9 mac

Kerrin A. Rounds
Acting Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

January 31, 2020

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 Medicaid Services, to enter into a **sole source** agreement with Elliot Health System (Vendor #174360), One Elliot Way, Manchester, NH, 03103, to develop and implement the Maternal Opioid Misuse (MOM) Model, in an amount not to exceed $619,086, effective upon Governor and Executive Council approval, through December 31, 2024. 100% Federal Funds.

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

05-95-47-470010-1371 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFF. OF MEDICAID & BUS. POLICY, MATERNAL OPIOID MISUSE MODEL

State Fiscal Year	Class/Account	Class Title	Job Number	Amount
2020	102/500731	Contracts for Program Services	47000063	$309,543
2021	102/500731	Contracts for Program Services	47000063	$309,543
			Total	**$619,086**

EXPLANATION

This request is **sole source** because the Department in consultation with the greater Manchester provider community believes that Elliot Health System (Elliot) is the optimal community care partner to assist the Department in developing and testing a new Maternal Opioid Misuse (MOM) Model. The MOM Model is designed to increase access to health care and social services for pregnant and post-partum women with Opioid Use Disorder (OUD) and their infants. Elliot manages most of the Neonatal Intensive Care Unit stays related to neonatal abstinence syndrome in the greater Manchester area and has an expansive health delivery network within the region. The MOM Model is funded by a grant through the Innovations Center at the Centers for Medicare and Medicaid Services (CMS).

Last year, CMS posted two (2), five (5) year grant opportunities related to at-risk populations. The MOM Model noted above addresses pregnant and post-partum women with OUD and their infants. The Integrated Care for Kids (InCK) Model focused on physical and mental health integration for children. CMS required a State to be the applicant when competing for both grants simultaneously. The providers in the greater Manchester community were interested in both grants and approached the Department to apply. The Department applied for both grants, however only the MOM Model grant funding was awarded.

The Manchester provider community was concerned the impact of the opioid situation was reaching a point in calendar year 2019 where the community was close to capacity in being able to effectively treat individuals with OUD, and there was particular concern around pregnant and post-partum mothers and their infants born exposed to substance use. Only sixty-two percent (62%) of all pregnant women in Manchester seek prenatal care during their first trimester. Women who misuse opioids during pregnancy place themselves and their infants at greater risk of health complications

As part of the MOM Model grant application process, CMS required states to name a community care partner with significant experience providing health care services to pregnant and perinatal women with OUD and their infants, and that can provide an expansive health delivery network within the selected community. As noted previously, in consultation with the provider community in Greater Manchester, the Department selected Elliot as the care partner for the MOM Model. The Department worked collaboratively with Elliot and other community-based partners in Manchester to prepare and submit a competitive application for grant funding that CMS awarded to the Department.

The purpose of this request is for the Department to work in partnership with Elliot to provide a Care Delivery System to develop and implement the CMS MOM Model. The MOM Model requires one (1) year of intensive community planning to prepare for the implementation of strategies to test whether Medicaid payments that support evidence-based coordinated care delivery for pregnant and postpartum women with OUD and their infants can improve quality of care and reduce costs.

Approximately 250 to 300 women will be served annually, beginning in State Fiscal Year 2021, in the Greater Manchester Area.

CMS, through the five (5) year grant award, intends to support the MOM Model for five (5) years. The scope of this request is for pre-implementation planning and design in Year One (1) of the MOM Model. During the initial period, the Department and Elliot will engage in community planning to address structural barriers and expand infrastructure to support better-coordinated care.

The Department intends to amend this agreement in subsequent grant years (i.e., years two (2) through five (5) of the contract period), upon receipt and acceptance of additional federal funds and as the project transitions to implementation of direct services. Future activities that will improve quality of care for the mother-infant dyad include wraparound care coordination, engagement for hard to reach participants and referral activities.

The Contractor, with its community partners, will engage in community planning to meet the needs of all Medicaid-eligible women with OUD in the Greater Manchester Community who are pregnant, may become pregnant and/or are postpartum, and their infants through the MOM Model. The final number of individuals to be served in the Implementation period of the MOM Model will be determined within Year One (1) of pre-implementation. However, in the months of July through December 2018, nearly six percent (6%) of births in the Greater Manchester region had documentation of either opioid exposure or monitoring for withdrawal or neonatal abstinence syndrome. The rate during this same time across the rest of New Hampshire was four and a half percent (4.5%). Almost thirty percent (30%) of New Hampshire births with exposure or concern of opioids occurred at hospitals within Manchester.

The Contractor will provide leadership and administrative support, as a Care Delivery Partner, to providers in the Greater Manchester area to create a system of care for pregnant and postpartum women with OUD and their infants. The MOM Model will test whether payments that support evidence-based, coordinated care delivery for pregnant and postpartum women with OUD and their infants can reduce

costs to Medicaid. New Hampshire estimates modest savings during the contract period, but estimates that there will be additional savings beyond the five (5) year contract period. By avoiding neonatal abstinence syndrome and other health complications, the Department expects large health and behavioral health savings over the life course of substance exposed infants. Savings may be substantial over eighteen (18) years of potential Medicaid enrollment.

The Department will monitor the effectiveness of the Contractor and the delivery of services under this agreement using the following measures and milestones:

- Contract Year One (1), Pre-Implementation Program Planning and Design, performance measures will be determined by the Department, based on federal technical assistance and requirements, and will be added to the agreement through a contract amendment as approved by the Governor and Executive Council. The Contractor will also assist the Department in completing documentation and meeting milestones regarding:
    - Care-delivery partners
    - Staffing and Clinical Delivery Site Information
    - Plan for potential CMS State Plan Amendments or Waivers
    - Final MOM Model Implementation Plan
- Contract Years Two (2) through Five (5), MOM Model Program Implementation, performance-based measures will be determined by the Department, based on federal technical assistance and requirements, and will be added to the agreement through a contract amendment as approved by the Governor and Executive Council, that may include:
    - Continuity of pharmacotherapy at delivery
    - Gains in Patient Activation Measure® (PAM) scores
    - Health-related social needs screening
    - Maternal engagement in OUD treatment
    - Postpartum care and family planning
    - Beneficiary screening for clinical depression and follow-up plan
    - Tobacco use screening and cessation intervention

Should the Governor and Executive Council not authorize this request, the Department would be unable to implement the MOM Model to improve the quality of care and improve health outcomes for pregnant and post-partum women with OUD and their infants, by avoiding neonatal abstinence syndrome and other complications. The Department expects significant savings over the life course of children affected by substance exposure. Savings may be substantial over eighteen (18) years of potential Medicaid enrollment. In addition, failure to implement the MOM Model will jeopardize federal grant funding awarded for this purpose.

Area served: Greater Manchester Area

Source of Funds: 100% Federal Funds from the Centers for Medicare and Medicaid Services, Maternal Opioid Misuse Model, Catalog of Federal Domestic Assistance (CFDA) #93.687, Federal Award Identification Number (FAIN) 2A2CMS331772.

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

Respectfully submitted,

Kerrin A. Rounds
Acting Commissioner

Subject: Maternal Opioid Misuse Model (SS-2020-DMS-01-MATER-01)

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Elliot Health System		1.4 Contractor Address One Elliot Way Manchester, NH 03103	
1.5 Contractor Phone Number 603-663-8905	1.6 Account Number 010-047-470010-13710000-102-500731	1.7 Completion Date December 31, 2024	1.8 Price Limitation $619,086
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number 603-271-9631	
1.11 Contractor Signature		1.12 Name and Title of Contractor Signatory W. Gregory Baxter, MD President	

1.13 Acknowledgement: State of NH, County of Hillsborough

On 1/24/2020, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal]

CAROL J. FURLONG
Justice of the Peace - New Hampshire
My Commission Expires March 23, 2021

1.13.2 Name and Title of Notary or Justice of the Peace

1.14 State Agency Signature Date: 1/28/20	1.15 Name and Title of State Agency Signatory Henry D. Lipman, Medicaid Director

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

By: Director, On:

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

By: CATHERINE PINOS, Attorney On: 1/31/20

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

By: On:

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

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

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

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

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

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

Contractor Initials _____
Date 1.24.20

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

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

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

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

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

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

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

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

Contractor Initials
Date 1-24-20

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

15. WORKERS' COMPENSATION.

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

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

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

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

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

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

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

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

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

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

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

Contractor Initials 

Date 1-24-20

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. For the purposes of this Agreement, the Department has identified the Contractor as a Subrecipient in accordance with 2 CFR 200.300.

1.4. The funding amount in Form P-37, Block 1.8, Price Limitation of this Agreement is allocated to Contract Year One (1) Scope of Work: Pre-Implementation Program Planning and Design, pursuant to Exhibit A, Scope of Services; Section 2.

1.5. Additional program services to be provided by the Contractor, as well as additional funding for Contract Years Two (2) through Five (5) shall be determined by the Department and will be added to this Agreement through contract amendments as approved by the Governor and Executive Council.

1.6. The Contractor shall work in collaboration with the Department as a Care Delivery partner to develop and implement the Maternal Opioid Misuse (MOM) Model to provide the opportunity for planning and implementation of strategies to test whether payments that support evidence-based, coordinated care delivery for pregnant and postpartum women with Opioid Use Disorder (OUD) and their infants, can improve quality of care and reduce Medicaid and Children's Health Insurance Program (CHIP) expenditures.

1.7. The Contractor, its staff, agents, providers, physicians and personnel; at all times; shall retain the right to exercise independent clinical judgment and to act in the best interest of patients seeking care under the MOM Model.

2. Contract Year One (1) Scope of Work: Pre-Implementation Planning and Design

2.1. The Contractor shall provide leadership and administrative support, as a Care Delivery Partner, to providers in the Greater Manchester area to create a system of care for pregnant and postpartum women with OUD and their infants.

2.2. The Contractor shall establish a Community-Based Advisory Executive Committee, in partnership with the Department, to ensure the ongoing planning and implementation efforts for a person-centered model, including development of workflows and standard approaches to care coordination.

2.3. The Contractor must provide an all-inclusive listing of its subcontracts with participating community-based partners to the Department in Year One (1) of the contract period, which must include:

2.3.1. Name(s) of Subcontractor(s);

2.3.2. Method of Selection; and

2.3.3. Period of Performance.

2.4. The Contractor shall work collaboratively with its community-based partners and the Department to plan for and implement evidence-based as well as best and promising practice models for the care of perinatal women, similar to models that include, but are not limited to:

2.4.1. The Children and Recovering Mothers (CHARM) Collaborative of Burlington, Vermont.

2.4.2. Horizons of North Carolina.

2.4.3. Project Nurture of Oregon.

2.5. The Contractor shall collaborate with participating community-based partners to plan for clinical and support services for perinatal women with OUD.

2.6. The Contractor shall, in partnership with the Department, implement the Comprehensive Core Standardized Assessment (CCSA) community-wide for perinatal women with OUD.

2.7. The Contractor shall utilize the CCSA to develop individualized care plans to be utilized by care teams to guide treatment and care management of pregnant and postpartum women and their infants, ensuring assessment domains include, but are not limited to:

2.7.1. Demographics.

2.7.2. Medical.

2.7.3. Substance use.

2.7.4. Housing.

2.7.5. Family and support services.

2.7.6. Education.

2.7.7. Employment and access to public assistance services including, but not limited to cash assistance.

2.7.8. Legal.

2.7.9. Risk assessment including suicide risk.

2.7.10. Functional status including activities of daily living, instrumental activities of daily living and cognitive functioning.

2.8. The Contractor shall build, adapt, develop or determine Health Information Technology (HIT) or other feasible data infrastructure to support data collection, data linkages and information sharing among community partners, as required by the MOM Model.

2.9. The Contractor shall develop an Outreach Plan to conduct outreach to enrolled beneficiaries, and must submit the plan to the Department for approval. Enrolled beneficiaries may include, but are not limited to, individuals who:

2.9.1. Are disengaged from care.

2.9.2. Have not received a physical in a given calendar month.

2.9.3. Have not received behavioral healthcare service in a given calendar month.

2.10. The Contractor shall ensure a Community Health Worker or Recovery Coach is stationed centrally on site or within a participating community partner organization to implement the Department-approved Outreach Plan in 2.8 above. The Community Health Worker or Recovery Coach shall:

2.10.1. Work in the community to identify pregnant women with OUD.

2.10.2. Assist the identified women with engaging in treatment for both prenatal care and OUD.

2.10.3. Ensure identified women remain engaged with services throughout their pregnancy and into their postpartum period as well as engaged in care for their infants.

