use Disorders: Translational Research and  
 Reward” World Conference of the World Association of Dual Disorders & International  
 Congress of the Spanish Society of Dual Disorders. Madrid, Spain. March 24.

**Formally Supervised Trainees (and current position)**

- 1987 – 1990 Mohammed Y Alam, M.D. (Post-doctoral Fellow)  
 Staff Psychiatrist, American Medical Research, Inc., Oak Brook, IL
- 1991 – 1993 Ileana Berman, M.D. (Post-doctoral Fellow)

- Private Practice, Attleboro, MA
- 1991 – 1993 Howard H. J. Chang, M.D., M.P.H. (Post-doctoral Fellow)  
Psychiatrist, South Shore Hospital, Weymouth, MA
- 1993 – 1995 Jayendra K. Patel, M.D. (Post-doctoral Fellow)  
Private Practice, Lake Charles, LA
- 1994 – 1998 Rahim Shafa, M.D. (Post-doctoral Fellow)  
Director, Novel Clinical Psychopharmacology Care, Natick, MA  
Staff Psychiatrist, Metrowest & Greater Boston CNS Research Center
- 1995 – 1997 Carla Canuso, M.D. (Post-doctoral Fellow)  
Senior Director of Neuroscience External Innovation at Johnson & Johnson
- 1997 – 1999 James Kelleher, M.D. (Post-doctoral Fellow)  
Associate Professor, Clinical Psychiatry and Behavioral Sciences,  
New York Medical College
- 1998 – 1999 Carmela Perez, Ph.D. (Post-doctoral Fellow)  
Private Practice Psychoanalyst, New York, NY  
Assistant Professor of Psychiatry, St. Vincent's Hospital  
Assistant Professor of Psychiatry, New York Medical College
- 1998 – 2000 Rael Strous, M.D. (Post-doctoral Fellow)  
Professor of Psychiatry, Sackler School of Medicine, Tel Aviv University.  
Senior Psychiatrist, Be'er Ya'akov Mental Health Center, Tel Aviv.
- 1998 – 2001 Jaskaran Singh, M.D. (Post-doctoral Fellow)  
Senior Director, Clinical Research, Neuroscience at Janssen,  
Johnson & Johnson Pharmaceutical Research and Development, San Diego, CA
- 1999 – 2001 Michael Rodriguez, Ph.D. (Post-doctoral Fellow)  
Assistant Professor, Department of Psychology, Harvard University
- 2000 – 2001 Amani Michael, M.D. (Post-doctoral Fellow)  
Psychiatrist, Integrated Behavioral Associates, Weymouth, MA
- 2000 – 2001 Wilson Woo, M.D., Ph.D. (Post-doctoral Fellow)  
Assistant Professor of Psychiatry, Harvard Medical School, Cambridge, MA.  
Director, Laboratory of Cellular Neuropathology, McLean Hospital, Boston, MA  
Medical Director, Harvard Brain Tissue Resource Center,  
Beth Israel Deaconess Medical Center, Boston, MA.
- 2001 – 2003 David Chau, Ph.D. (Post-doctoral Fellow)  
Founder and President of Amazing Grace Pharmaceuticals
- 2002 – 2006 Vivianne Tawfik, M.D., Ph.D. (Pre-doctoral Student)  
Instructor, Anesthesiology, Perioperative and Pain Medicine  
Stanford School of Medicine, Stanford, CA.
- 2005 – 2006 Timothy Laumann (Dartmouth Undergraduate)  
M.D. Ph.D. student, Washington University, St. Louis
- 2007 – 2010 Matthew Garlinghouse, Ph.D. (Post-doctoral Fellow)  
Senior Neuropsychologist at Henry Ford Health Systems, Detroit, MI.
- 2007 – 2010 Michael Henderson, J.D. (Pre-doctoral Student)  
Associate University Counsel, Temple University, Philadelphia, PA.
- 2009 – 2010 Victoria Stockman (Dartmouth Undergraduate)  
PhD Student, Department of Systems Biology,  
Columbia University Graduate School of Arts and Sciences, New York, NY.
- 2009 – 2011 Danielle Gulick, Ph. D. (Post-doctoral Fellow)  
Assistant Professor, Morsani College of Medicine, University of South Florida

- 2009 – 2011 Natalie Colaneri (Dartmouth Undergraduate)  
 Visiting Researcher, Oxford Uehiro Centre for Practical Ethics,  
 University of Oxford, England.
- 2010 – 2011 Eric Arehart, M.D. Ph.D. (Post-doctoral Fellow)  
 Resident, Neurology, Duke Children’s Hospital & Health Center, Durham, NC.
- 2010 – 2012 Yip Wong, B.S. (Pre-doctoral Fellow – Program in Experimental Molecular  
 Medicine)
- 2010 – 2013 Adina Fischer, M.D., Ph.D. (Pre-doctoral Fellow)  
*Resident Physician, Psychiatry and Research Track, Stanford University*
- 2011 – 2013 Sarah Aronson (Dartmouth Undergraduate)  
 MD-PhD Candidate, University of Maryland School of Medicine
- 2011 – 2013 Jill MacLeod, Ph.D. (Post-doctoral Fellow)  
 Biotoxin Monitoring, State of Maine Department of Marine Resources
- 2013– 2013 Jaime Bravo (Dartmouth Graduate Rotating Student)  
 Graduate Student in Biomedical Engineering, Dartmouth College
- 2011 – 2013 Wilder Doucette, M.D., Ph.D.  
 Assistant Professor of Psychiatry, Geisel School of Medicine
- 2012 – Jibrán Khokhar, Ph.D. (Post-doctoral Fellow)  
 Department of Psychiatry, Postdoctoral Fellowship
- 2013 – 2015 Sarah C. Akerman, M.D.  
 Assistant Professor of Psychiatry, Geisel School of Medicine at Dartmouth
- 2013 – Hersh Trivedi  
 Dartmouth Undergraduate Student
- 2013 – Michael Sun  
 Dartmouth Undergraduate Student
- 2013 – Mia Harrow-Mortelliti  
 Dartmouth Undergraduate Student
- 2014 – 2016 Nicholas Deveau  
 Dartmouth Undergraduate Student
- 2014 – 2014 David Mallick  
 Dartmouth Graduate Rotating Student
- 2014 – 2016 Jared Boyce  
 Dartmouth Undergraduate Student
- 2015 – Amanda Simon  
 Dartmouth Undergraduate Student
- 2015 – Megan Cheng  
 Dartmouth Undergraduate Student
- 2015 – 2015 Carey Allmendinger  
 Dartmouth Graduate Rotation Student
- 2015 – Rebecca Zegans  
 Wesleyan Undergraduate Student
- 2015 – Robert Tokhunts  
 Dartmouth Medical Student
- 2015- Lucas Dwiel (graduate student)  
 Dartmouth Program in Experimental and Molecular Medicine
- 2016- Angela Hendricks (Post-doctoral fellow)  
 NIDA T32 Fellowship on Dual Disorders

## Bibliography

### Articles

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299. Whitfield-Gabrieli S, Fischer AS, Roth RM, Green AI. Functional connectivity of the default mode network in patients with schizophrenia and the effects of cannabinoid agonist administration. Poster presented at: 4th Biennial Conference on Resting State Brain Connectivity, Boston, MA, 2014.
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306. Green AI. Alcohol and Schizophrenia: Approaches to Pharmacologic Intervention. American Psychiatric Association, Toronto, Ontario, 2015.
307. Green AI. Substance Use and Schizophrenia: Risk and Reward. International Congress of Dual Disorders, Addictions and Other Mental Disorders. Barcelona, Spain, 2015.
308. Green AI. Cannabis Use in Schizophrenia. International Congress of Dual Disorders, Addictions and Other Mental Disorders. Barcelona, Spain, 2015.
309. Green AI. Clozapine for Substance Use Disorders in Schizophrenia: A Unifying Hypothesis? International Congress of Dual Disorders, Addictions and Other Mental Disorders. Barcelona, Spain, 2015.

310. Khokhar JY, Chen X, Lu H, Gimi B, Stein EA, Green AI. Impaired Brain Reward Circuitry May Underlie Alcohol Drinking in a Rat Model of Schizophrenia and Co-Occurring Alcohol Use Disorder. American College of Neuropsychopharmacology. Hollywood, Florida, 2016.
311. Khokhar J, Todd T, Doucette W, Bucci D, Green A. Long-Lasting Impact of Adolescent Cannabinoid Exposure on Reward-Related Behaviors: Potential Interaction with Schizophrenia. First World Congress of the World Association on Dual Disorders & Fifth International Congress of the Spanish Society on Dual Disorders. Madrid, 2017.
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**EDUCATION**

- 1978 - 1980      Simmons School of Social Work, Boston, Massachusetts. M.S.W.
- 1971 - 1975      Wellesley College, Wellesley, Massachusetts. B.A. in Psychology.

**PROFESSIONAL POSITIONS**

- 10/03 to present      Independent Consultant and Trainer, Philadelphia, PA.  
Providing workshops and follow-up consultation for Illness Management and Recovery (IMR), Recovery After an Initial Schizophrenia Episode (RAISE), NAVIGATE Early Treatment Program, Social Skills Training, Helping Individuals Reduce Relapses, and Working with Families of Persons with Mental Illness.
- 3/2014 to present      Coordinator of training for NAVIGATE Early Treatment Program
- 10/2012 to present      Boston University, Boston, MA  
Member of the development team and trainer for Health Technology Program, part of a grant from Center for Medicare and Medicaid Improvement (CMMI) for using technology to help improve mental health and prevent hospitalizations.
- 10/00 to 2013      New Hampshire-Dartmouth Psychiatric Research Center, Concord, NH.  
Co-chair of the development team and trainer for the following:  
*IMR (Illness Management and Recovery)*, part of SAMHSA'S Evidence-Treatment Practices toolkit project  
*NAVIGATE Treatment Model*, part of the RAISE (Recovery After an Initial Schizophrenia Episode) multi-site NIMH project  
*Relapse Prevention Planning component of The Health Technology Program*, part of the Improving Care and Reducing Costs project, sponsored by CMMI (Center for Medicare and Medicaid Innovation).
- 1/96 – 1/02      Delaware Psychiatric Center, Newcastle, Delaware.  
Psychiatric Rehabilitation Consultant.
- 10/89-10/96      Eastern Pennsylvania Psychiatric Institute, Philadelphia, Pennsylvania.  
Social Skills Trainer and Research Associate for the Educational Family Therapy Program

- 12/88-1/91 New York State Psychiatric Institute, New York, New York.  
Supervisor/consultant for Multiple Family Education groups, conducted as part of Family Support Demonstration Project (William McFarlane, MD).
- 12/87-7/89 Hillside Hospital, Long Island Jewish Medical Center, Glen Oaks, New York.  
Mt. Sinai Hospital, New York, New York.  
Research clinician for Post-Psychotic Depression Study (Sam Siris, MD).

### **PUBLICATIONS**

- 2013 Mueser, K.T., Gottlieb, J.D., & Gingerich, S. Social skills and problem solving training. In S.G. Hoffman (Ed.), Wiley Handbook of Cognitive Behavioral Therapy (pp. 243-271). New York: Wiley.
- 2013 Mueser, K.T., & Gingerich, S. Treatment of co-occurring psychotic and substance use disorders. Social Work in Public Health, 28, 424-39.
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- 2011 Mueser, K., & Gingerich, S. Collaborating with Families of People with Serious Mental Illness. In Rudnick, A. and Roe, D. (Editors). Serious Mental Illness: Person-Centered Approaches. NY, NY: Radcliffe Publishing.
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- 2011 Mueser, K.T., & Gingerich, S. Illness self-management programmes. In G. Thornicroft, G. Szmukler, K.T. Mueser, & R.E. Drake (Eds.), Oxford Textbook of Community Mental Health. Oxford, England: Oxford University Press (pp. 211-219)
- 2010 Meyer, P., Mueser, K. & Gingerich, S. A guide to implementation and clinical practice of Illness Management and Recovery for people with schizophrenia. In Rubin, Springer, and Trawver (Eds.), Psychosocial treatment of Schizophrenia. New York, NY: Wiley.

- 2009 Whitley, R.E., Gingerich, S., Lutz, W.J., & Mueser, K.T. Implementing the Illness Management and Recovery program in community mental health settings: Facilitators and barriers. Psychiatric Services, 60, 202-209.
- 2009 Gingerich, S. Guidelines for social skills training for persons with mental illness. In Social Workers' Desk Reference, second edition. Roberts, A. & Greene, G., editors. Oxford Press.
- 2008 Mueser, K. & Gingerich, S. Illness self-management training. In Clinical Handbook of Schizophrenia. Mueser, K. and Jeste, D, editors. Guilford Press
- 2008 Gingerich, S., & Mueser, K.T. (2008). Illness Management and Recovery (IMR): An evidence-based practice that can benefit persons with schizophrenia, bipolar disorder and major depression. Society for Social Work Leadership in Healthcare Newsletter, 10 (6), 2-3, 8.
- 2008 Mueser, K. & Gingerich, S. Making Choices: Substances and You. Module 7 in Team Solutions. Eli Lilly and Company. Available at [www.treatmentteam.com](http://www.treatmentteam.com).
- 2007 Gingerich, S. & Mueser, K. Family intervention for severe mental illness. In Cognitive Behavior Therapy in Clinical Social Work Practice. Ronen, T. and Freeman, A. editors. New York: Springer Publishers.
2006. Mueser, K., & Gingerich, S. The Complete Family Guide to Schizophrenia. Guilford Press. Winner of NAMI Ken Book Award.
- 2005 Gingerich, S. & Mueser, K. Illness Management and Recovery. In Evidence-Based Practices in Mental Health: A Textbook. Merrens, M., et al., editors. W.W. Norton.
- 2005 Gingerich, S, & Mueser K. Coping Skills Group: A Session-by-Session Guide. Wellness Reproductions.
- 2005 Mueser, K.T., & Gingerich, S. Illness Management and Recovery (IMR) Scales. In T. Campbell-Orde, J. Chamberlin, J. Carpenter, & H.S. Leff (Eds.), Measuring the Promise: A Compendium of Recovery Measures (Vol. II). Cambridge, MA: Evaluation Center @ Human Services Research Institute.
- 2004 Bellack, A., Mueser, K., Gingerich, S., & Agresta, J. Social Skills Training for Schizophrenia, second edition. Guilford Press.
- 2002 Mueser, K., Corrigan, P., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S., Essock, S., Tarrier, N., Morey, B., Vogel-Scibilia, S., & Herz, M. Illness management and recovery: A review of the research. Psychiatric Services 53 (10). 1272-1284.

- 2002 McFarlane, W., Gingerich, S., Deakins, S., Dunne, E., Horen, B., & Newmark, M. Co-author of four chapters in Multiple Family Groups in the Treatment of Severe Psychiatric Disorders by William McFarlane. Guilford Press.
- 2002 Gingerich, S. Guidelines for social skills training for persons with mental illness. In Social Workers' Desk Reference, First Edition. Roberts, A. & Greene, G., editors. Oxford Press.
- 2002 Gingerich, S. Social workers as crisis counselors. In Social Workers in Mental Health Practice. Kia Bentley, editor. Wordsworth-Brooks/Cole.
- 1998 Gingerich, S. Stigma: Critical issues for clinicians assisting individuals with severe mental illness. Cognitive and Behavioral Practice 5 (13): 277-285.
- 1997 Bellack, A., Mueser, K., Gingerich, S., & Agresta, J. Social Skills Training For Schizophrenia. New York: Guilford Press.
- 1995 Gingerich, S. & Bellack, A. Research-based family interventions for the treatment of schizophrenia. Clinical Psychologist 48 (1): 24-27.  
Reprinted in Research on Social Work Practice 6 (1): 122-126.
- 1994 Mueser, K. & Gingerich, S. Coping with Schizophrenia: A Guide for Families. Oakland: New Harbinger Publications.
- 1994 Mueser, K., Gingerich, S., & Rosenthal, C. Educational family therapy for schizophrenia: a new treatment model for clinical service and research. Schizophrenia Research 13: 99-108.
- 1993 Mueser, K., Gingerich, S., & Rosenthal, C. Familial factors in psychiatry. Current Opinion in Psychiatry 6: 251-257.
- 1990 Mason, S., Gingerich, S., & Siris, S. Patients and caregivers' adaptation to improvement in schizophrenia. Hospital and Community Psychiatry 41(5): 541-544.  
Reprinted in Critical Strategies for Academic Thinking and Writing, Boston: Bedford Books of St. Martin's Press, 628-634.
- 1989 Siris, S., Cutler, J., Owen, A., Mason, S., Gingerich, S., & Lang, M. Controlled trial of adjunctive imipramine maintenance in schizophrenic patients with remitted post-psychotic depressions. American Journal of Psychiatry 146: 1495-1497.
- 1988 Falloon, I., Gingerich, S., Mueser, K., Rappaport, S. McGill, C., & Hole, V. Behavioral Family Therapy: A Workbook. Buckingham, England: FACTS Press.

1983 Vannicelli, M., Gingerich, S., & Ryback, R. Family problems related to the treatment and outcome of alcoholic patients. British Journal of Addictions.

## MANUALS

2013 Gingerich, S., Meyer, P., & Mueser, K. Relapse Prevention Planning manual for the Health Technology Program (part of a grant from CMMI, the Center for Medicaid and Medicare Improvement)

2013 Gingerich, S., Miller, J., Monroe-Devita, M., Mors, G., Mueser, K., & Hamilton, A. ACT+IMR: Integrating Illness Management and Recovery into Assertive Community Treatment Teams.