2.11. The Contractor and its staff shall participate in the CMS MOM Model learning system events and mandatory evaluation over the full duration of the contract period, which may include, but is not limited to:

2.11.1. Arranging site visits.

2.11.2. Observations.

2.11.3. Interviews and focus groups with providers and patients as well as program staff.

2.12. The Contractor shall ensure all participating community-based partners, their staffs, and all patients upon receiving patient content, participate in the CMS MOM Model learning system events and mandatory evaluation over the full duration of the contract period, which may include, but is not limited to:

2.12.1. Arranging site visits.

2.12.2. Observations.

2.12.3. Interviews and focus groups with providers and patients as well as program staff.

2.13. The Contractor shall provide timely responses, participation and cooperation to requests for data from the Department related to beneficiary contacts, in response to CMS program audits, for the duration of the contract period.

2.14. The Contractor shall, if needed, apply for Institutional Review Board (IRB) approval and obtain any other necessary permissions for evaluation activities, data collection, and data sharing and submission, as necessary.

2.15. The Contractor shall develop a report to reflect all disbursements of funds to community-based partners, as well as develop a schedule in collaboration with the Department of mutually agreed-upon intervals said reports shall be submitted to the Department.

2.16. The Contractor shall ensure staffing includes, but is not limited to:

2.16.1. A Program Director to perform duties that include, but are not limited to:

2.16.1.1. Develop and maintain partnerships with all participating community-based partner organizations.

2.16.1.2. Develop and coordinate a Community-Based Advisory Executive Committee.

2.16.1.3. Ensure all administrative tasks required under this Agreement are met.

2.16.2. A Project Analyst to assist with administrative functions required under this Agreement.

2.16.3. A Community Health Worker or Recovery Coach stationed centrally on site or within a participating community-based partner organization.

2.16.4. A Medication Assisted Treatment (MAT) Care Coordinator to engage and support patients receiving MAT, stationed on site or within a participating community-based partner organization.

3. Contract Years Two (2) through Five (5) Scope of Work: MOM Model Program Implementation

3.1. The Contractor shall coordinate meetings of the Community-Based Advisory Executive Committee, established in Year One (1) of the contract period, to ensure ongoing planning and implementation efforts for a person-centered model which includes, but are not limited to:

3.1.1. The development of workflows.

3.1.2. Standard approaches to care coordination.

3.2. The Contractor shall assist its participating community partners with implementing a community-based continuum of care for pregnant and postpartum women, and infants affected by substance use and OUD, ensuring the continuum of care includes, but is not limited to:

3.2.1. Enhanced case findings of pregnant women and women at risk of pregnancy with OUD.

3.2.2. Comprehensive and integrated perinatal and OUD care.

3.2.3. Effective data sharing and coordination of care with community-based supports.

3.2.4. Trauma informed social supports for pregnant women as well as postpartum women and their infants.

3.3. The Contractor shall enroll patients in the MOM Model beginning in Year Two (2) of the contract period, and shall continue enrolling patients in Years Three (3) through Five (5) of the contract period.

3.4. The Contractor shall implement the CCSA community-wide for perinatal women with OUD.

3.5. The Contractor shall utilize the CCSA process as the basis to develop individualized care plans.

3.6. The Contractor care teams shall utilize the individualized care plans to guide the treatment and management of the target population in 2.1.

3.7. The Contractor shall monitor its subcontracted participating community-based partners to ensure compliance with MOM model requirements.

3.8. The Contractor shall conduct outreach to enrolled beneficiaries who are disengaged from care, in accordance with the Department-approved Outreach Plan in 2.8 above, which may include but is not limited to beneficiaries who have not received a physical or behavioral healthcare service in a given calendar month.

3.9. The Contractor shall develop and submit reports reflecting any disbursement of funds to community-based providers to the Department at mutually agreed upon intervals.

3.10. The Contractor shall develop and submit quarterly and annual aggregate reports of MOM-Model enrolled beneficiaries to the Department, upon receipt of appropriate patient consent, applicable State and Federal laws and regulations and technological capabilities. The Contractor shall ensure aggregate data includes, but is not limited to:

3.10.1. Gains in Patient Activation Scores.

3.10.2. Health-related Social Needs Screening.

3.10.3. Postpartum follow up.

3.10.4. Initiation and engagement in OUD treatment; and continuity of pharmacotherapy at delivery.

3.11. The Contractor shall assist the Department with responding to the Center for Medicare & Medicaid Innovation (CMMI) findings for quality improvement purposes based on both Operational Milestones and Performance Milestones.

3.12. The Contractor shall cooperate with the Center for Medicare & Medicaid Services (CMS) subcontractor(s)' annual provider surveys and practice audits.

3.13. The Contractor shall provide additional MOM Model Program Implementation services in Years Two (2) through Five (5) of the contract period as determined by the parties and added to this Agreement through a contract amendment, as approved by Governor and Executive Council.

4. Data Sharing

4.1. The Contractor shall not collect, receive, store, or manage confidential data related to the scope of work and deliverables identified in this Exhibit A unless or until the parties have agreed in writing to a Data Sharing Plan that must include:

4.1.1. The purpose of the data exchange;

4.1.2. A description of the Department data elements to be disclosed, including:

4.1.2.1. Source or Systems of Records;

4.1.2.2. Number of Records Involved and Operational Time Factors;

4.1.2.3. Data Elements Involved; and

4.1.2.4. Reporting and Secure Transmission of Confidential Data.

4.1.3. A description of the Contractor data elements to be disclosed; and

4.1.4. The responsibilities of both parties regarding the exchange of data.

4.2. The Contractor shall execute the Data Sharing Plan in a timely manner so as not to impede the scope of work and deliverables identified in this Exhibit A.

4.3. The Contractor agrees to modify the Data Sharing Plan in writing as necessary, due to any changes to the scope of work and deliverables identified in this Exhibit A.

4.4. The Contractor shall comply with the terms of Exhibit K, DHHS Information Security Requirements, attached hereto and incorporated by reference herein.

5. Deliverables and Reporting

5.1. The Contractor shall submit a copy of its Substance Use Disorder (SUD) patient consent form, required for the sharing of all substance use information, to the Department within thirty (30) days of the contract effective date.

5.2. The Contractor shall develop, in collaboration with the Department, program implementation performance-based measures and benchmarks within sixty (60) days of the contract effective date.

5.3. The Contractor shall, in Year One (1) of the contract period, submit a proposed Outreach Plan to the Department for approval, in accordance with Subsection 2.9 above.

5.4. The Contractor shall, in Year One (1) of the contract period, submit an all-inclusive listing of its subcontracts with participating community-based partners to the Department, in accordance with Subsection 2.3 above, at an agreed-upon timeframe to be determined by the parties.

5.5. The Contractor shall, in Years One (1) through Five (5) of the contract period, submit monthly data reports of MOM Model enrolled beneficiaries, in accordance with Subsection 3.10 above, to the Department, no later than the last day of each month or the next business day if the last day of the month is on a weekend or holiday, and annually by the last day of the year, or the next business day if the last day of the year is on a weekend. The reports shall include but are not limited to:

5.5.1. Engaged beneficiaries.

5.5.2. Patients seen by care providers in the past month.

5.6. The Contractor shall, in Years One (1) through Five (5) of the contract period, submit reports reflecting all disbursements of funds to participating community-based partners to the Department, in accordance with Subsection 2.15.

5.7. The Contractor shall, in Years One (1) through Five (5) of the contract period, submit monthly data reports to the Department no later than the last day of each month, or the next business day if the last day of the month is on a weekend or holiday, that must include but is not limited to:

5.7.1. Budget status.

5.7.2. Operational Milestones.

5.8. The Contractor shall, in Years One (1) through Five (5) of the contract period, develop and submit additional reports, as determined and required by Department, relative to the MOM Model.

5.9. The Contractor shall, in Years Two (2) through Five (5) of the contract period, submit quarterly and annual aggregate data reports of MOM Model enrolled beneficiaries, in accordance with Subsection 3.10 above, to the Department no later than the last day of each quarter, or the next business day if the last day of the quarter is on a weekend or holiday; and annually by the last day of the year, or the next business day if the last day of the year is on a weekend.

5.10. The Contractor shall, in Years Two (2) through Five (5) of the contract period, submit monthly data reports to the Department by the last day of each month, or the next business day if the last day of the month is on a weekend or holiday, that must include, but is not limited to:

5.10.1. Care-delivery partner engagement.

5.10.2. Staffing.

5.10.3. Clinical delivery sites.

5.10.4. Budget status.

5.10.5. Operational Milestones.

6. Performance Measures

6.1. Contract Year One (1):

6.1.1. Pre-Implementation Program Planning and Design performance measures determined by the Department, based on federal technical assistance and requirements, shall be added to this agreement through a contract amendment as approved by the Governor and Executive Council.

6.2. Contract Years Two (2) through Five (5):

6.2.1. MOM Model Program Implementation performance-based measures determined by the Department, based on federal technical assistance and requirements, shall be added to this Agreement through a contract amendment as approved by the Governor and Executive Council. Performance measures and milestones may include, but are not limited to:

6.2.1.1. Continuity of pharmacotherapy at delivery.

6.2.1.2. Gains in Patient Activation Measure® (PAM) scores.

6.2.1.3. Health-related social needs screening.

6.2.1.4. Maternal engagement in OUD treatment.

6.2.1.5. Postpartum care and family planning.

6.2.1.6. Beneficiary screening for clinical depression and follow-up plan.

6.2.1.7. Tobacco use screening and cessation intervention.

Exhibit B

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Form P-37, Block 1.8, Price Limitation for the services provided pursuant to Exhibit A, Scope of Services.
2. This Agreement is funded with federal funds from the Centers for Medicare and Medicaid Services (CMS), Center for Medicare and Medicaid Innovation, Maternal Opioid Misuse Model, Catalog of Federal Domestic Assistance (CFDA) #93.687, Federal Award Identification Number (FAIN) 2A2CMS331772.
3. The Contractor agrees to provide the services in Exhibit A, Scope of Service, in compliance with funding requirements.
4. The Contractor agrees that additional funding for Years Two (2) through Five (5) of the contract period shall be determined by the Department, and is contingent upon the Department receiving Federal Notices of Award. Additional funds shall be added to this agreement through contract amendments requiring Governor and Executive Council approval.
5. The Contractor shall utilize a maximum of $66,361 of the total allocated funding in Year One (1) of the contract period to fund its participating community-based subcontractors, contingent upon the Department receiving notification of all community-based subcontractors, which must include:
   5.1. Name of Subcontractor(s);
   5.2. Method of Selection; and
   5.3. Period of Performance.
6. The funded Contractor's current and future funding is contingent upon the Contractor providing the services, and meetng all deliverabes, as specified in Exhibit A, Scope of Services.
7. Payment for said services shall be made as follows:
   7.1. Payment is contingent upon current and future funding by the Department, received through Federal Notices of Award.
   7.2. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this agreement, and shall be in accordance with the budget line items in Exhibit B-1, Budget and Exhibit B-2, Budget.
   7.3. The Contractor shall submit the first (1st) invoice no later than ninety (90) days after the contract effective date, in a form satisfactory to the State, which identifies budget line items, dates of service, description of services and associated costs. In addition, the Contractor shall attach supporting

documentation for each budget-line item costs incurred in the first ninety (90) days of the contract period.

7.4. Upon submission of the first (1st) invoice in 7.2, the Contractor shall submit monthly invoices in a form satisfactory to the State no later than the twentieth (20th) working day of each month, which identifies budget line items, dates of service, description of services and associated costs. In addition, the Contractor shall attach supporting documentation to each invoice for each budget-line item costs incurred in the prior month.

7.5. The Contractor shall ensure each invoice is completed, signed, dated and returned to the Department in order to initiate payment.

7.6. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to Department approval, and if sufficient funds are available.

7.7. The Contractor shall keep detailed records of their activities related to Department-funded programs and services and have records available for Department review, as requested.

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

8. Invoices must be mailed to:

Financial Administrator
Division of Medicaid Services
Department of Health and Human Services
129 Pleasant Street.
Concord, NH 03301

9. Payment may be withheld pending receipt of required reports or documentation as identified in Exhibit A, Scope of Services, and in this Exhibit B.

10. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

11. Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts between budget line items, related items, amendments of related budget exhibits within the price limitation, and to adjusting encumbrances between State Fiscal Years, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B-1, Budget

Maternal Opioid Misuse Model
Operating Budget

Period: Jan 1, 2020 to June 30, 2020 (State Fiscal Year 2020)

Line Item	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1. Total Salary/Wages (Clinic)	$ 52,854					$ 52,854
2. Employee Benefits	$ 14,799					$ 14,799
3. Project Administration & Collaboration						$ -
4. IT Infrastructure	$ 201,250					$ 201,250
EHR Build and Reporting	$ 131,500					$ 131,500
IT Hardware	$ 7,500					$ 7,500
IT Infrastructure	$ 2,250					$ 2,250
Data Sharing	$ 60,000					$ 60,000
5. Vouchers						$ -
Transportation						$ -
Child Care						$ -
6. Staff Education and Training						$ -
7. Travel	$ 2,500					$ 2,500
8. Occupancy	$ 10,000					$ 10,000
Sub Total	**$ 281,403**	$ -	$ -	$ -	$ -	**$ 281,403**
9. Contingency @ 10%	$ 28,140					$ 28,140
TOTAL	**$ 309,543**	$ -	$ -	$ -	$ -	$ 309,543

Exhibit B-1, Budget
Elliot Health System
SS-2020-DMS-01-MATER-01

Contractor Initials

Date 1.24.20

Exhibit B-2, Budget

Maternal Opioid Misuse Model
Operating Budget

Period: Jul 1, 2020 to Dec 31, 2020 (State Fiscal Year 2021)						
Line Item	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
1. Total Salary/Wages (Clinic)	$ 52,854					$ 52,854
2. Employee Benefits	$ 14,799					$ 14,799
3. Project Administration & Collaboration						$ -
4. IT Infrastructure	$ 201,250					$ 201,250
EHR Build and Reporting	$ 131,500					$ 131,500
IT Hardware	$ 7,500					$ 7,500
IT Infrastructure	$ 2,250					$ 2,250
Data Sharing	$ 60,000					$ 60,000
5. Vouchers						$ -
Transportation						$ -
Child Care						$ -
6. Staff Education and Training						$ -
7. Travel	$ 2,500					$ 2,500
8. Occupancy	$ 10,000					$ 10,000
Sub Total	**$ 281,403**	$ -	$ -	$ -	$ -	**$ 281,403**
9. Contingency @ 10%	$ 28,140					$ 28,140
TOTAL	**$ 309,543**	$ -	$ -	$ -	$ -	**$ 309,543**

Exhibit B-2, Budget
Elliot Health System
SS-2020-DMS-01-MATER-01

Contractor Initials 

Date 1.24.20

SPECIAL PROVISIONS

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

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

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

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

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

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

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

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

   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

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

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

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:

8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.

9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.

When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:

19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
19.3. Monitor the subcontractor's performance on an ongoing basis

Contractor Initials
Date 1.24.20

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

20. **Contract Definitions:**

20.1. 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.

20.2. DEPARTMENT: NH Department of Health and Human Services.

20.3. 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 and/or goods to be provided 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.

20.4. 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.

20.5. 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 time to time.

20.6. SUPPLANTING OTHER FEDERAL FUNDS: Funds provided to the Contractor under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO STANDARD CONTRACT LANGUAGE

1. **Revisions to Form P-37, General Provisions**

1.1. Section 4, 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, and the Contractor shall have the right to cease all work under the Agreement. The State shall notify the Contractor of such reduction, termination or modification. The State shall have the right to reduce, terminate or modify services under this Agreement. At no time will the Contractor be expected to perform any obligations under this Agreement that will not be reimbursed by funding made available to the State for this purpose. 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.

1.2. Section 10, Termination, is amended by adding the following language:

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

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

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

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

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

2. **Revisions to Standard Exhibits**

2.1. Exhibit I, HEALTH INSURANCE PORTABILITY ACT BUSINESS ASSOCIATE AGREEMENT, is not applicable. Should the State determine Exhibit I is applicable at any time, the Contractor agrees to execute Exhibit I for inclusion in this Agreement through a contract amendment as approved by the Governor and Executive Council.

Contractor Initials _____
Date 1.24.20

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

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

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

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

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

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

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

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

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

Vendor Name:

1-24-20
Date

Name: W. Gregory Baxter, MD
Title: President

Vendor Initials

Date 1-24-20

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Vendor Name:

1-24-20
Date

Name: W. Gregory Baxter, MD
Title: President

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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

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

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

Vendor Name:

1-24-20
Date

Name: W. Gregory Baxter MD
Title: President

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1-24-20
Date

Vendor Name:

Name: W. Gregory Baxter, MD
Title: President

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Vendor Name:

1-24-20
Date

Name: W. Gregory Baxter, MD
Title: President

HEALTH INSURANCE PORTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

Pursuant to Exhibit C-1 of this Agreement, Exhibit I is not applicable.

Remainder of page intentionally left blank.

Contractor Initials
Date 1.24.20

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:

1-24-20
Date

Name: W. Gregory Baxter, MD
Title: President

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: 073991085

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: _____

I. Definitions

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

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

2. "Computer Security Incident" shall have the same meaning as "Computer Security Incident" in Section 2.1 of NIST Publication 800-61 Rev. 2, Computer Security Incident Handling Guide.

3. "Confidential Information" or "Confidential Data" means all information owned, managed, created, received from, or on behalf of, the Department of Health and Human Services (DHHS) that is protected by information security, privacy or confidentiality rules and state and federal laws. This information includes but is not limited to Derivative Data, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), Social Security Administration, and Criminal Justice Information Services (CJIS) data.

4. "Derivative Data" means data or information based on or created from Confidential Data.

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

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

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

8. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information

Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted or Confidential Data.

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

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

11. "Virtual Private Network" (VPN) shall mean network technology that creates a secure private connection between the device and endpoint; hiding IP address and encrypting all data in motion.

II. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit DHHS Confidential Information except as required or permitted as outlined under this Contract and to carry out its obligations hereunder or as required by law.
2. The Contractor must not disclose any DHHS Confidential Information in connection with this Agreement in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure unless a subpoena requires such disclosure.
3. The Contractor agrees that DHHS Confidential Data or derivative therefrom disclosed to an End User must only be used pursuant to the terms of this Contract.
4. The Contractor agrees to provide to the authorized representative of the State of New Hampshire minimal necessary physical and logical process procedures, systems documents, and logs, specifically related to DHHS Confidential data, where possible, for the purpose of validating HIPAA/HITRUST/NIST controls to confirm compliance with the terms of this Contract.

III. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If Contractor is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cybersecurity and that said application's encryption capabilities ensure secure transmission via the internet. Contractor will encrypt DHHS confidential data, when practical, throughout the data lifecycle while within EHS's network when using, storing, transmitting, and sharing DHHS confidential data within the terms of

this agreement with any applicable End User.

2. Encrypted Email. Contractor may only employ email to transmit Confidential Data if email is protected using encryption protection and being sent to and being received by email addresses of persons authorized to receive such information.
3. Encrypted Website. If Contractor is employing the Web to transmit DHHS Confidential Data, the secure socket layers (SSL) must be used and the website must be secure (SSL encrypts data transmitted via a website).
4. File Hosting Services, also known as File Sharing Sites. Contractor may not use personal, unmanaged, and unprotected file hosting services, such as Dropbox or Google Cloud Storage, to transmit DHHS Confidential Data, without written exception from DHHS Information Security.
5. Ground Mail Service. Contractor may only transmit DHHS Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
6. Open Wireless Networks. Contractor may not transmit DHHS Confidential Data via an open wireless network unless employing a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, such as a virtual private network (VPN).
7. Contractor will employ data protections and secure data management policies, processes, and technologies when handling, storing and transmitting DHHS Confidential Data, including during remote user communication, secure file transfer protocol, using wireless devices, and other file transfer mechanisms. Transport layer security protocol (TLS), as a standalone solution, may not be used to transmit Confidential Data without written exception from DHHS Information Security.

IV. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain DHHS Confidential Data and any derivative of DHHS Confidential Data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy DHHS Confidential Data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. If it is infeasible to return or destroy the Confidential Data, protections pursuant to Exhibit K survive this contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process DHHS Confidential Data or State of New Hampshire intellectual property collected or accessed in connection with the services rendered under this Contract outside of the United States without written exception from DHHS Information Security. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.

2. The Contractor agrees NH DHHS Confidential Data will not be stored on personal devices.
3. The Contractor agrees to ensure security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or DHHS Confidential Information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
4. The Contractor agrees to provide or require security awareness and education for/of its End Users in support of protecting DHHS Confidential Information.
5. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified herein.
6. The Contractor agrees Federal Confidential Data, identified as such to the contractor, stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding privacy and security. The Contractor agrees DHHS Confidential must follow the HIPAA Security Rule, Privacy Rule, and HIPAA Cloud Computing Guidance (https://www.hhs.gov/hipaa/for-professionals/special-topics/cloud-computing/index.html). All servers and devices must follow the hardening standards as outline in NIST 800-123 (https://nvlpubs.nist.gov/nistpubs/legacy/sp/nistspecialpublication800-123.pdf) . As well as current, updated, and maintained anti-malware utilities (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware). The environment, as a whole, must have intrusion-detection services and intrusion protection services, as well as, firewall protection.
7. The Contractor agrees to work collaboratively with the State's Chief Information Security Officer (CISO) in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

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

will include all details necessary to demonstrate DHHS Confidential Data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction. In the event where the Contractor has comingled data and the destruction is not feasible the State and Contractor will jointly evaluate regulatory and professional standards for retention requirements prior to destruction.

2. Unless otherwise specified or otherwise deemed impracticable by Contractor within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of State of NH Confidential Data using a secure method such as shredding. Contractor must notify DHHS Information Security immediately upon determining destruction of DHHS hard copy Confidential Data, in connection with this agreement, is impracticable within said timeframe. The Contractor and DHHS Information Security will agree upon an acceptable timeframe for hard copy destruction. If it is agreed it is infeasible to return or destroy the Confidential Data within the agreed upon time period or at all, protections are extended to such information, in accordance with this Agreement.
3. Unless otherwise specified or otherwise deemed impracticable by Contractor within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic State of NH Confidential Data, in connection with this agreement, by means of data erasure, also known as secure data wiping. Contractor must notify DHHS Information Security immediately upon determining destruction of DHHS electronic Confidential Data is impracticable within said timeframe. The Contractor and DHHS Information Security will agree upon an acceptable timeframe for hard copy destruction. If it is agreed it is infeasible to return or destroy the Confidential Data within the agreed upon time period or at all, protections are extended to such information, in accordance with this Agreement.

V. PROCEDURES FOR SECURITY

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

1. The Contractor will maintain security controls to protect DHHS Confidential Information collected, processed, managed, and/or stored in the delivery of contracted services. If the Contractor has access to Confidential Information/Data, the Contractor agrees to follow the terms of the most recently executed Information Exchange Agreement (s) between DHHS and the federal agency regulating said data.

2. The Contractor will maintain policies and procedures to protect DHHS Confidential Information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e. tape, disk, paper, etc.).

3. The Contractor will maintain authentication and access controls to contractor systems that collect, transmit, or store DHHS Confidential Information where applicable.

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

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

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

7. Data Security Breach Liability. In the event of any incident, computer security incident, or breach, Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future incident, computer security incident or breach and minimize any damage or loss resulting from the incident, security incident, or breach. Should an incident, computer security incident, or breach be determined to have been caused by the Contractor and/or End User's negligent or willful failure to safeguard State of New Hampshire networks, systems or DHHS Confidential Data, then the State shall recover from the Contractor and/or End User all costs of response and recovery from the Incident, Computer Security Incident, or Breach.

8. Contractor must comply with all applicable state and federal regulations regulating to the privacy and security of DHHS Confidential Information, and safeguard DHHS Confidential Information at level consistent with the requirements applicable to state and federal agencies. Contractor agrees to establish and maintain administrative, technical, and physical safeguards to protect the confidentiality of DHHS Confidential Data and to prevent unauthorized use or access to it. The safeguards, in connection with DHHS data under this agreement, must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology consistent with the scope of the contract Other than HIPAA/HIRTUST standards and regulations, NH DHHS will advise contractor and list standards that apply to the data defined in the subsequent data sharing language and/or document(s)

9. Contractor agrees to maintain a documented breach notification and incident response process.

10. Contractor agrees to use the minimum necessary Confidential Data in performance of this Contract.

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

12. The Contractor is responsible for ensuring that laptops and other electronic devices/media containing Confidential Information/Data are encrypted and password-protected.