2013 Meyer, P., Gingerich, S., Fox, L., & Mueser, K. Minnesota Clinical Competency Scale for Enhanced IMR for Co-occurring Disorders, First Edition.

2011 Overall co-editor and contributing author to the following RAISE-Early Treatment Program manuals: Individual Resiliency Training, Family Education Program, Supported Employment and Education, and Team Members' Guide.

2009 Gingerich, S., Arnold, K. & Mueser, K. The Happy, Healthy Life Group (an Adaptation of the Illness Management and Recovery Toolkit for Persons with Mental Illness and Intellectual Disabilities and/or Cognitive Challenges).

2007 Meyer, P., Gingerich, S., & Mueser, K. Minnesota IMR Clinical Competency Scale.

2006 Gingerich, S. & Agresta, J. Multiple Family Groups for Adolescents with Mood Disorders.

2002 Gingerich, S., & Mueser, K., Illness Management and Recovery: Implementation Toolkit. Substance Abuse and Mental Health Services Administration.

2001 Gingerich, S. Conducting Groups for Clients in an Inpatient Psychiatric Facility.

1994 Bellack, A., Gingerich, S., Agresta, J. & Mueser, K. Social Skills Training for Psychiatric Clients with Persistent Symptoms.

1991 Mueser, K., Gingerich, S. & Rosenthal, C. Educational Family Therapy.

1989 McFarlane, W., Deakins, S., Gingerich, S., Horen, B., & Newmark, M. Conducting Multiple Family Psychoeducational Groups.



## ***Curriculum Vitae***

**DELBERT GAIL ROBINSON, M.D.**

### **BIRTHDATE AND PLACE**

### **EDUCATION AND TRAINING**

|                      |           |  |
|----------------------|-----------|--|
|                      | 1971-1975 | Vanderbilt University, Nashville, TN<br>B.A., Molecular Biology, 1975.                                     |
| <b>GRADUATE</b>      | 1976-1979 | The University of Tennessee Center for the<br>Health Sciences, Memphis, TN,<br>M.D., 1979.                 |
| <b>POST-GRADUATE</b> | 1979-1980 | The Mary Hitchcock Memorial Hospital<br>Dartmouth College, Hanover, New Hampshire<br>Internship.           |
|                      | 1980-1983 | Western Psychiatric Institute and Clinic,<br>University of Pittsburgh, PA<br>Resident: General Psychiatry. |
|                      | 7/83-6/85 | College of Physicians & Surgeons<br>Columbia University, NY, NY<br>Research Fellow                         |

### **PROFESSIONAL EMPLOYMENT AND HOSPITAL APPOINTMENTS :**

|  |              |  |
|--|--------------|--|
|  | 7/82-7/83    | Affective Disorders Module<br>Western Psychiatric Institute and Clinic<br>Chief Resident             |
|  | 1984/6/85    | College of Physicians & Surgeons<br>Columbia University, NY, NY<br>Instructor in Clinical Psychiatry |
|  | 1984-6/85    | Columbia Presbyterian Medical Center, NY, NY<br>Assistant Psychiatrist                               |
|  | 7/85-12/85   | Downstate Medical School, Brooklyn, NY<br>Assistant Professor of Clinical Psychiatry                 |
|  | 7/85-12/85   | Kings County Hospital, Brooklyn, NY<br>Chief, Medical Student Teaching Ward                          |
|  | 1/86-present | The Zucker Hillside Hospital, division of<br>North Shore Long Island Jewish Health System            |

- Glen Oaks, NY  
Research Psychiatrist
- 1/91-1/99 The Zucker Hillside Hospital, division of  
North Shore Long Island Jewish Health System  
Glen Oaks, NY  
Chief, Obsessive Compulsive Disorders Program
- 1/91-2004 The Zucker Hillside Hospital, division of  
North Shore Long Island Jewish Health System  
Glen Oaks, NY  
Chief, Clinical Assessment and  
Training Unit of the Clinical Research Center for  
the Study of Schizophrenia
- 1/96-1/98 The Zucker Hillside Hospital, division of  
North Shore Long Island Jewish Health System  
Glen Oaks, NY  
Acting Co-Director, Clinical Research Center for  
the Study of Schizophrenia
- 1/96-1/99 The Zucker Hillside Hospital, division of  
North Shore Long Island Jewish Health System  
Glen Oaks, NY  
Co-Director, Psychopharmacology Unit of the  
Clinical Research Center for the Study of  
Schizophrenia
- 1/01-Present Feinstein Institute for Medical Research  
North Shore-Long Island Jewish Health System  
Associate Investigator
- 11/03-6/05 Co-Director, Scientific Direction And  
Administration Unit, Intervention Research  
Center for Course of Illness in Schizophrenia:  
Optimizing Outcomes.
- 7/05-6/10 The Zucker Hillside Advanced Center for  
Intervention and Services Research. Early  
Phase Schizophrenia: Optimizing Outcomes  
Co-Director
- 7/05-6/10 The Zucker Hillside Advanced Center for  
Intervention and Services Research. Early  
Phase Schizophrenia: Optimizing Outcomes  
Co-Director, Scientific Direction and  
Administration Unit

- 7/05-Present The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes/Early Phase Psychosis: Informing Treatment Decisions  
Co-Director, Trials Operation Unit
- 7/05-6/10 The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes  
Co-Director, Research Network Development Core
- 7/05-6/10 The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes  
Director, Functional Outcomes Assessment Unit
- 5/08-4/14 The Zucker Hillside CIDAR Dissecting Heterogeneity of Treatment Response of First episode Schizophrenia  
Co-Director, Operations and Clinical Assessment Core
- 7/10-Present The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes  
Director, Adherence Unit

**OTHER ACADEMIC APPOINTMENTS:**

- 4/91-6/04 Albert Einstein College of Medicine  
New York, NY  
Assistant Professor of Psychiatry and Behavioral Sciences
- 7/04-6/09 Albert Einstein College of Medicine  
New York, NY  
Associate Professor of Psychiatry and Behavioral Sciences
- 7/09-6/11 Albert Einstein College of Medicine  
New York, NY  
Professor of Psychiatry and Behavioral Sciences

6/11-present Hofstra North Shore-LIJ School of Medicine at  
Hofstra University  
Hempstead, NY  
Professor of Psychiatry and of Molecular  
Medicine

**BOARD CERTIFICATION:**

1980 Medical License - Pennsylvania  
1983 Medical License - New York  
1985 Board Certification in Psychiatry

**PROFESSIONAL SOCIETY MEMBERSHIP:**

American Psychiatric Association  
International Early Psychosis Association  
American College of Neuropsychopharmacology

**AWARDS AND HONORS**

1975 Phi Beta Kappa (Vanderbilt)  
1979 Outstanding Student in Psychiatry (The University of  
Tennessee)  
2000 Exemplary Psychiatrists Award from the National  
Alliance for the Mentally Ill

**OTHER PROFESSIONAL ACTIVITIES**

**JOURNAL REVIEWER**

*Archives of General Psychiatry*  
*American Journal of Psychiatry*  
*Acta Psychiatrica Scandinavica*  
*Schizophrenia Bulletin*  
*Neuropsychopharmacology*  
*Schizophrenia Research*  
*Journal of Substance Abuse*  
*Primary Psychiatry*  
*Clinical Psychology Review*  
*Journal of Clinical Psychiatry*  
*Journal of Mental Health*  
*International Journal of Neuropsychopharmacology*  
*Journal of Clinical Psychopharmacology*

**GRANT REVIEWER**

National Institute of Mental Health (former member of the Neural Basis Of

Psychopathology, Addictions And Sleep Disorders Study Section; ad hoc for other study sections)

Peer Review Committee, Schizophrenia Trials Network (NIMH)

Ontario Mental Health Foundation

The Netherlands Organisation for Health Research and Development

Deutsche Forschungsgemeinschaft (DFG) German Research Foundation

Feinstein Institute for Medical Research

#### **NATIONAL COMMITTEES**

DSM-IV Work Group Advisor, Schizophrenia and Other Psychotic Disorders

Principal Contributor, American Psychiatric Association Task Force for the Handbook of Psychiatric Measures

Member, Psychopharmacologic Drugs Advisory Committee, Center For Drug Evaluation And Research, U.S. Food And Drug Administration

Texas Medication Algorithm Project

#### **NATIONAL WORKSHOPS**

First Episode Schizophrenia: Preventing Chronicity, Improving Outcomes, National Institute of Mental Health

#### **NEW YORK STATE COMMITTEES**

First Episode of Psychosis Augmented Treatment Program (FEAT) Workgroup, New York State Office of Mental Health