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and this Security Requirements Exhibit.

14. The Contractor will collaborate with the DHHS to demonstrate compliance with the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time as the Confidential Information/Data is disposed of in accordance with this Contract.

VII LOSS REPORTING

The Contractor must notify the DHHS Security Office, and the Program Contact via the email address provided in Section VIII of this Exhibit, immediately upon the Contractor determining that a breach or security incident has occurred and that DHHS confidential Information/data may have been exposed or compromised.

The Contractor must comply with all applicable state and federal regulations regulating to the privacy and security of State of NH and DHHS Confidential information, and safeguard DHHS Confidential Information at level consistent with the requirements applicable to state and federal agencies. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents;
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and
6. Address and report Incidents, Computer Security Incidents, and/or Breaches that implicate Personal Information in accordance with NH RSA 359-C:20.

VIII PERSONS TO CONTACT

1. DHHS contact for Information Security, Privacy and Data Management Issues::
   DHHSInformationSecurityOffice@dhhs.nh.gov

2. DHHS contact program and policy:
   DHHS-Contracts@dhhs.nh.gov
   (In subject line insert RFP/Contract Name and Number)

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 ELLIOT HEALTH SYSTEM is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on June 25, 1999. 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: **320130**
Certificate Number: **0004793041**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 31st day of January A.D. 2020.

William M. Gardner
Secretary of State

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 ELLIOT HEALTH SYSTEM is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on June 25, 1999. 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: **320130**

Certificate Number: **0004793041**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 31st day of January A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Paul W. Hoff, PhD, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary of Elliot Health System.
(Corporation/LLC Name)

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on January 16, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That W. Gregory Baxter, MD - President (may list more than one person)
(Name and Title of Contract Signatory)

Is duly authorized on behalf of Elliot Health System to enter into contracts or agreements with
(Name of Corporation or LLC)

the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

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

Dated: 1/16/2020

Paul W. Hoff, PhD
Secretary

STATE OF NEW HAMPSHIRE

County of Hillsborough

The foregoing instrument was acknowledged before me this 16th day of Janvary, 2020.

By Paul Hoff
(Name of Elected Clerk/Secretary of the Agency)

(Notary Public/Justice of the Peace)

(NOTARY SEAL)

JOHN E. FRIBERG JR. JUSTICE OF THE PEACE NEW HAMPSHIRE MY COMMISSION EXPIRES MAY 4, 2021

Commission Expires:

Rev. 09/23/19

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/22/2020

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

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

PRODUCER Willis Towers Watson Northeast, Inc. fka Willis of Massachusetts, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	CONTACT NAME: Willis Towers Watson Certificate Center PHONE (A/C, No, Ext): 1-877-945-7378 FAX (A/C, No): 1-888-467-2378 E-MAIL ADDRESS: certificates@willis.com
INSURED Elliot Health System One Elliot Way Manchester, NH 03303	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Elliot Health Systems — C2753 INSURER B: Safety National Casualty Corporation — 15105 INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES CERTIFICATE NUMBER: W15277391 REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:			SELF INSURED TRUST	09/01/2019	09/01/2020	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG OTHER	$ 1,000,000 $ 0 $ 0 $ 0 $ 3,000,000 $ 0 $
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) OTHER	$ $ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE OTHER	$ $ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [ ] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		AGC4059249	09/01/2019	09/01/2020	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ $ 1,000,000

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

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

Julie M Powers

SR ID: 19157878 BATCH: 1540895

Elliot Health System
A MEMBER OF SOLUTIONHEALTH

MISSION STATEMENT

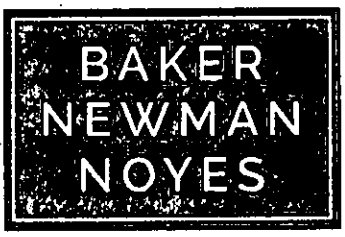
Elliot Health System

Elliot Health System strives to:

INSPIRE wellness

HEAL our patients

SERVE with compassion in every interaction



Elliot Hospital and Affiliates

Audited Consolidated Financial Statements
and Other Financial Information

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

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

ELLIOT HOSPITAL AND AFFILIATES

AUDITED CONSOLIDATED FINANCIAL STATEMENTS
AND OTHER FINANCIAL INFORMATION

June 30, 2019 and 2018

TABLE OF CONTENTS

BAKER NEWMAN NOYES

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

INDEPENDENT AUDITORS' REPORT

Board of Trustees
Elliot Hospital and Affiliates

We have audited the accompanying consolidated financial statements of Elliot Hospital and Affiliates (the Hospital), which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively, the financial statements).

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Board of Trustees
Elliot Hospital and Affiliates

Opinion

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

Emphasis of Matter

As discussed in Note 2 to the financial statements, in 2019, the Hospital adopted the provisions of Accounting Standards Update (ASU) No. ASU No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
September 18, 2019

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED BALANCE SHEETS

June 30, 2019 and 2018

ASSETS

	2019	2018
Current assets:		
Cash and cash equivalents	$ 66,138,993	$ 63,976,084
Accounts receivable, less allowance for doubtful accounts of $20,825,740 in 2019 and $17,884,386 in 2018 (notes 2, 5 and 12)	44,191,258	48,461,909
Inventories	4,002,497	3,443,050
Amounts due from affiliates	–	278,164
Other current assets (note 2)	16,465,785	8,921,786
Total current assets	130,798,533	125,080,993
Property, plant and equipment, less accumulated depreciation (notes 4, 5 and 13)	171,638,356	160,343,769
Investments (notes 6 and 14)	75,712,637	58,304,112
Other assets (note 2)	9,128,937	11,231,738
Assets whose use is limited (notes 6 and 14):		
Board designated and donor restricted investments	110,341,008	110,067,887
Held by trustee under revenue bond and note agreements	3,250	11,830,241
Employee benefit plans and other (note 2)	19,813,013	17,006,819
Beneficial interest in perpetual trusts (note 2)	7,438,506	7,233,609
	137,595,777	146,138,556
Total assets	$524,874,240	$501,099,168

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities:		
Accounts payable and accrued expenses	$ 32,667,097	$ 27,822,684
Accrued salaries, wages and related accounts	32,425,275	31,579,177
Amounts due to affiliates	255,971	–
Accrued interest	1,737,267	1,771,081
Amounts payable to third-party payors (note 3)	20,512,332	16,244,878
Current portion of long-term debt (note 5)	5,920,428	5,403,469
Total current liabilities	93,518,370	82,821,289
Accrued pension (note 8)	93,892,022	72,698,777
Self-insurance reserves and other liabilities (note 2)	39,988,107	37,765,254
Long-term debt, less current portion (note 5)	155,156,065	161,066,094
Total liabilities	382,554,564	354,351,414
Net assets:		
Without donor restrictions	127,280,063	131,942,786
With donor restrictions (note 7)	15,039,613	14,804,968
	142,319,676	146,747,754
Total liabilities and net assets	$524,874,240	$501,099,168

See accompanying notes.

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended June 30, 2019 and 2018

	2019	2018
Net patient service revenues (net of contractual allowances and discounts) (notes 2, 3, 10 and 15)	$549,628,246	$521,148,429
Provision for bad debts (notes 2, 3 and 10)	(27,369,147)	(26,001,597)
Net patient service revenues less provision for bad debts	522,259,099	495,146,832
Investment income (note 6)	5,090,433	2,825,813
Other revenues (note 9)	32,891,740	26,363,428
Total revenues	560,241,272	524,336,073
Expenses (note 11):		
Salaries, wages and fringe benefits (note 8)	337,116,153	324,411,447
Supplies and other expenses (note 13)	156,144,927	150,805,950
Depreciation and amortization	18,938,677	16,314,595
New Hampshire Medicaid Enhancement Tax (note 15)	22,564,148	22,004,678
Interest	6,885,935	7,160,179
Total expenses	541,649,840	520,696,849
Income from operations	18,591,432	3,639,224
Nonoperating gains (losses), net:		
Investment return, net (notes 2 and 6)	4,080,104	4,971,431
Other (note 9)	697,766	973,532
Net periodic pension gain (cost), net of service cost (note 8)	2,510,152	(1,385,079)
Nonoperating gains, net	7,288,022	4,559,884
Excess of revenues and nonoperating gains over expenses	25,879,454	8,199,108
Pension adjustment (note 8)	(24,577,745)	11,834,331
Net transfers to affiliates (note 9)	(5,964,432)	(6,379,025)
(Decrease) increase in net assets without donor restrictions	$ (4,662,723)	$ 13,654,414

See accompanying notes.

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended June 30, 2019 and 2018

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total
Balances at July 1, 2017	$118,288,372	$14,662,555	$132,950,927
Excess of revenues and nonoperating gains over expenses	8,199,108	–	8,199,108
Investment return, net (note 6)	–	94,896	94,896
Net unrealized gain on investments (notes 2 and 6)	–	47,517	47,517
Pension adjustment (note 8)	11,834,331	–	11,834,331
Net transfers to affiliates (note 9)	(6,379,025)	–	(6,379,025)
Increase in net assets	13,654,414	142,413	13,796,827
Balances at June 30, 2018	131,942,786	14,804,968	146,747,754
Excess of revenues and nonoperating gains over expenses	25,879,454	–	25,879,454
Investment return, net (note 6)	–	277,895	277,895
Net unrealized loss on investments (notes 2 and 6)	–	(43,250)	(43,250)
Pension adjustment (note 8)	(24,577,745)	–	(24,577,745)
Net transfers to affiliates (note 9)	(5,964,432)	–	(5,964,432)
(Decrease) increase in net assets	(4,662,723)	234,645	(4,428,078)
Balances at June 30, 2019	$127,280,063	$15,039,613	$142,319,676

See accompanying notes.

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended June 30, 2019 and 2018

	2019	2018
Operating activities and net gains:		
(Decrease) increase in net assets	$ (4,428,078)	$ 13,796,827
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities and net gains:		
Depreciation and amortization	18,938,677	16,314,595
Loss on disposal of property, plant and equipment	8,331	86,262
Restricted investment income and net gain on investments	(277,895)	(94,896)
Net transfers to affiliates	5,964,432	6,379,025
Pension adjustment	24,577,745	(11,834,331)
Net realized and unrealized gains on investments	(3,676,824)	(4,530,537)
Changes in operating assets and liabilities:		
Accounts receivable, net	4,270,651	6,104,014
Inventories	(559,447)	(295,515)
Other current and noncurrent assets	(5,441,198)	(8,160,355)
Accounts payable and accrued expenses	4,844,413	4,553,276
Accrued salaries, wages and related accounts	846,098	4,373,293
Accrued interest	(33,814)	(12,705)
Amounts due to/from affiliates	534,135	(80,568)
Accrued pension	(3,384,500)	1,357,275
Self-insurance reserves and other liabilities	2,222,853	7,570,595
Amounts payable to third-party payors	4,267,454	3,308,329
Net cash provided by operating activities and net gains	48,673,033	38,834,584
Investing activities:		
Acquisition of property, plant and equipment	(30,152,703)	(23,031,569)
Net change in assets whose use is limited	12,219,603	15,732,530
Net change in investments	(17,408,525)	(58,304,112)
Net cash used by investing activities	(35,341,625)	(65,603,151)
Financing activities:		
Repayment of long-term debt	(5,481,962)	(5,186,066)
Net cash transfers to affiliates	(5,964,432)	(6,379,025)
Restricted investment income and net gain on investments	277,895	94,896
Net cash used by financing activities	(11,168,499)	(11,470,195)
Increase (decrease) in cash and cash equivalents	2,162,909	(38,238,762)
Cash and cash equivalents at beginning of year	63,976,084	102,214,846
Cash and cash equivalents at end of year	$ 66,138,993	$ 63,976,084

See accompanying notes.

1. Organization

Elliot Hospital is a not-for-profit acute care hospital which serves residents of Southern New Hampshire. Elliot Health System (the System) is the sole member of Elliot Hospital. In the year ending June 30, 2018, the board of the System, accompanied by the board of Southern New Hampshire Health System, Inc., approved an affiliation agreement between the organizations. The sole corporate member of the System became SolutionHealth, Inc.

Elliot Hospital is the sole corporate member for Elliot Physician Network (EPN), a not-for-profit network of primary care physicians, and Elliot Professional Services (EPS), a not-for-profit network of specialty care physicians. These financial statements reflect the consolidated financial position, results of operations and cash flows of EPN, EPS and Elliot Hospital. These entities are collectively referred to as "the Hospital" in these financial statements.

Elliot Hospital (excluding EPN and EPS) and the System comprise the Obligated Group as defined under a Master Trust Indenture dated November 1, 2016 (as amended) under the 2013 and 2016 bond offerings. See note 5.

The Hospital also participates in certain other strategic affiliation and joint operating agreements with outside entities.

2. Significant Accounting Policies

The accounting policies that affect the more significant elements of the financial statements of the Hospital are summarized below:

Principles of Consolidation

The financial statements include the accounts of Elliot Hospital, EPN and EPS. All significant intercompany balances and transactions have been eliminated in the consolidation.

Charity Care

The Hospital's patient acceptance policy is based on its mission and its community service responsibilities. Accordingly, the Hospital accepts patients in immediate need of care, regardless of their ability to pay. It does not pursue collection of amounts determined to qualify as charity care based on established policies. These policies define charity care as those services for which no payment is due for all or a portion of the patient's bill. For financial reporting purposes, charity care is excluded from net patient service revenue.

In estimating the cost of providing charity care, the Hospital uses the ratio of average patient care cost to gross charges and then applies that ratio to the gross uncompensated charges associated with providing charity care.

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

Cash and Cash Equivalents

Cash and cash equivalents include short-term investments and secured repurchase agreements which have an original maturity of three months or less when purchased.

The Hospital maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Hospital has not experienced any losses on such accounts.

Net Patient Service Revenues and Accounts Receivable

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

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

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

Periodically throughout the year, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience. The results of this review are then used to make any modifications to the provision for bad debts to establish an appropriate allowance for doubtful accounts. The increase in the provision for bad debts in 2019 is driven primarily by an overall increase in self pay revenues. Accounts receivable are written off after collection efforts have been followed in accordance with internal policies.

Income Taxes

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

2. Significant Accounting Policies (Continued)

Performance Indicator

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

The statements of operations also include excess of revenues and nonoperating gains (losses) over expenses. Changes in net assets without donor restrictions which are excluded from excess of revenues and nonoperating gains (losses) over expenses, consistent with industry practice, include net assets released from restrictions for capital purchases, pension adjustments, and transfers to or from affiliates.

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), restricted net assets are reclassified as net assets without donor restrictions and reported in the statement of operations as either net assets released from restrictions for operations (for noncapital-related items) or net assets released from restrictions for property, plant and equipment (for capital-related items). Some restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Investments and Investment Income

Investments, including funds held by trustee under revenue bond and note agreements, are measured at fair value in the balance sheets. Interest and dividend income on unlimited use investments and operating cash is reported within operating revenues. Investment income or loss on assets whose use is limited (including realized and unrealized gains and losses on investments, and interest and dividends) is reported as nonoperating gains (losses). The Hospital has elected to reflect changes in the fair value of investments and assets whose use is limited, including both increases and decreases in value whether realized or unrealized in nonoperating gains or losses.

Beneficial Interest in Perpetual Trusts

The Hospital has an irrevocable right to receive income earned on certain trust assets established for its benefit. Distributions received by the Hospital are restricted by the donor for use in nursing education and women's and children's services. The Hospital's interest in the fair value of the trust assets is included in assets whose use is limited. Changes in the market value of beneficial trust assets are reported as increases or decreases to net assets with donor restrictions.

2. Significant Accounting Policies (Continued)

Investment Policies

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

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

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

Management of these assets is designed to maximize total return while preserving the capital values of the funds, protecting the funds from inflation, and providing liquidity as needed. The objective is to provide a real rate of return that meets inflation, plus 4.5%, over a long-term time horizon (greater than 7 to 10 years).

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

Spending Policy for Appropriation of Assets for Expenditure

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

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

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

Inventories

Inventories of supplies and pharmaceuticals are carried at the lower of cost, determined on a weighted-average method, or net realizable value.

Bond Issuance Costs/Original Issue Premium or Discount

The bond issuance costs incurred to obtain financing for construction and renovation programs and the original issue premium or discount are being amortized over the life of the bonds. The original issue premium or discount and bond issuance costs are presented as a component of the face amount of bonds payable.

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase, or fair market value at time of donation, less reductions in carrying value based upon impairment and less accumulated depreciation. The Hospital's policy is to capitalize expenditures for major improvements and charge maintenance and repairs for expenditures which do not extend the lives of the related assets. The provision for depreciation is computed on the straight-line method at rates intended to amortize the cost of the related assets over their estimated useful lives. Assets which have been purchased but not yet placed in service are included in construction and projects in progress and no depreciation expense is recorded.

Federal Grant Revenue and Expenditures

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

Advertising Expense

Advertising costs are expensed as incurred and totaled approximately $1,753,000 and $1,583,000 in 2019 and 2018, respectively.

Retirement Benefits

The Hospital participates in a defined benefit pension plan for certain of its employees, the Elliot Health System Pension Plan (the Plan), which is sponsored by the System. Effective July 1, 2006, the Plan was amended to close the Plan to employees hired after June 30, 2006. Eligible employees hired prior to July 1, 2006 are grandfathered under the Plan and will continue to accrue benefits as long as they remain at a participating System entity and in an eligible status. See note 8 regarding subsequent changes to this Plan.

The System's funding policy is to contribute amounts to the Plan sufficient to meet minimum funding requirements set forth in the *Employee Retirement Income Security Act of 1974*, plus such additional amounts as might be determined to be appropriate from time to time. The Plan is intended to constitute a plan described in Section 414(k) of the Internal Revenue Code, under which benefits derived from employer contributions are based on the separate account balances of participants in addition to the defined benefits under the Plan.

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

The System provides, and the Hospital participates in, a defined contribution program for all eligible employees hired on or after July 1, 2006. Under this program, eligible employees may receive annual employer contributions to a System 403(b) plan or 401(k) plan up to 3% of annual base pay.

The System also provides matching contributions at the discretion of the System to a 403(b) plan or 401(k) plan for eligible employees hired on or after July 1, 2006 equal to up to one-half of the employee's contribution to a maximum of 4% of their annual base pay. Total expense incurred by the Hospital was $5,089,290 and $4,138,003 under these defined contribution plans for the years ended June 30, 2019 and 2018, respectively.

The System sponsors deferred compensation plans for certain qualifying employees. The amounts ultimately due to employees are to be paid upon the employees attaining certain criteria, including age. At June 30, 2019 and 2018, $19,813,013 and $17,006,819, respectively, is reflected in assets whose use is limited and $19,813,013 and $17,006,819, respectively, in other long-term liabilities related to such agreements.

Workers' Compensation

The System, including the Hospital, is self-insured for workers' compensation. The System has secured its obligation through a surety bond. The System maintains an excess insurance policy to limit its exposure on claims to $650,000 per occurrence. Reserves for claims made and potential unreported claims have been established to provide for incurred but unpaid claims. The amount of the reserve has been determined by an actuarial consultant.

Employee Health and Dental Insurance

The Hospital participates in a self-insurance plan for employee health and dental, sponsored by the System. Under the terms of the plan, employees meeting certain eligibility requirements and their dependents are eligible for participation and, as such, the System is responsible for the administration of the plan and any resultant liability incurred. The System maintains individual stop-loss insurance coverage.

Employee Fringe Benefits

The Hospital has an earned time plan. Under this plan, each qualifying employee earns paid leave for each pay period worked. These hours of paid leave may be used for vacations, holidays or illnesses. Hours earned but not used are vested with the employee and are paid to the employee upon termination subject to certain limits. The Hospital accrues a liability for such paid leave as it is earned, which totaled approximately $14,361,000 and $13,294,000 at June 30, 2019 and 2018, respectively, and is recorded in accrued salaries, wages and related accounts on the accompanying balance sheets.

2. Significant Accounting Policies (Continued)

Malpractice Loss Contingencies

The System, including the Hospital, is insured against malpractice loss contingencies under claims-made insurance policies. A claims-made policy provides specific coverage for claims made during the policy period. The System maintains excess professional and general liability insurance policies to cover claims in excess of liability retention levels. At June 30, 2019, there were no known malpractice claims outstanding for the System which, in the opinion of management, will be settled for amounts in excess of insurance coverage, nor were there any unasserted claims or incidents which required specific loss accruals. The System has established reserves to cover professional liability exposures for incurred but unpaid or unreported claims. The amounts of the reserves have been determined by actuarial consultants. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System.

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24), at June 30, 2019 and 2018, the Hospital recorded a liability of $17,244,125 and $18,474,188, respectively, related to estimated professional liability losses relating to reported cases as well as potentially incurred but not reported claims. At June 30, 2019 and 2018, the Hospital also recorded a receivable of $4,830,031 and $6,298,613, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in self-insurance reserves and other liabilities, and other assets, respectively, on the balance sheets.

Litigation

The Hospital is involved in litigation and regulatory reviews arising in the ordinary course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's financial position, results of operations or cash flows.

Fair Value of Financial Instruments

The fair value of financial instruments is determined by reference to various market data and other valuation techniques as appropriate. Financial instruments consist of cash and cash equivalents, investments, accounts receivable, assets whose use is limited, accounts payable, amounts payable to third-party payors and long-term debt.

The fair value of all financial instruments other than long-term debt approximates their relative book value as these financial instruments have short-term maturities or are recorded at fair value as disclosed in note 14. The fair value of the Hospital's long-term debt is estimated using discounted cash flow analyses, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements, and is disclosed in note 5 to the financial statements.

2. Significant Accounting Policies (Continued)

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities, at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Estimates are used when accounting for the allowance for doubtful accounts, insurance costs, alternative investment funds, employee benefit plans, contractual allowances, amounts payable to third-party payors and contingencies. It is reasonably possible that actual results could differ from those estimates. Adjustments made with respect to the use of estimates often relate to improved information not previously available.

Reclassifications

Certain 2018 amounts have been reclassified to permit comparison with the 2019 financial statements presentation format.

Subsequent Events

Events occurring after the balance sheet date are evaluated by management to determine whether such events should be recognized or disclosed in the financial statements. Management has evaluated subsequent events through September 18, 2019 which is the date the financial statements were available to be issued.

Recent Accounting Pronouncements

In August 2016, FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the Hospital for year ended June 30, 2019. The Hospital has adjusted the presentation of these financial statements and related footnotes accordingly. The ASU has been applied retrospectively to all periods presented.

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the Hospital expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the Hospital on July 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The Hospital is evaluating the impact that ASU 2014-09 will have on its financial statements and related disclosures. Although management's analysis is not complete, the adoption of ASU 2014-09 is not expected to have a material effect on the financial statements.

2. Significant Accounting Policies (Continued)

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*, which requires that lease arrangements longer than twelve months result in an entity recognizing an asset and liability. The pronouncement is effective for the Hospital beginning July 1, 2020 but likely to be deferred one year, with early adoption permitted. The guidance may be adopted retrospectively. Management is currently evaluating the impact this guidance will have on the Hospital's financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for the Hospital beginning after July 1, 2019, with early adoption permitted. The Hospital is currently evaluating the impact that ASU 2018-08 will have on its financial statements. Although management's analysis is not complete, the adoption of ASU 2018-08 is not expected to have a material effect on the financial statements.