#### **HOSPITAL COMMITTEES**

Long Island Jewish Research Committee

Quality Assurance Committee, Hillside Research Department

Protocol Review Committee, Hillside Research Department

Scientific Executive Advisory Committee, Feinstein Institute for Medical Research, North Shore-Long Island Jewish Research Institute

#### **RESEARCH**

**PRINCIPAL INVESTIGATOR (FUNDED STUDIES)**

Nocturnal Polysomnography in Obsessive-Compulsive Disorder (Long Island Jewish Faculty Award)

1/90 - 6/92

Double-Blind 12-Week Parallel Comparison of Sertraline and Placebo in Outpatients with Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)

9/91 - 8/93

Double-Blind Parallel Comparison of Sertraline, Imipramine and Placebo in Outpatients with Dysthymia (Pfizer Pharmaceuticals) and Double-Blind Follow-Up Study of Sertraline, Imipramine and Placebo in Outpatients with Dysthymia (Pfizer Pharmaceuticals)

11/91 - 10/93

Double-Blind Parallel Comparison of Sertraline and Desipramine in Outpatients with Concurrent Major Depression and Obsessive Compulsive Disorder (Pfizer Pharmaceuticals) and Double-Blind Follow-Up Study of Sertraline and Desipramine in Outpatients with Concurrent Major Depression and Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)

8/92 - 9/95

Brain Morphology in Obsessive Compulsive Disorder (National Institute of Mental Health)

5/92 - 4/95

Sertraline Treatment Followed by a Double-Blind Comparison of Sertraline and Placebo in the Prevention of Relapse in Outpatients with Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)

3/94 - 9/96

12-Week Double-Blind Comparison of Two Sertraline Dose Regimens in "Nonresponder" Outpatients with Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)

9/94 - 4/96

Fluvoxamine: A Multi-Center, Placebo-Controlled, Randomized, Double-Blind Relapse Prevention Study in the Maintenance Treatment of Outpatients with Obsessive-Compulsive Disorder (Solvay Pharmaceuticals)

1/96 - 12/00

A Prospective, Randomized, International Parallel-Group Comparison of Clozaril/Leponex vs Zyprexa in the Reduction of Suicidality in Patients with Schizophrenia and SchizoAffective Disorder Who Are at Risk for Suicide (Novartis Pharmaceuticals)

4/98 - 4/01

Olanzapine in Attentional Deficits in Schizophrenia (Lilly Research Institute; investigator initiated)  
5/98 – 5/03

Preventing Morbidity in First Episode Schizophrenia, Part 1 and Part 2 (competing renewal) (National Institute of Mental Health)  
9/98 – 6/11

Long-Acting Risperidone For Patients Who Fail Their First Antipsychotic Treatment Trial (NARSAD)  
9/05 – 5/13

2-Way Pagers to Improve Schizophrenia Medication Adherence (National Institute of Mental Health)  
5/06 – 3/10

Detecting Which Patients With Schizophrenia Will Improve With Omega 3 Treatment (National Institute of Mental Health)  
7/13-6/15

**SITE PRINCIPAL INVESTIGATOR**

Decision Support for Smoking Cessation in Young Adults with Severe Mental Illness (National Cancer Institute)  
9/12-ongoing

**DIRECTOR**

ACISR: Early Phase Psychosis: Informing Treatment Decisions Adherence Unit  
7/10-ongoing

**CO-DIRECTOR**

ACISR: Early Phase Schizophrenia-Optomizing Outcomes Adherence Unit  
9/05- 6/10

CIDAR: Dissecting Heterogeneity of Treatment Response of First episode Schizophrenia Operations and Clinical Assessment Core (National Institute of Mental Health)  
5/08 – 4/13

**CO-PRINCIPAL INVESTIGATOR**

Prospective Study of First Episode Schizophrenia (National Institute of Mental Health)  
8/87 - 6/96

**CO-INVESTIGATOR**

Course of Illness in Schizophrenia: Optimizing Outcomes Schizophrenia  
(National Institute of Mental Health)  
2/00 – 1/06

Longitudinal Neuroimaging of First Episode Schizophrenia (National Institute  
of Mental Health)  
7/00 - 6/05

Recovery After Initial Schizophrenia Episode (National Institute of Mental  
Health)  
7/09-ongoing

Improving Substance Use and Clinical Outcomes in Heavy Cannabis Users  
(National Institute of Health)  
7/10-6/13

Improving Quality And Reducing Cost In Schizophrenia Care With New  
Technologies And New Personnel (CMMS/CMMI)  
7/12-ongoing

A Cluster Randomized, Multi-center, Parallel-group, Rater-blind Study  
Comparing Treatment with Aripiprazole Once Monthly and Treatment as  
Usual on Effectiveness in First Episode and Early Phase Illness in  
Schizophrenia (Investigator Initiated, supported by Otsuka)  
8/14-ongoing

**CONSULTANT**

Educational Material for Geriatric Psychopharmacology: Phase I (Small  
Business Innovation Research Program)  
7/96 - 12/96

Educational Material for Geriatric Psychopharmacology: Phase II (Small  
Business Innovation Research Program)  
11/00 – 4/05

A New Scale to Assess Psychopathology in Schizophrenia (NARSAD)  
6/01 – 11/05

**BIBLIOGRAPHY**

**ORIGINAL COMMUNICATIONS IN REVIEWED JOURNALS:**

Akiskal HS, King D, Rosenthal T, Robinson D, Scott-Strauss A: Chronic depressions Part  
I. Clinical and familial characteristics in 137 probands. *Journal of Affective Disorders*



3:297-315, 1981.

Robinson DG and Spiker DG: Delusional depression: A one year follow-up. *Journal of Affective Disorders* 9:79-83, 1985.

McGrath PJ, Robinson D, Stewart JW: Atypical panic attacks in major depression. *American Journal of Psychiatry* 142:1224, 1985.

Ryan ND, Puig-Antich J, Ambrosini P, Rabinovich H, Robinson D, Nelson B, Iyengar S, Twomey J: The clinical picture of major depression in children and adolescents. *Archives of General Psychiatry* 44:854-861, 1987.

Ryan NC, Puig-Antich J, Rabinovich H, Ambrosini P, Robinson D, Nelson B, Novacenko H: Growth hormone response to desmethylimipramine in depressed and suicidal adolescents. *Journal of Affective Disorders* 15:323-337, 1988.

Wager S, Robinson D, Goetz R, Nunes E, Gully R, Quitkin F: The cholinergic induction test in atypical depression - A pilot study. *Sleep Research* 17, 1988.

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Wager S, Robinson D, Goetz R, Nunes N, Gully R, Quitkin F: Cholinergic REM sleep induction in atypical depression. *Biological Psychiatry* 27:441-446, 1990.

Walsleben J, Robinson D, Lemus C, Hackshaw R, Norman R, Alvir J: Polysomnographic aspects of obsessive-compulsive disorder. *Sleep Research* 19: 177, 1990.

Robinson D, Mayerhoff D, Alvir J, Lieberman J: Mood responses of remitted schizophrenics to methylphenidate infusion. *Psychopharmacology* 105:247-252, 1991.

Lemus CZ, Robinson D, Kronig M, Cole K, Lieberman JA: Behavioral responses to a dopaminergic challenge in obsessive-compulsive disorder. *Journal of Anxiety Disorders* 5: 369-373, 1991.

Levy DL, Smith M, Robinson D, Jody D, Lerner G, Alvir J, Geisler SH, Szymanski SR, Gonzalez A, Mayerhoff DI, Lieberman JA, Mendell NR: Methylphenidate increases thought disorder in recent onset schizophrenics, but not in normal controls. *Biological Psychiatry* 34: 507-514, 1993.

Robinson D, Woerner M, Koreen AR, Siris SG, Chakos M, Alvir J, Mayerhoff D, Lieberman J: First-Episode schizophrenia and depression - Reply (Letter). *American Journal of Psychiatry* 152: 476-477, 1995.

Robinson D, Wu Houwei, Munne R, Ashtari M, Lerner G, Koreen A, Cole K, Bogerts B: Reduced caudate nucleus volume in obsessive-compulsive disorder. *Archives of General Psychiatry* 52: 393-398, 1995.

Greist JH, Jenike MA, Robinson D, Rasmussen SA: Efficacy of fluvoxamine in obsessive-compulsive disorder: results of a multicentre, double blind, placebo-controlled trial. *European Journal of Clinical Research* 7: 195-204, 1995.

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Strakowski SM, Flaum M, Amador X, Bracha HS, Pandurangi AK, Robinson D, Tohen M: Racial differences in the diagnosis of psychosis. *Schizophrenia Research* 21: 117-124, 1996.

Lieberman JA, Sheitman B, Chakos M, Robinson D, Schooler NR, Keith S: The development of treatment resistance in patients with schizophrenia: A clinical and pathophysiologic perspective. *Journal of Clinical Psychopharmacology* 18: 20S-24S, 1998.

Robinson D, Walsleben J, Pollack S, Lerner G: Nocturnal polysomnography in obsessive-compulsive disorder. *Psychiatry Research* 80: 257-263, 1998.

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Kronig MH, Apter J, Asnis G, Bystritsky A, Curtis G, Ferguson J, Landbloom R, Munjack D, Riesenber R, Robinson D, Roy-Byrne P, Phillips K, Du Pont IJ: Placebo-controlled, multicenter study of sertraline treatment for obsessive-compulsive disorder. *Journal of Clinical Psychopharmacology* 19: 172-176, 1999.

Schulz S, Thompson P, Marc J, Ninan P, Robinson D, Weiden P, Yadalam K, Glick I, Odbert C: Lithium augmentation fails to reduce symptoms in poorly responsive schizophrenic outpatients. *Journal of Clinical Psychiatry* 60:366-372, 1999.

Bilder RM, Wu H, Bogerts B, Ashtari M, Robinson D, Woerner M, Lieberman JA, DeGreef G: Cerebral volume asymmetries in schizophrenia and mood disorders: A quantitative magnetic resonance imaging study. *International Journal of Psychophysiology* 34:197-205, 1999.

Szeszko PR, Robinson D, Alvir JMaJ, Bilder RM, Lencz T, Ashtari M, Wu H, Bogerts B:

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Saltz BL, Woerner MG, Robinson DG, Kane JM: Side effects of antipsychotic drugs Avoiding and minimizing their impact in elderly patients. *Postgraduate Medicine* 107:169-178, 2000.

Bilder RM, Goldman RS, Robinson D, Reiter G, Bell L, Bates JA, Pappadopulos E, Willson DF, Alvir JMaJ, Woerner M, Geisler S, Kane JM, Lieberman JA: Neuropsychology of first episode psychosis: Initial characterization and clinical correlates. *American Journal of Psychiatry* 157: 549-559, 2000.

Robinson D, Woerner MG, Schooler N: Intervention Research in Psychosis: Issues Related to Clinical Assessment. *Schizophrenia Bulletin* 26: 551-556, 2000.

Lieberman J, Chakos M, Wu H, Alvir J, Hoffman E, Robinson D, Bilder R: Longitudinal study of brain morphology in first episode schizophrenia. *Biological Psychiatry* 49: 487-499, 2001.

Sevy S, Robinson DG, Holloway S, Alvir JM, Woerner MG, Bilder R, Goldman R, Lieberman J, Kane J. Correlates of substance misuse in patients with first-episode schizophrenia and schizoaffective disorder. *Acta Psychiatrica Scandinavica* 104: 367-374, 2001.

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Koran LM, Hackett E, Rubin A, Wolkow R, Robinson D. Efficacy of sertraline in the long-term treatment of obsessive-compulsive disorder. *American Journal of Psychiatry* 159: 88-95, 2002.

Goldstein RZ, Giovannetti T, Schullery M, Zuffante PA, Lieberman JA, Robinson DG, Barr WB, Bilder RM. Neurocognitive correlates of response to treatment in formal thought disorder in patients with first-episode schizophrenia. *Neuropsychiatry, Neuropsychology, and Behavioral Neurology* 15: 88-98, 2002.

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Robinson DG, Woerner MG, Alvir JMaJ, Bilder RM, Hinrichsen GA, Lieberman JA. Predictors of medication discontinuation by patients with first episode schizophrenia and schizoaffective disorder. *Schizophrenia Research* 57: 209-219, 2002.

Gunduz H, Wu H, Ashtari M, Bogerts B, Crandall D, Robinson DG, Alvir J, Lieberman J, Kane J, Bilder R. Basal ganglia volumes in first-episode schizophrenia and healthy comparison subjects. *Biological Psychiatry*. 51: 801-808, 2002.

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Woerner MG, Robinson DG, Alvir JMaJ, Sheitman BB, Lieberman JA, Kane M: Clozapine as a first treatment for schizophrenia. *American Journal of Psychiatry* 160:1514–1516, 2003.

Szeszko, PR, Goldberg E, Gunduz-Bruce H, Ashtari M, Robinson D, Malhotra AK, Lencz T, Bates J, Crandall DT, Kane JM, Bilder RM: Smaller anterior hippocampal formation volume in antipsychotic-naive patients with first-episode schizophrenia. *American Journal of Psychiatry* 160: 2190-2197, 2003.

Szeszko PR, Bates J, Robinson D, Kane J, Bilder RM. Investigation of unirhinal olfactory identification in antipsychotic-free patients experiencing a first-episode of schizophrenia. *Schizophrenia Research*, 67: 219-225, 2004.

Robinson DG, Woerner MG, McMeniman M, Mendelowitz A, Bilder RM: Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. *American Journal of Psychiatry* 161: 473-479, 2004.

Narr KL, Bilder RM, Kim S, Thompson PM, Szeszko P, Robinson D, Luders E, Toga AW: Abnormal gyral complexity in first-episode schizophrenia. *Biological Psychiatry* 55: 859-867, 2004.

Saltz BL, Robinson DG, Woerner MG: Recognizing and managing antipsychotic drug treatment side effects in the elderly. *Primary Care Companion Journal of Clinical Psychiatry* 6 [supplement 2]: 14-19, 2004.

Strous RD, Alvir JMaJ, Robinson D, Gal G, Sheitman B, Chakos M, Lieberman JA: Premorbid function in schizophrenia: relation to baseline symptoms, treatment response and medication side effects. *Schizophrenia Bulletin*, 30: 265-278, 2004.

Narr KL, Thompson PM, Szeszko P, Robinson D, Jang S, Woods RP, Kim S, Hayashi KM, Asuncion D, Toga AW, Bilder RM: Regional specificity of hippocampal volume reductions in first-episode schizophrenia. *NeuroImage*, 21: 1563-1575, 2004.

Szeszko PR, Ardekani BA, Ashtari M, Kumra S, Robinson DG, Sevy S, Gunduz-Bruce H,

Malhotra AK, Kane JM, Bilder RM, Lim KO: White matter abnormalities in first-episode schizophrenia or schizoaffective disorder: a diffusion tensor imaging study. *American Journal of Psychiatry*. 162: 602-605, 2005.

Narr KL, Toga AW, Szeszko P, Thompson PM, Woods RP, Robinson D, Sevy S, Wang YP, Schrock K, Bilder RM: Cortical thinning in cingulate and occipital cortices in first episode schizophrenia. *Biological Psychiatry*, 58: 32-40, 2005.

Narr KL, Bilder RM, Toga AW, Woods RP, Rex DE, Szeszko PR, Robinson D, Sevy S, Gunduz-Bruce H, Wang YP, DeLuca H, Thompson PM. Mapping cortical thickness and gray matter concentration in first episode schizophrenia. *Cerebral Cortex*, 15: 708-719, 2005

Szeszko PR, Ardekani BA, Ashtari M, Malhotra AK, Robinson DG, Bilder RM, Lim KO. White matter abnormalities in obsessive-compulsive disorder: a diffusion tensor imaging study. *Archives of General Psychiatry*, 62: 782-90, 2005.

Robinson DG, Woerner MG, Delman HM, Kane JM. Pharmacological treatments for first-episode schizophrenia. *Schizophrenia Bulletin*, 31: 705-722, 2005.

Miller R, Caponi JM, Sevy S, Robinson D: The insight-adherence-abstinence triad: an integrated treatment focus for cannabis-using first-episode schizophrenia patients. *Bulletin of the Menninger Clinic*, 69: 220-236, 2005.

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Nagendra A, Schooler NR, Kane JM, Robinson DG, Mueser KT, Estroff SE, et al. Demographic, psychosocial, clinical, and neurocognitive baseline characteristics of Black Americans in the RAISE-ETP study. *Schizophr Res.* 2017 Jul 11;

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#### **BOOKS, CHAPTERS IN BOOKS AND REVIEW ARTICLES**

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# Piper Suzanne Meyer-Kalos, Ph.D., LP

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## Education and Licensure

- Minnesota Licensed Psychologist (#LP5617)** April 30, 2013
- North Carolina Licensed Psychologist and Health Services Provider Psychologist (#3277)** October 2, 2006
- Postdoctoral Fellow** 2003- 2005  
National Research Service Award (NRSA) Fellowship, Mental Health and Substance Abuse Systems and Services, Cecil G. Sheps Center for Health Services Research, University of North Carolina Chapel Hill, North Carolina
- Doctorate, Clinical Rehabilitation Psychology** 1997- 2003  
Purdue University School of Science, Indianapolis, IN  
Dissertation: The cognitive factor of the PANSS: A confirmatory factor analysis and related cognitive correlates
- Master of Science, Clinical Rehabilitation Psychology** 1999  
Purdue University School of Science, Indianapolis, IN  
Master's Thesis: The impact of atypical antipsychotics on vocational outcomes
- Bachelor Arts, Psychology, Minor: Sociology** 1995  
DePauw University, Greencastle, IN
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## Professional Appointments/Employment

- Executive Director** 2013 - Current  
Minnesota Center for Chemical and Mental Health (MNCAMH), St. Paul, MN  
Director of a statewide center of excellence to provide training, research, and resources for emerging and existing practitioners and to build and sustain excellence in the delivery of mental health services. Coordinating and conducting mental health and addictions research and workforce development, acquiring external support, connecting the Center to the community providers, establishing center infrastructure, and supervising professional staff and graduate research assistants.
- Research Projects:
- Minnesota First Episode Psychosis Navigate Training Technical Assistance and Evaluation for three NAVIGATE teams.
  - Enhanced Illness Management and Recovery (E-IMR). Piloted an intervention and training protocol for persons with co-occurring mental illness and substance use disorders in six community mental health/substance abuse agencies across the State of Minnesota.