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

3. Patient Service Revenues

An estimated breakdown of patient service revenue, net of contractual allowances, discounts and provision for bad debts recognized in 2019 and 2018 from major payor sources, is as follows:

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Bad Debts	Net Patient Service Revenues Less Provision for Bad Debts
2019				
Private payors (includes coinsurance and deductibles)	$ 581,548,141	$232,717,951	$17,257,490	$ 331,572,700
Medicaid	173,512,424	133,877,160	252,436	39,382,828
Medicare	514,453,419	370,404,544	2,178,473	141,870,402
Self-pay	26,936,113	9,822,196	7,680,748	9,433,169
	$1,296,450,097	$746,821,851	$27,369,147	$ 522,259,099

3. **Patient Service Revenues (Continued)**

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Bad Debts	Net Patient Service Revenues Less Provision for Bad Debts
2018				
Private payors (includes coinsurance and deductibles)	$ 542,580,321	$208,669,434	$17,345,372	$316,565,515
Medicaid	148,963,909	108,446,357	575,827	39,941,725
Medicare	466,022,727	329,450,707	1,939,799	134,632,221
Self-pay	25,275,236	15,127,266	6,140,599	4,007,371
	$1,182,842,193	$661,693,764	$26,001,597	$495,146,832

The Hospital maintains contracts with the Social Security Administration (Medicare) and the State of New Hampshire Department of Health and Human Services (Medicaid). The Hospital is paid a prospectively determined fixed price for Medicare and Medicaid inpatient acute care services depending on the type of illness or the patient's diagnostic related group classification. Reimbursement for Medicare for outpatient services is based upon a prospective standard rate for procedures performed or services rendered. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed rate. The Hospital receives payment for other Medicare and Medicaid inpatient and outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports. The percentage of net patient service revenue earned from the Medicare and Medicaid programs was 26% and 4%, respectively, in 2019 and 26% and 8%, respectively, in 2018.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. The Hospital believes that it is in substantial compliance with all applicable laws and regulations. However, there is at least a reasonable possibility that recorded estimates could change by a material amount in the near term. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known. The differences between amounts previously estimated and amounts subsequently determined to be recoverable from third-party payors increased net patient service revenues by approximately $1,200,000 and $1,400,000 in 2019 and 2018, respectively.

The Hospital also maintains contracts with Anthem Blue Cross, Cigna, Harvard Pilgrim Health Care, certain commercial carriers, managed care plans and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge and per day, discounts from established charges and fee schedules.

4. Property, Plant and Equipment

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

	2019	2018
Operating properties:		
Land and land improvements	$ 8,803,319	$ 8,807,619
Buildings and fixed equipment	222,666,413	205,167,985
Major movable equipment	201,621,793	181,063,652
Construction and projects in progress	8,817,191	16,968,967
	441,908,716	412,008,223
Less accumulated depreciation	(279,540,984)	(261,116,148)
	162,367,732	150,892,075
Rental properties:		
Major movable equipment	74,894	71,420
Buildings and fixed equipment	13,154,812	13,066,417
	13,229,706	13,137,837
Less accumulated depreciation	(3,959,082)	(3,686,143)
	9,270,624	9,451,694
Net property, plant and equipment	$ 171,638,356	$ 160,343,769

5. Debt

Long-term debt of the Hospital consists of the following at June 30:

	2019	2018
New Hampshire Health and Education Facilities Authority - Revenue Bonds:		
Elliot Hospital Obligated Group Series 2016 Bonds with interest ranging from 2.00% to 5.00% per year. Principal payments commenced in October 2017 and are payable in annual installments ranging from $2,875,000 to $10,915,000 through October 2038	$141,745,000	$144,465,000
Plus unamortized original issue premium/discount	16,367,101	16,555,500
	158,112,101	161,020,500
Elliot Hospital Obligated Group Series 2013 Bonds with a fixed interest rate of 2.05% per year and a total monthly payment of principal and interest of $217,925 through October 1, 2020	3,437,558	5,953,148
Capital lease obligations	–	11,248
	161,549,659	166,984,896
Less current portion	(5,920,428)	(5,403,469)
Less net unamortized bond issuance costs	(473,166)	(515,333)
	$155,156,065	$161,066,094

5. Debt (Continued)

On November 15, 2016, the Hospital refunded its existing 2009 Series Bonds outstanding of $126,470,000 through the issuance of $147,020,000 in fixed rate New Hampshire Health and Education Facilities Authority Revenue Bonds with interest rates ranging from 2.00% to 5.00%. As of June 30, 2019 and 2018, the balance of defeased 2009 Series Bonds payable not included in the accompanying balance sheets was $124,390,000 and $125,455,000, respectively.

The Obligated Group's agreement with the New Hampshire Health and Education Facilities Authority for the 2016 and 2013 Bonds grants the Authority a security interest in the Hospital's gross receipts and a mortgage on the Hospital's existing and future facilities and equipment. In addition, under the terms of the master indenture, the Obligated Group is required to meet certain covenants requirements. For the years ended June 30, 2019 and 2018, the Hospital was in compliance with all required financial covenants.

Interest paid totaled $6,919,749 and $7,172,884 for the years ended June 30, 2019 and 2018, respectively. There was no interest capitalized for the years ended June 30, 2019 and 2018.

Aggregate annual principal payments required under the bond agreements for each of the five years ending June 30 are approximately: 2020 - $5,920,000; 2021 - $6,427,000; 2022 - $6,717,000; 2023 - $5,655,000; and 2024 - $5,987,000.

The fair value, based on current market rates, of the Hospital's long-term debt was approximately $161,400,000 and $167,900,000 as of June 30, 2019 and 2018, respectively.

The System has entered into a $25,000,000 unsecured line of credit agreement with a bank which is due on demand. The line of credit agreement bears interest at LIBOR plus 1.15% (3.55% at June 30, 2019). At June 30, 2019 and 2018, there were no borrowings outstanding under this agreement. The agreement grants the bank a security interest in the System's securities, cash and deposit account balances to collateralize any future outstanding advances.

Subsequent to June 30, 2019, the Hospital entered into a ten year $20,500,000 equipment lease financing with Bank of America to acquire various property and equipment. The financing agreement is due in monthly principal and interest payments at an interest rate of 1.92%.

6. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited at fair value are comprised of the following at June 30:

	2019	2018
Cash and equivalents	$ 5,250,325	$ 14,165,627
Marketable equity securities	76,064,375	60,393,079
Fixed income securities	48,709,870	58,304,112
U.S. Government obligations and corporate bonds	43,731,421	40,123,159
Employee benefit plans and other	19,813,013	17,006,819
Beneficial interest in perpetual trusts	7,438,506	7,233,609
Alternative investments	12,300,904	7,216,263
	$213,308,414	$204,442,668

6. Investments and Assets Whose Use is Limited (Continued)

Board designated and donor restricted investments of the Hospital are pooled with other System entities into the Elliot Common Trust Fund LLC. The Hospital's allocation of this pool, along with self-insured trust funds, is comprised of the following at June 30:

	2019	2018
Board designated:		
Capital, working capital and community service	$ 92,809,320	$ 89,216,140
Self-insurance	7,791,592	11,486,480
	100,600,912	100,702,620
Donor restricted and other	9,740,096	9,365,267
	$110,341,008	$110,067,887

Funds held by trustee under revenue bond and note agreements are comprised of the following at June 30:

	2019	2018
Construction funds	$ –	$11,828,769
Debt service funds	3,250	1,472
	$3,250	$11,830,241

Investment income, and realized and unrealized gains (losses) on investments are summarized as follows for the years ended June 30:

	2019	2018
Unrestricted investment income and net gains on investments are summarized as follows:		
Investment income	$ 5,090,433	$ 2,825,813
Nonoperating investment income	360,030	488,411
Realized gains on sale of investments, net	6,724,282	1,980,278
Net unrealized (losses) gains on investments	(3,004,208)	2,502,742
	9,170,537	7,797,244
Restricted investment income and net gains on investments are summarized as follows:		
Investment income and net income on investments	277,895	94,896
Net unrealized (losses) gains on investments	(43,250)	47,517
	234,645	142,413
Total restricted and unrestricted	$ 9,405,182	$ 7,939,657

7. Net Assets With Donor Restrictions

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

	2019	2018
Purpose restriction:		
Health care services	$ 392,110	$ 427,827
Equipment and capital improvements	944,983	878,838
Education and scholarships	40,822	37,187
	1,377,915	1,343,852
Perpetual in nature:		
Investments, gains and income from which is donor restricted	9,010,858	8,810,276
Investments, gains and income from which is released to net assets without donor restrictions	4,650,840	4,650,840
	13,661,698	13,461,116
Total net assets with donor restrictions	$15,039,613	$14,804,968

Net assets with donor restrictions are managed in accordance with donor intent and are invested in various portfolios.

8. Retirement Benefits

A reconciliation of the changes in the Elliot Health System Pension Plan's projected benefit obligation and the fair value of plan assets and a statement of funded status of the plan are as follows as of and for the years ended June 30:

	2019	2018
Changes in benefit obligation:		
Projected benefit obligations, beginning of year	$(345,960,316)	$(363,896,351)
Service cost	(9,061,649)	(9,958,934)
Interest cost	(14,170,462)	(14,072,056)
Benefits paid	8,220,337	22,463,260
Actuarial (loss) gain	(32,757,908)	17,992,287
Administrative expenses paid	1,017,500	1,511,478
Projected benefit obligations, end of year	$(392,712,498)	$(345,960,316)
Changes in plan assets:		
Fair value of plan assets, beginning of year	$ 270,918,072	$ 277,929,739
Actual return on plan assets	24,178,941	6,963,071
Contributions by plan sponsor	10,000,000	10,000,000
Benefits paid	(8,220,337)	(22,463,260)
Actual administrative expense paid	(1,017,499)	(1,511,478)
Fair value of plan assets, end of year	$ 295,859,177	$ 270,918,072

8. Retirement Benefits (Continued)

	2019	2018
Funded status:		
Fair value of plan assets	$ 295,859,177	$ 270,918,072
Projected benefit obligations	(392,712,498)	(345,960,316)
Funded status of the plan	$ (96,853,321)	$ (75,042,244)

The accumulated benefit obligation at June 30, 2019 and 2018 was $374,353,677 and $329,167,274, respectively.

Amounts recognized in the statements of financial position consist of the following at June 30:

	2019	2018
Net liability recognized by the System	$(96,853,321)	$ (75,042,244)
Amounts recognized by the Hospital	$(93,892,022)	$ (72,698,777)

The weighted-average assumptions used to develop the projected benefit obligation are as follows as of June 30:

	2019	2018
Discount rate	3.55%	4.19%
Rate of compensation	3.75	3.75

In 2019, the System began using the MP-2018 mortality improvement scale which also had an impact on the projected benefit obligation.

Amounts recognized in net assets without donor restrictions consist of the following at June 30:

	2019	2018
Net actuarial loss	$87,721,465	$62,382,598
Total amount recognized by the System	$87,721,465	$62,382,598
Amounts recognized by the Hospital	$84,960,609	$60,382,864

8. Retirement Benefits (Continued)

Pension Plan Assets

The fair values of the System's pension plan assets and target allocations by asset category are as follows as of June 30, 2019 and 2018 (see note 14 for level definitions):

	Target Allocation	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
2019					
Short-term investments:	5%				
Cash and sweeps		$ 37,361,929	$ 37,361,929	$ –	$ –
Equity securities:	40%				
Mutual funds		130,671,600	130,671,600	–	–
Other equities		13,498,235	13,498,235	–	–
Fixed income securities:	55%				
Corporate and foreign bonds		113,373,633	–	113,373,633	–
		294,905,397	$181,531,764	$113,373,633	$ –
Unallocated insurance contract		953,780			
		$295,859,177			
2018					
Short-term investments:	5%				
Money market fund		$ 3,477,343	$ 3,477,343	$ –	$ –
Equity securities:	40%				
Common stocks		39,385,395	39,385,395	–	–
Mutual funds		10,460,924	10,460,924	–	–
Other equities		32,231,459	32,231,459	–	–
Fixed income securities:	55%				
Corporate and foreign bonds		184,376,327	–	184,376,327	–
		269,931,448	$ 85,555,121	$184,376,327	$ –
Unallocated insurance contract		986,624			
		$270,918,072			

8. Retirement Benefits (Continued)

Management of the assets is designed to maximize total return while preserving the capital values of the fund, protecting the fund from inflation, and providing liquidity as needed for plan benefits. The objective is to provide a rate of return that meets inflation, plus 5.5%, over a long-term horizon.

In addition to the total return goal, the portfolio is constructed to hedge a portion of the interest rate risk of the Plan's liability. The portion of the interest rate risk hedged is the percent of assets allocated to fixed income investments multiplied by the Plan's funded status. The fixed income asset class is structured to reduce the volatility of the funded status by matching the duration of the Plan's liability which is currently approximately 15 years. The current strategic asset allocation target for the fixed income portfolio is 55% of total plan assets, which is designed to hedge approximately 35% of the plan liability.

These funds are managed as permanent funds with disciplined longer term investment objectives and strategies designed to meet cash flow requirements of the plan. Funds are managed in accordance with ERISA and all other regulatory requirements.