- Integrated Coping Awareness Therapy (I-CAT). NIMH funded pilot study of mindfulness and positive psychology intervention aimed at reducing stress reactivity in persons with first episode psychosis.
- Integrated Illness Management and Recovery (I-IMR). Conducted focus groups and evaluated I-IMR on ten Assertive Community Treatment Teams across Minnesota focusing on improving psychiatric and physical health outcomes of persons with serious mental illness (SMI)
- IMRapp. Translated IMR iPad application into English in preparation for piloting the application in the United States.

**Research Assistant Professor**

2005 - 2013

UNC-CH Department of Psychology, Chapel Hill, NC

Research coordinator for a clinical psychology lab focused on psychosocial treatment for schizophrenia and the assessment of social cognition in schizophrenia. Supervised undergraduate lab staff, provided clinical supervision for research projects, participated in development of grants, and development of psychosocial curriculum. Developed community alliances with county/state agencies to recruit for research studies.

**Research Projects:**

- Recovery After Initial Schizophrenia Episode (RAISE). Co-developed an individual therapy for people with first episode psychosis, and conducted training, ongoing clinical supervision, and fidelity evaluations for 13 national sites.
- The Farm at Penny Lane. Coordinating the development of a garden/farm program for persons with mental health disorders. Developing program evaluation measures to evaluate nutrition, weight, mental health, and activity level.
- Positive Living. Adapted a positive psychology treatment for people with schizophrenia and conducted pilot studies with persons with schizophrenia. Utilized pilot research in recent grant application.
- Social Cognition and Interaction Training (SCIT). Project coordinator for a treatment aimed at improving social cognition for persons with schizophrenia.
- An investigation of Group Cognitive Behavioral Therapy (CBT) compared to Supportive Therapy for Auditory Hallucinations. Project coordinator and group facilitator.

**Postdoctoral Fellowship**, Cecil G Sheps Center, University of North Carolina  
Chapel Hill, NC

2003- 2005

**Research Assistant**, Mental Illness and Research Education and Clinical Center  
(MIRECC), Veteran's Administration, Baltimore, MD

2002 - 2003

**Intensive Case Manager**, CREOKS Mental Health Services, Oklahoma State Certified  
Case Manager for Creek County. Sapulpa, OK

1995 - 1997

## Clinical Experience

Postdoctoral Fellowship, Department of Psychiatry, 2003 –2005  
STEP Clinic, University of North Carolina, Chapel Hill, NC

- Provided manualized individual and therapy for adults with serious mental illness using Illness Management and Recovery and Graduated Recovery Intervention Program.

Clinical Psychology Intern, Serious Mental Illness Track 2002 - 2003  
University of Maryland School of Medicine,  
Baltimore, MD (APA approved program)

- Provided individual therapy and case management in an urban community Baltimore, MD (APA approved program)
- Provided individual therapy and case management in an urban community mental health center. Taught psychoeducational groups and social skills training groups. Participated in specialty rotations including sex offender's treatment clinic and mental health and substance abuse treatment program for federal pretrial and probation.

Practicum, LaRue Carter Hospital, 2000 - 2001  
Indianapolis, IN

- Adolescent Inpatient Unit. Therapist for adolescents on an inpatient unit with developmental disabilities, learning disabilities, medical disorders, and behavioral problems.

Practicum, Indiana Women's Prison, 2000  
Indianapolis, IN

- Special Needs Unit and Indiana Women's Intake Unit. Provided group therapy on the Special Needs Unit. Conducted psychological evaluations including tests of intelligence, personality, and neuropsychology.

Practicum, Counseling and Psychological Services, IUPUI 2000  
Indianapolis, IN

- University counseling center. Provided individual and couples counseling including cognitive-behavioral therapy for persons aged 18 to 45.

Practicum, Veterans Administration, 1998 - 1999  
Indianapolis, IN

- Provided group and individual psychotherapy for individuals with psychiatric disabilities. Population was primarily those with serious mental illness. Assisted in research projects.

Practicum, Veterans Administration, NIMH Research Project,  
Indianapolis, IN

1998

- Conduct assessment interviews for elderly depressed women, including SCID, CES-D, Mini Mental Status, Coping, and Network Transactions.

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## Teaching and Training Experience

|  |                |
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| <u>Instructor</u> , University of Haifa, Israel, Social Cognition and Interaction Training (SCIT) and Positive Psychotherapy for people with schizophrenia.  | September 2011 |
| <u>Consultation and Training</u> , State of Missouri, Illness Management and Recovery for an inpatient forensic unit.  | 2011 - 2013    |
| <u>Consultation and Training</u> , University of Medicine and Dentistry of New Jersey, for the state of New Jersey, Illness Management and Recovery, Supervisor's training for IMR, CBT strategies for IMR | 2007 – 2013    |
| <u>Consultation and Training</u> , Minnesota Department of Human Services, Illness Management and Recovery, Supervisor's training for IMR, CBT strategies For IMR, IMR Clinical Competency Scales          | 2006 – 2013    |
| <u>Consultation and Training</u> , North Carolina Evidence-Based Practice Center, Wellness Management and Recovery   | 2004 – 2007    |
| <u>Recitation Instructor</u> , Introductory Psychology, IUPUI, Indianapolis, IN  | 2002 - 2002    |

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## Awards

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|---|------------|
| <b>Clinical Rehabilitation Psychology Outstanding Master's Student Award</b><br>IUPUI, Indianapolis, IN | 1999       |
| <b>Rehabilitation Services Administration Fellowship</b><br>IUPUI, Indianapolis, IN                     | 1997 -1998 |
| <b>Outstanding Service Award</b><br>CREOKS Mental Health, Sapulpa, OK                                   | 1996       |

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## Professional Organizations



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## Publications

- Baumel, A., Correll, C.U., Hauser, M., Brunette, M.F., Rotondi, A., Ben-Zeev, D., Gottlieb, J.D., Mueser, K.T., Achtyes, E.D., Schooler, N.R., Robinson, D.G., Gingerich, S., Marcy, P., **Meyer, P.S.**, Kane, J.M. (2016). Health Technology Intervention After Hospitalization for Schizophrenia: Service Utilization and User Satisfaction. *Psychiatric Services*, 67(9), 1035-1038.
- Browne, J., Edwards, A. N., Penn, D. L., **Meyer-Kalos, P. S.**, Gottlieb, J. D., Julian, P., & Kane, J. M. (2016). Factor structure of therapist fidelity to individual resiliency training in the Recovery After an Initial Schizophrenia Episode Early Treatment Program. *Early Intervention in Psychiatry*.
- Brunette, M., Rotondi, A.J., Ben-Zeev, D., Gottlieb, J.D., Mueser, K.T., Robinson, D.G., Achtyes, E.D.,Gingerich, S., Marcy,P., Schooler, N.R., **Meyer, P.S.**, Kane, J.M. (2016). Coordinated Technology-Delivered Treatment to Prevent Rehospitalization in Schizophrenia: A Novel Model of Care. *Psychiatric services*, 67(4), 444-447.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., **Meyer-Kalos, P. S.**, Gottlieb, J. D., Glynn, S. M., Lynde, D.W., Pipes, R., Kurian, B. T., Miller, A. L., Azrin, S. T., Goldstein, A. B., Severe, J., Lin, H., Kyaw, J., Majnu, J., Heinssen, R. K. (2016). Comprehensive versus usual care for first episode psychosis: Two-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173(4), 362-372.
- Meyer, P. S.**, Gottlieb, J. D., Penn, D., Mueser, K. T., & Gingerich, S. (2015). Individual resiliency training (IRT): An early intervention approach to enhance well-being in persons with first episode psychosis. *Psychiatric Annals*, 45(11), 554-560.
- Meyer-Kalos, P. S.**, Lee, M. G., Studer, L. M., Line, T. A., & Fisher, C. M. (2016). Opportunities for Integrating Physical Health Within Assertive Community Treatment Teams: Results from Practitioner Focus Groups. *Community Mental Health Journal*.
- Mueser, K.T., Penn, D.L., Addington, J., Brunette, M.F., Gingerich, S., Glynn, S.M., Lynde, D.W., Gottlieb, J.D., **Meyer-Kalos, P.S.**, McGurk, S.R., Cather, C., Saade, S., Robinson, D. G., Schooler, N.R., Rosenheck, R.A., & Kane, J.M. (2015). The NAVIGATE program for first episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services*, 66(7), 680-690.
- Krentzman, A.R., Hassett, A.L., Mannella, K.A., Barnett, N., Cranford, J.A., Brower, K.J., Higgins, M.M., & **Meyer, P.S.** (2015). Feasibility, Acceptability, and Impact of a Web-based Gratitude Exercise among Individuals in Outpatient Treatment for Alcohol Use Disorders. *The Journal of*