Net periodic pension cost includes the following components at June 30:

	2019	2018
Service cost	$ 9,061,649	$ 9,958,934
Interest cost	14,170,462	14,072,056
Expected return on plan assets	(19,033,704)	(18,711,959)
Amortization:		
Actuarial loss	2,273,804	6,061,981
Prior service cost	–	7,551
Net periodic pension cost - System	$ 6,472,211	$ 11,388,563
Amount recognized by the Hospital	$ 6,383,056	$ 11,121,707

The weighted-average assumptions used to develop net periodic pension cost were as follows for the years ended June 30:

	2019	2018
Discount rate	4.19%	3.91%
Expected return on plan assets	6.75	6.75
Rate of compensation	3.75	3.75

In selecting the long-term rate of return on assets, the System considered the average rate of earnings expected on the funds invested or to be invested to provide for the benefits of the plan. This included considering the trust's asset allocation and the expected returns likely to be earned over the life of the plan, as well as the historical returns on the types of assets held and the current economic environment.

The loss amount expected to be recognized in net periodic benefit cost in 2020 totals $7,066,439.

8. Retirement Benefits (Continued)

Contributions

The System expects to contribute $10 million to its pension plan in 2020.

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid by the System:

Fiscal Year	Pension Benefits
2020	$ 9,891,900
2021	11,303,900
2022	12,825,600
2023	14,057,000
2024	15,365,400
Years 2025 – 2029	91,850,400

On May 16, 2019, the Board of Directors of the System resolved to freeze the defined benefit pension plan effective December 31, 2019. Any employee who is a participant of the plan on that date will continue as a participant. No other person will become a participant after that date. Benefits to participants also will stop accruing on December 31, 2019. This amendment will impact the present value of accumulated plan benefits by eliminating the increase due to annual benefit accruals. In the fiscal year ended June 30, 2020, the Hospital expects to recognize a gain of approximately $18.4 million related to this change.

9. Related Party Transactions

Elliot Health System

The Hospital transferred cash and certain assets to and received certain assets from Elliot Health System and its affiliates for the following purposes during the years ended June 30:

	2019	2018
40 Buttrick Road	$ –	$ 1,000,000
Tarrytown Real Estate Holdings	(5,177,940)	(4,600,000)
Mary and John Elliot Charitable Foundation	60,000	(1,790,025)
Elliot Health System	(140,270)	(989,000)
SolutionHealth	(706,222)	–
Net transfers to Elliot Health System and affiliates	$(5,964,432)	$(6,379,025)

9. Related Party Transactions (Continued)

In addition, for the years ended June 30, 2019 and 2018, the Hospital provided professional services for affiliates of the System. Included in other operating revenues for the years ended June 30, 2019 and 2018 is $3,215,769 and $3,029,544, respectively, which management has determined to be the cost of services incurred by the Hospital and provided and allocated to these affiliates. At June 30, 2019 and 2018, amounts due to/from affiliates related to these services are $(255,971) and $278,164, respectively. These amounts are eliminated upon consolidation in the System financial statements.

Leases

The Hospital leases various spaces that it owns under operating lease arrangements primarily to related parties. Rental income for the years ended June 30, 2019 and 2018 was $2,242,686 and $2,109,353, respectively. These amounts are included in other nonoperating gains (losses) in the accompanying statements of operations.

10. Community Benefits (Unaudited)

The mission of the Hospital is to provide quality, accessible healthcare services to patients regardless of their ability to pay. The Hospital subsidizes certain health care services, supports community-based healthcare providers, and provides outreach and educational programs.

Charity Care

The Hospital provides services to patients who are uninsured or underinsured under its charity care policy at no charge or at amounts less than its established charges. The estimated costs of providing charity care services are determined using the ratio of average patient care costs to gross charges, and then applying that ratio to the gross charges associated with providing such services.

Community Programs and Subsidized Services

The Hospital provides community health programs, health professional education through partnerships with local post-secondary organizations, health screenings, health publications and other health information services. Many of these services are provided at a financial loss and are subsidized by the Hospital in order to meet important community needs that otherwise would not be available. In addition, supporting contributions and in-kind services are made to a number of community organizations for the promotion of health-related activities.

Government-Sponsored Programs

The Hospital provided services to Medicare and Medicaid recipients. Reimbursement for such services is at rates substantially below cost.

10. Community Benefits (Unaudited) (Continued)

The estimated cost of providing community benefits for the years ended June 30, 2019 and 2018 are summarized below:

	2019	2018
Charity care	$ 8,464,813	$ 6,657,705
Community programs and subsidized services	2,458,886	1,978,480
Government-sponsored programs	124,801,352	109,961,931
	$135,725,051	$118,598,116

In addition, the Hospital provides a significant amount of uncompensated care to patients that are reported as bad debts. For the years ended June 30, 2019 and 2018, the Hospital reported provisions for bad debts of $27,369,147 and $26,001,597, respectively.

11. Functional Expenses

The Hospital provides general health care services to residents within its geographic location including inpatient, outpatient, physician and emergency care. Expenses related to providing these services are as follows for the years ended June 30, 2019:

	Health Services	General and Administrative	Total
Salaries, wages and fringe benefits	$252,125,447	$ 84,990,706	$337,116,153
Supplies and other expenses	100,263,822	55,881,105	156,144,927
Interest	3,457,220	3,428,715	6,885,935
New Hampshire Medicaid Enhancement Tax	22,564,148	–	22,564,148
Depreciation and amortization	7,279,546	11,659,131	18,938,677
	$385,690,183	$155,959,657	$541,649,840

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

12. Concentration of Credit Risk

The Hospital grants credit without requiring collateral from its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows for the years ended June 30:

	2019	2018
Medicare	31%	30%
Medicaid	11	9
Managed care and other	26	25
Patients (self-pay)	19	23
Anthem Blue Cross	13	13
	100%	100%

13. Leases

The Hospital leases various office facilities and equipment from unrelated parties under noncancelable operating leases. Total rental expense, including month-to-month rentals, for the years ended June 30, 2019 and 2018 was $7,813,214 and $7,276,968, respectively.

Future minimum lease payments required under operating leases are as follows as of June 30, 2019:

Year Ending June 30:	
2020	$2,403,841
2021	402,262
2022	177,158
2023	14,295
2024	7,687
Thereafter	1,080
	$3,006,323

See also note 9 for certain related party lease arrangements.

14. Fair Value Measurements

Fair value of a financial instrument is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Hospital uses various methods including market, income and cost approaches. Based on these approaches, the Hospital often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Hospital utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the Hospital is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

In determining the appropriate levels, the Hospital performs a detailed analysis of the assets and liabilities that are subject to fair value measurements. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3. The following is a description of the valuation methodologies used:

Marketable Equity Securities

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

Fixed Income Securities

The fair value for debt instruments is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The Hospital holds U.S. governmental and federal agency debt instruments, municipal bonds, corporate bonds and foreign bonds, which are primarily classified as Level 2 within the fair value hierarchy.

14. Fair Value Measurements (Continued)

Alternative Investments

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

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

Beneficial Interests in Perpetual Trusts

The Hospital is the beneficiary of two perpetual trusts held by a third party. Under the terms of the trusts, the Hospital has the irrevocable right to receive the income earned on the assets of the trusts in perpetuity, but never receives the assets held in the trusts. The Hospital has transparency into the holdings of the trusts. These investments are generally classified as Level 1 within the fair value hierarchy.

Employee Benefit Plan and Other

Underlying plan investments within these funds are stated at quoted market prices. These investments are generally classified as Level 1 within the fair value hierarchy.

Fair Value on a Recurring Basis

The System invests certain assets on behalf of the Hospital. The System invests the amount in a pooled investment fund and allocates the return from the investment pool to the hospital, of which the Hospital is entitled to the majority of the pooled investment fund. The investment pool is invested in a variety of investments and amounts are available to the Hospital on demand.

14. Fair Value Measurements (Continued)

The following presents the balances of assets measured at fair value on a recurring basis at June 30:

	Total	Level 1	Level 2	Level 3
2019:				
Investments and assets whose use is limited:				
Cash and equivalents	$ 5,250,325	$ 5,250,325	$ –	$ –
Marketable equity securities:				
Common stocks	76,064,375	76,064,375	–	–
Fixed income securities:				
U.S. Government obligations	8,498,868	–	8,498,868	–
Municipal bonds	874,272	–	874,272	–
Corporate bonds	80,427,021	–	80,427,021	–
Foreign bonds	2,641,130	–	2,641,130	–
Beneficial interest in perpetual trusts	7,438,506	7,438,506	–	–
Employee benefit plans and other	19,813,013	19,813,013	–	–
Investments and assets whose use is limited	201,007,510	$108,566,219	$92,441,291	$ –
Alternative investment funds measured at net asset value	12,300,904			
Total assets	$213,308,414			
2018:				
Investments and assets whose use is limited:				
Cash and equivalents	$ 14,165,627	$ 14,165,627	$ –	$ –
Marketable equity securities:				
Common stocks	60,393,079	60,393,079	–	–
Fixed income securities:				
U.S. Government obligations	18,672,864	–	18,672,864	–
Municipal bonds	2,687,768	–	2,687,768	–
Corporate bonds	74,782,883	–	74,782,883	–
Foreign bonds	2,283,756	–	2,283,756	–
Beneficial interest in perpetual trusts	7,233,609	7,233,609	–	–
Employee benefit plans and other	17,006,819	17,006,819	–	–
Investments and assets whose use is limited	197,226,405	$ 98,799,134	$98,427,271	$ –
Alternative investment funds measured at net asset value	7,216,263			
Total assets	$204,442,668			

The alternative investments consist of interests in eleven and six funds at June 30, 2019 and 2018, respectively, that are not actively traded.

14. Fair Value Measurements (Continued)

Net Assets Value Per Share

In accordance with ASU 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, the table below sets forth additional disclosures for alternative investments valued based on net asset value to further demonstrate the nature and risk of the investments by category at June 30:

Investment	Net Asset Value	Unfunded Commitment of the Hospital	Redemption Frequency	Redemption Notice Period
2019				
Equity fund	$2,341,442	$ –	Monthly	90 days
Multi-strategy hedge fund	703,907	–	Illiquid	N/A
Global equity fund	103,860	162,574	Liquid	N/A
Commingled REIT fund	298,795	1,628,746	Liquid	N/A
Multi-strategy hedge fund	1,219,477	–	Annually	N/A
Multi-strategy hedge fund	2,727,533	–	Quarterly	65 days
Multi-strategy hedge fund	2,129,013	–	Quarterly	95 days
Multi-strategy hedge fund	562,764	257,425	Illiquid	N/A
Equity fund	37,931	776,111	Illiquid	N/A
Multi-strategy hedge fund	504,879	1,156,686	Illiquid	N/A
Multi-strategy hedge fund	1,671,303	–	Quarterly	100 days
2018				
Equity fund	$2,357,334	$ –	Monthly	90 days
Multi-strategy hedge fund	620,983	–	Illiquid	N/A
Global equity fund	78,934	91,462	Liquid	N/A
Commingled REIT fund	366,118	1,635,708	Liquid	N/A
Multi-strategy hedge fund	1,142,546	–	Annually	N/A
Multi-strategy hedge fund	2,650,348	–	Quarterly	65 days

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

Investment Strategies

Fixed Income Securities (Debt Instruments)

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

14. Fair Value Measurements (Continued)

Marketable Equity Securities

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

Alternative Investments

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

15. Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.4% of net patient service revenues, with certain exclusions. The amount of tax incurred by the Hospital for fiscal 2019 and 2018 was $22,564,148 and $22,004,678, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. The Hospital recorded $16,214,638 and $17,472,570 in disproportionate share revenue for the years ended June 30, 2019 and 2018, respectively, which is recorded in net patient service revenues.

CMS has completed the audits of the State's program and the disproportionate share payments made by the State from 2011 to 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The Hospital has recorded reserves to address its exposure based on the audit results to date.

16. Financial Assets and Liquidity Resources

As of June 30, 2019, financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, consisted of the following:

Cash and cash equivalents	$ 66,138,993
Accounts receivable	44,191,258
	$110,330,251

To manage liquidity, the Hospital maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the Hospital. In addition, the Hospital has board-designated assets and investments without donor restrictions that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of June 30, 2019, the balance in board-designated assets and investments were $100,600,912 and $75,712,637, respectively.