Positive Psychology, 10(6), 477-488. Doi: 10.1080/17439760.2015.1015158

- Parks, A., Kleiman, E. M., Kashdan, T. B., Hausmann, L. R. M., **Meyer, P. S.**, Day, A. M., Spillane, N.S., & Kahler, C. W. (2014). Positive Psychotherapeutic and Behavioral Interventions. In Jeste and Palmer, (eds.) *Positive Psychiatry, A Clinical Handbook*. American Psychiatric Press.
- Romeo, K. H., **Meyer, P. S.**, Johnson, D., & Penn, D. L. (2014). An investigation of the relationship between therapist characteristics and alliance in group therapy for individuals with treatment-resistant auditory hallucinations. *Journal of Mental Health*, 23(4), 166-170
- Buck, B., Ludwig, K., **Meyer, P. S.**, Penn, D. (2014). The use of narrative sampling in the assessment of social cognition: The Narrative of Emotions Task (NET). *Psychiatry Research*, 217(3), 233-239.
- Meyer, P. S.**, Johnson, D., Parks, A., Iwanski, C., Penn, D. (2012). Positive living: pilot study of group positive psychotherapy for people with schizophrenia. *Journal of Positive Psychology*, 7(3), 239-248.
- Johnson, D.J., Penn, D.L., Fredrickson, B., Kring, A., **Meyer, P.**, Brantley, M. (2011). Loving-kindness meditation for schizophrenia. *Schizophrenia Research*, 129(2/3), 137-140.
- Meyer, P. S.** & Mueser, K. T. (2011). Resiliency in persons with severe mental illness. In Southwick, Litz, Charney, Friedman, (eds.) *Resilience and Mental Health: Responding to challenges across the lifespan*. Cambridge University Press.
- Garland, E. L., Fredrickson, B., Kring, A. M., Johnson, D. J., **Meyer, P. S.**, Penn, D. L. (2010). Upward spirals of positive emotions counter downward spirals of negativity: Insights from the broaden-and-build theory and affective neuroscience on the treatment of emotion dysfunctions and deficits in psychopathology. *Clinical Psychology Review*, 30(7), 849-864.
- Meyer, P. S.**, Mueser, K. T., Gingerich, S. (2010). A guide for the implementation and clinical practice of Illness Management and Recovery for people with schizophrenia. In Rubin, A. and Springer, D. (eds.) *Psychosocial treatment for schizophrenia*. John Wiley & Sons.
- Penn, D. L., Keefe, R. S., Davis, S. M., **Meyer, P. S.**, Perkins, D. O., Losardo, D., Lieberman, J. A., (2009). The effects of antipsychotic medications on emotion perception in patients with chronic schizophrenia in the CATIE trial. *Schizophrenia Research*, 115 (1), 17-23.
- Penn, D. L., **Meyer, P. S.**, Evans, E., Cai, K., Wirth, R. J., Burchinal, M. (2009). A randomized controlled trial of group cognitive behavior therapy versus enhanced supportive therapy for auditory hallucinations. *Schizophrenia Research*, 109 (1-3), 52-59.
- Johnson, D.J., Penn, D.L., Fredrickson, B., Kring, A., **Meyer, P.**, Brantley, M. (2009). Loving-kindness meditation to enhance the psychological recovery of individuals with persistent negative symptoms of schizophrenia: A case study. *Journal of Clinical Psychology*, 65(5), 499-509.
- Johnson, D. P., Penn, D. L., Bauer, D. J., **Meyer, P.**, Evans, E. (2008). Predictors of the therapeutic alliance in group therapy for individuals with treatment-resistant auditory hallucinations. *British Journal of Clinical Psychology* 47(2), 171-183.

- Morrissey, J. P., **Meyer, P. S.**, Cuddeback, G. (2007). Extending ACT to criminal justice settings: Origins, evidence, and future directions. Community Mental Health Journal 43(5), 527-544.
- Meyer, P.S.** & Morrissey, J. P. (2007). Assertive community treatment, intensive case management, and the paradox of rural mental health services. Psychiatric Services 58(1), 121-127.
- Cuddeback, G., Morrissey, J. P., **Meyer, P. S.** (2006). How many assertive community treatment teams do we need? Psychiatric Services 57(12), 1803-1806.
- Mueser, K. T., **Meyer, P. S.**, Penn, D. L., Clancy, R., Clancy, D. M., Salyers, M. P. (2006). The Illness Management and Recovery program: Rationale, development, and preliminary findings. Schizophrenia Bulletin, 32, S32-S43.
- Evans, J. D., Bond, G. R., **Meyer, P. S.**, Kim, H. W., Lysaker, P. H., Gibson, P. J., Tunis, S. (2004). Cognitive and clinical predictors of success in vocational rehabilitation in schizophrenia. Schizophrenia Research, 70(2-3), 331-342.
- Bond, G. R., Kim, H. W., **Meyer, P. S.**, Gibson, P. J., Tunis, S., Evans, J. D., Lysaker, P. (2004) Response to vocational rehabilitation during treatment with first- or second-generation antipsychotics. Psychiatric Services, 55(1), 59-66.
- Bond, G. R., Kim, H. W., **Meyer, P. S.**, Gibson, P. J., Tunis, S., Evans, J. D., Lysaker, P., McCoy, M. L., Dincin, J., Xie, H. (2004). Response to Vocational Rehabilitation During Treatment with First- or Second-Generation Antipsychotics. Psychiatric Services, 55, 59-66.
- Salyers, M. P., Evans, L. J., Bond, G. R., **Meyer, P. S.** (2004). Barriers to assessment and treatment of posttraumatic stress disorder and other trauma-related problems in people with severe mental illness: Clinician perspectives. Community Mental Health Journal, 40, 17-31.
- Meyer, P. S.**, Bond, G. R., Tunis, S. L., McCoy, M. L. (2002). Comparison between atypical and traditional antipsychotics in work status for clients in a psychiatric rehabilitation program. Journal of Clinical Psychiatry, 63, 108-116.
- Lysaker, P.H., **Meyer, P.S.**, Evans, J.E., Clements, C.A. & Marks, K.A. (2001) Psychosocial correlates of childhood sexual trauma in schizophrenia. Psychiatric Services, 52, 1485- 1488.
- Lysaker, P.H., **Meyer, P.S.**, Evans, J.E., & Marks, K.A. (2001). Neurocognitive correlates of self - reported sexual abuse in schizophrenia spectrum disorders. Annals of Clinical Psychiatry, 13, 89-92.
- Bond, G.R. & **Meyer, P. S.** (1999). The role of medications in the employment of people with schizophrenia. Journal of Rehabilitation, 65(4), 9-16.

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## Presentations

- Meyer, P. S.** (May 2015). The Minnesota approach to integrated care: Integrated illness management and recovery on ACT teams. Symposium at American Psychiatric Association.
- Meyer, P. S.** (May 2015). The implementation of individual resiliency training (IRT). Symposium at American Psychiatric Association.
- Meyer, P. S.** (May 2015). Positive psychotherapeutic and behavioral interventions. Symposium at American Psychiatric Association.
- Meyer, P.S.,** (July 2011). Positive Living: A pilot study of group positive psychotherapy for people with schizophrenia. Symposium at Second World Congress on Positive Psychology.
- Meyer, P.S.,** Johnson, D., Penn, D. L. (November 2009). Positive living: An adaptation of group positive psychotherapy for people with psychotic disorders. Symposium at the Association for Behavioral and Cognitive Therapies.
- Meyer, P.S.,** Penn, D.L., Roberts, D., Koren, D. (November 2008). The relationship between metacognition, social cognition, and social functioning in schizophrenia. Poster presentation at the Association for Behavioral and Cognitive Therapies.
- Johnson, D., Penn, D., **Meyer, P.,** Fredrickson, B., Kring, A., Brantley, M. (November 2008). Loving kindness group meditation for the negative symptoms of schizophrenia. Poster presentation at the Association for Behavioral and Cognitive Therapies.
- Meyer, P.S.,** Penn, D.L., Evans, E., Cai, K., Burchinal, M. (November 2007) A randomized controlled trial of group CBT and supportive therapy for auditory hallucinations. Poster presentation at the Association for Behavioral and Cognitive Therapies.
- Meyer, P.S.,** Penn, D., Mueser, K., Waldheter, E. (April 2005). A pilot study of *Illness Behavioral and Cognitive Therapies.*
- Meyer, P.S.,** Penn, D., Mueser, K., Waldheter, E. (April 2005). A pilot study of illness management and recovery for persons with psychotic disorders. Poster presentation at the International Congress on Schizophrenia Research.
- Meyer, P.S. & Morrissey, J. P.** (June 2004). Overlooked Obstacles in Disseminating Assertive Community Treatment in Rural Settings. Poster presentation at the NIMH Trainees Research Conference.
- Meyer, P.S.,** Gearon, J., Bellack, A., & Brown, C. (March 2003). The Relationship Between Traumatic Life Events and Posttraumatic Stress Disorder in Substance Abusing Women with Schizophrenia. Poster presentation at the International Congress on Schizophrenia Research.
- Bond, G.R., **Meyer, P.S.,** Kim, H., Marks, K. & Tunis, S.L. (February 2001). The promise of new antipsychotics and psychiatric rehabilitation for improving work outcomes: Why haven't state mental health systems embraced best practices? Oral presentation at the NASMHPD Eleventh Annual Conference on State Mental Health Agency Services Research, Program Evaluation.

Kim, H.W., Tunis, S.L., Bond, G.R., Marks, K.A., & Meyer, P.S. (2001). Psychiatric Symptoms & Adverse Events Commonly Reported During Antipsychotic Treatment for Individuals with Schizophrenia Participating in Psychiatric Rehabilitation Programs. Poster presentation at the Annual Convention of the American Psychiatric Association.

Lysaker, P.H., Evans, J.D., Kim, H.W., Marks, K.A., Meyer, P.S., Tunis, S.L., & Bond, G.R. (2001). Symptoms and work performance in schizophrenia. Poster presentation at the International Congress of Schizophrenia.

Meyer, P. S., Kim, H. W., Bond, G. R., Tunis, S., McCoy, M., & Dincin, J. (October, 2000). Impact of Antipsychotic Medications on Vocational Outcomes for Persons with Schizophrenia. Oral presentation at the MRI/UPENN Rehabilitation and Research Training Center 4<sup>th</sup> Biennial Research Seminar on Work.

Meyer, P., Bond, G. R., Herbeck, D., McCoy, T., and Rowan, D. (May 1999). The promise of newer antipsychotics: Implications for social and vocational outcomes. Workshop presented at International Association of Psychosocial Rehabilitation Services. Minneapolis, MN.

Meyer, P. S., Bond, G. R., McCoy, T., Herbeck, D., Rowan, D., and Tunis, S. (April, 1999). The influence of atypical antipsychotics on work outcomes. Poster presented at the International Congress on Schizophrenia Research, Santa Fe, NM.

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### Unpublished Manuscripts

Meyer, P. S. and Morrissey, J. P. (2004). Assertive community treatment in North Carolina: Implementation status and training needs. Report submitted to North Carolina Science to Service, Research Triangle Park, NC.

Bond, G., Meyer, P., Rollins, A., McCoy, M., Herbeck, D., and Rowan, D. (1998). The impact of atypical antipsychotics on vocational outcomes in a psychiatric rehabilitation agency. Reported submitted to Eli Lilly, Indianapolis, IN.

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### References Available upon Request

David W. Lynde, MSW, LICSW  
Mental Health Services Consultant & Trainer

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**Education**

- Boston University, Masters in Social Work, 1992
  - University of New Hampshire, B.A. in Social Work, 1982
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**Employment**

David W Lynde Independent Consultant and Trainer Implementing Evidence Based Mental Health Practices, 2004 - Present

- Consultant and Trainer to NH Bureau of Mental Health Services for Dartmouth Hitchcock Medical Center regarding implementation and sustaining of Mental Health Evidence Based Practices (Supported Employment, Assertive Community Treatment, and Illness Management & Recovery)
- Deputy Project Director for Dissemination for the National Registry for Evidence-based Practices and Programs (NREPP) for the Substance Abuse and Mental Health Services Administration (SAMHSA) (Developmental Services Group, Inc.)
- Developer, Trainer and Consultant regarding NIMH RAISE project for Supported Employment and Supported Education for national first episode psychosis project
- Expert consultant to United States Department of Justice regarding Supported Employment implementation for State of Georgia Olmstead Settlement Agreement
- Consultant to Marc Gould Associates regarding the development and implementation of the Pathways to Careers employment model for people with mental illness
- Expert consultant to Arizona Department of Health Services vis-à-vis National Association of State Mental Health Program Directors regarding implementation of four EBPs
- Co-Director, Atlas Research & Easter Seals National Training Program for National Veterans Administration "Homeless Veteran Supported Employment Program"
- Consultant and Trainer for Department of Veterans Affairs regarding national implementation of Supported Employment in Compensated Work Therapy program
- Evidence Based Practices implementation consultation and technical assistance to multiple state, county, municipal and national mental health systems regarding implementation of Evidence Based Mental Health Practices

Dartmouth Psychiatric Research Center, 2000-2013

- Co-Director, Dartmouth Evidence Based Practices (EBP) Center for Implementing Evidence-Based Mental Health Practices
- Consultant and Trainer regarding Organizational Change and Implementation of Evidence-Based Practices for State, County and Municipal Mental Health Systems
- Developer, Technical Assistant and Consultant regarding five Evidence Based Practices "toolkits" and implementation process for National Implementing Evidence Based Practices Project from SAMHSA

- Co-developer of the State Health Authority Yardstick (SHAY) to measure and guide State and System level implementation actions for evidence-based mental health services.
- National Core Staff, Johnson & Johnson – Dartmouth Community Mental Health Program for multi-state implementation of Supported Employment Services
- Director of Consultation and Training services regarding implementation of EBPs for all Community Mental Health Centers in New Hampshire and NH Bureau of Behavioral Health
- 2005-2008 Information technology workgroup leader and leadership committee member, Governor's Commission on the transformation of services for mental illness in New Hampshire
- Co-Chair and Quality Workgroup Leader for New Hampshire Governor's Commission on the transformation of mental health services

University of New Hampshire, Durham, NH

- Adjunct Faculty, Social Work Department, 1994-2005
- University of New Hampshire Social Work Department Advisory Board, 1992-2010

Boston University School of Social Work

- Adjunct Faculty, Graduate Social Work Program 2004-2005

Center for Life Management, Community Mental Health Center, Salem, New Hampshire

- Director of Community Support Programs, 1997-2000
- Director of Clinical Services, Community Support Programs, 1995-1997
- State Psychiatric Hospital Liaison 1990-1995
- Director of Outpatient Support Services, 1993-1995
- Clinician, Community Support Services, 1990-1993
- Case Manager, Community Support Services, 1987-1990
- Residential Manager, Adolescent Treatment Facility, 1985-1987

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**Professional Licensure**

- Licensed Independent Clinical Social Worker, State of New Hampshire, 1994-Present (current status inactive)

**CONTRACTOR NAME**

Key Personnel

| Name                   | Job Title  | Salary               | % Paid from this Contract      | Amount Paid from this Contract |
|------------------------|--|----------------------|--------------------------------|--------------------------------|
| Alan I. Green, MD      | Executive Director, Dartmouth First Episode Center of Excellence | N/A                  | 0%                             | \$ -                           |
| Susan Gingerich, MSW   | Director and Family Clinician Trainer-Consultant                 | N/A                  | 100%                           | \$37,394.00                    |
| Delbert Robinson, MD   | Prescriber Trainer and Consultant                                | N/A                  | 100%                           | \$35,800.00                    |
| Piper Meyer-Kalos, PhD | Individual Resiliency Trainer (IRT) and Consultant               | N/A                  | 100%                           | \$41,696.00                    |
| David Lynde, MSW       | Supported Employment and Education Trainer (SEE) and Consultant  | N/A                  | 100%                           | \$23,204.00                    |
|                        |  |                      | <b>Consultant Subtotal</b>     | <b>\$138,094.00</b>            |
| TBD                    | Program Coordinator/Admin. Support                               | \$25.00/hr. + fringe | 100%                           | \$2,193.75                     |
|                        |  |                      | <b>Admin. Support Subtotal</b> | <b>\$2,193.75</b>              |
|                        |  |                      | <b>Indirects Subtotal</b>      | <b>\$41,104.31</b>             |
|                        |  |                      | <b>GRAND TOTAL</b>             | <b>\$181,392.06</b>            |