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

INDEPENDENT AUDITORS' REPORT ON OTHER FINANCIAL INFORMATION

Board of Trustees
Elliot Hospital and Affiliates

We have audited the consolidated financial statements of Elliot Hospital and Affiliates (the Hospital) as of and for the years ended June 30, 2019 and 2018, and have issued our report thereon which contains an unmodified opinion on those consolidated statements. See page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Newman & Noyes LLC

Manchester, New Hampshire
September 18, 2019

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATING BALANCE SHEET

June 30, 2019

ASSETS

	Elliot Hospital	Elliot Physician Network	Elliot Professional Services	Elimi-nations	Consol-idated
Current assets:					
Cash and cash equivalents	$ 63,333,827	$ 1,085,068	$ 1,720,098	$ –	$ 66,138,993
Accounts receivable, net	39,951,318	1,109,175	3,130,765	–	44,191,258
Inventories	4,002,497	–	–	–	4,002,497
Other current assets	15,926,255	74,716	464,814	–	16,465,785
Total current assets	123,213,897	2,268,959	5,315,677	–	130,798,533
Property, plant and equipment, net	171,286,758	15,976	335,622	–	171,638,356
Investments	75,712,637	–	–	–	75,712,637
Other assets	9,128,937	–	–	–	9,128,937
Assets whose use is limited:					
Board designated and donor restricted investments	110,341,008	–	–	–	110,341,008
Held by trustee under revenue bond and note agreements	3,250	–	–	–	3,250
Employee benefit plans and other	19,813,013	–	–	–	19,813,013
Beneficial interest in perpetual trusts	7,438,506	–	–	–	7,438,506
	137,595,777	–	–	–	137,595,777
Total assets	$516,938,006	$ 2,284,935	$ 5,651,299	$ –	$524,874,240

LIABILITIES AND NET ASSETS

	Elliot Hospital	Elliot Physician Network	Elliot Professional Services	Elimi-nations	Consol-idated
Current liabilities:					
Accounts payable and accrued expenses	$ 32,181,526	$ 132,542	$ 353,029	$ –	$ 32,667,097
Accrued salaries, wages and related accounts	20,689,976	2,957,693	8,777,606	–	32,425,275
Amounts due to affiliates	(2,875,742)	1,756,828	1,374,885	–	255,971
Accrued interest	1,737,267	–	–	–	1,737,267
Amounts payable to third-party payors	20,500,569	–	11,763	–	20,512,332
Current portion of long-term debt	5,920,428	–	–	–	5,920,428
Total current liabilities	78,154,024	4,847,063	10,517,283	–	93,518,370
Accrued pension	85,305,724	5,878,779	2,707,519	–	93,892,022
Self-insurance reserves and other liabilities	39,988,107	–	–	–	39,988,107
Long-term debt, less current portion	155,156,065	–	–	–	155,156,065
Total liabilities	358,603,920	10,725,842	13,224,802	–	382,554,564
Net assets:					
Without donor restrictions	143,294,473	(8,440,907)	(7,573,503)	–	127,280,063
With donor restrictions	15,039,613	–	–	–	15,039,613
	158,334,086	(8,440,907)	(7,573,503)	–	142,319,676
Total liabilities and net assets	$516,938,006	$ 2,284,935	$ 5,651,299	$ –	$ 524,874,240

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended June 30, 2019

	Elliot Hospital	Elliot Physician Network	Elliot Professional Services	Elimi-nations	Consol-idated
Net patient service revenues (net of contractual allowances and discounts)	$474,935,149	$31,825,150	$ 57,328,013	$(14,460,066)	$ 549,628,246
Provision for bad debts	(24,944,071)	(688,810)	(1,736,266)	–	(27,369,147)
Net patient service revenues, less provision for bad debts	449,991,078	31,136,340	55,591,747	(14,460,066)	522,259,099
Investment income	5,090,433	–	–	–	5,090,433
Other revenues	35,436,708	2,542,586	3,203,457	(8,291,011)	32,891,740
Total revenues	490,518,219	33,678,926	58,795,204	(22,751,077)	560,241,272
Expenses:					
Salaries, wages and fringe benefits	229,356,693	36,142,634	86,076,892	(14,460,066)	337,116,153
Supplies and other expenses	151,743,706	7,077,970	7,367,410	(10,044,159)	156,144,927
Depreciation and amortization	18,628,351	147,585	162,741	–	18,938,677
New Hampshire Medicaid Enhancement Tax	22,564,148	–	–	–	22,564,148
Interest	6,885,935	–	–	–	6,885,935
Total expenses	429,178,833	43,368,189	93,607,043	(24,504,225)	541,649,840
Income (loss) from operations	61,339,386	(9,689,263)	(34,811,839)	1,753,148	18,591,432
Nonoperating gains (losses):					
Investment return, net	4,080,104	–	–	–	4,080,104
Other	2,405,788	(4,611)	49,737	(1,753,148)	697,766
Net periodic pension gain, net of service cost	2,270,154	167,956	72,042	–	2,510,152
Nonoperating gains (losses), net	8,756,046	163,345	121,779	(1,753,148)	7,288,022
Excess (deficiency) of revenues and nonoperating gains (losses) over expenses	70,095,432	(9,525,918)	(34,690,060)	–	25,879,454
Pension adjustment	(21,736,922)	(2,007,049)	(833,774)	–	(24,577,745)
Net transfers (to) from affiliates	(48,389,432)	8,940,000	33,485,000	–	(5,964,432)
Decrease in net assets without donor restrictions	$ (30,922)	$(2,592,967)	$ (2,038,834)	$ –	$ (4,662,723)

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATING BALANCE SHEET

June 30, 2018

ASSETS

	Elliot Hospital	Elliot Physician Network	Elliot Professional Services	Elimi-nations	Consol-idated
Current assets:					
Cash and cash equivalents	$ 61,417,223	$ 968,732	$ 1,590,129	$ –	$ 63,976,084
Accounts receivable, net	42,047,720	1,945,738	4,468,451	–	48,461,909
Inventories	3,443,050	–	–	–	3,443,050
Amounts due from affiliates	3,224,402	(1,767,180)	(1,179,058)	–	278,164
Other current assets	8,531,124	91,090	299,572	–	8,921,786
Total current assets	118,663,519	1,238,380	5,179,094	–	125,080,993
Property, plant and equipment, net	159,991,418	20,831	331,520	–	160,343,769
Investments	58,304,112	–	–	–	58,304,112
Other assets	11,231,738	–	–	–	11,231,738
Assets whose use is limited:					
Board designated and donor restricted investments	110,067,887	–	–	–	110,067,887
Held by trustee under revenue bond and note agreements	11,830,241	–	–	–	11,830,241
Employee benefit plans and other	17,006,819	–	–	–	17,006,819
Beneficial interest in perpetual trusts	7,233,609	–	–	–	7,233,609
	146,138,556	–	–	–	146,138,556
Total assets	$494,329,343	$ 1,259,211	$ 5,510,614	$ –	$501,099,168

LIABILITIES AND NET ASSETS

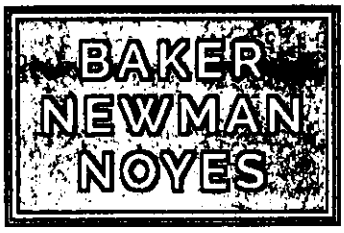
	Elliot Hospital	Elliot Physician Network	Elliot Professional Services	Elimi-nations	Consol-idated
Current liabilities:					
Accounts payable and accrued expenses	$ 27,363,969	$ 48,225	$ 410,490	$ –	$ 27,822,684
Accrued salaries, wages and related accounts	20,357,448	2,582,983	8,638,746	–	31,579,177
Accrued interest	1,771,081	–	–	–	1,771,081
Amounts payable to third-party payors	16,233,115	–	11,763	–	16,244,878
Current portion of long-term debt	5,403,469	–	–	–	5,403,469
Total current liabilities	71,129,082	2,631,208	9,060,999	–	82,821,289
Accrued pension	66,238,550	4,475,943	1,984,284	–	72,698,777
Self-insurance reserves and other liabilities	37,765,254	–	–	–	37,765,254
Long-term debt, less current portion	161,066,094	–	–	–	161,066,094
Total liabilities	336,198,980	7,107,151	11,045,283	–	354,351,414
Net assets:					
Without donor restrictions	143,325,395	(5,847,940)	(5,534,669)	–	131,942,786
With donor restrictions	14,804,968	–	–	–	14,804,968
	158,130,363	(5,847,940)	(5,534,669)	–	146,747,754
Total liabilities and net assets	$494,329,343	$ 1,259,211	$ 5,510,614	$ –	$501,099,168

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended June 30, 2018

	Elliot Hospital	Elliot Physician Network	Elliot Professional Services	Elimi-nations	Consol-idated
Net patient service revenues (net of contractual allowances and discounts)	$450,049,453	$31,010,685	$ 53,957,296	$(13,869,005)	$ 521,148,429
Provision for bad debts	(21,471,096)	(1,135,037)	(3,395,464)	–	(26,001,597)
Net patient service revenues, less provision for bad debts	428,578,357	29,875,648	50,561,832	(13,869,005)	495,146,832
Investment income	2,825,712	48	53	–	2,825,813
Other revenues	28,389,967	2,384,379	3,428,759	(7,839,677)	26,363,428
Total revenues	459,794,036	32,260,075	53,990,644	(21,708,682)	524,336,073
Expenses:					
Salaries, wages and fringe benefits	224,469,751	33,352,679	80,458,022	(13,869,005)	324,411,447
Supplies and other expenses	147,156,643	6,395,212	6,857,689	(9,603,594)	150,805,950
Depreciation and amortization	16,084,180	101,040	129,375	–	16,314,595
New Hampshire Medicaid Enhancement Tax	22,004,678	–	–	–	22,004,678
Interest	7,160,179	–	–	–	7,160,179
Total expenses	416,875,431	39,848,931	87,445,086	(23,472,599)	520,696,849
Income (loss) from operations	42,918,605	(7,588,856)	(33,454,442)	1,763,917	3,639,224
Nonoperating gains (losses):					
Investment return, net	4,971,431	–	–	–	4,971,431
Other	2,673,527	2,113	61,809	(1,763,917)	973,532
Net periodic pension cost, net of service cost	(1,261,118)	(86,776)	(37,185)	–	(1,385,079)
Nonoperating gains (losses), net	6,383,840	(84,663)	24,624	(1,763,917)	4,559,884
Excess (deficiency) of revenues and nonoperating gains (losses) over expenses	49,302,445	(7,673,519)	(33,429,818)	–	8,199,108
Pension adjustment	10,980,648	621,234	232,449	–	11,834,331
Net transfers to (from) affiliates	(45,749,025)	6,975,000	32,395,000	–	(6,379,025)
Increase (decrease) in net assets without donor restrictions	$ 14,534,068	$ (77,285)	$ (802,369)	$ –	$ 13,654,414



Elliot Hospital and Affiliates

Audited Consolidated Financial Statements

Years Ended June 30, 2018 and 2017
With Independent Auditors' Report

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

ELLIOT HOSPITAL AND AFFILIATES

AUDITED CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2018 and 2017

TABLE OF CONTENTS

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

INDEPENDENT AUDITORS' REPORT

Board of Trustees
Elliot Hospital and Affiliates

We have audited the accompanying consolidated financial statements of Elliot Hospital and Affiliates (the Hospital), which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively, the financial statements).

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of June 30, 2018 and 2017, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Baker Newman & Noyes LLC

Manchester, New Hampshire
December 11, 2018

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED BALANCE SHEETS

June 30, 2018 and 2017

ASSETS

	2018	2017
Current assets:		
Cash and cash equivalents	$ 63,976,084	$102,214,846
Accounts receivable, less allowance for doubtful accounts of $17,884,386 in 2018 and $16,239,490 in 2017 (notes 2, 5 and 11)	48,461,909	54,565,923
Inventories	3,443,050	3,147,535
Amounts due from affiliates	278,164	197,596
Other current assets (note 3)	8,921,786	6,209,607
Total current assets	125,080,993	166,335,507
Property, plant and equipment, less accumulated depreciation (notes 4, 5 and 12)	160,343,769	153,624,166
Investments (notes 6 and 13)	58,304,112	–
Other assets (note 2)	11,231,738	5,783,562
Assets whose use is limited (notes 6 and 13):		
Board designated and donor restricted investments	110,067,887	107,099,437
Held by trustee under revenue bond and note agreements	11,830,241	28,342,297
Employee benefit plans and other (note 2)	17,006,819	14,746,583
Beneficial interest in perpetual trusts (note 2)	7,233,609	7,152,232
	146,138,556	157,340,549
Total assets	$501,099,168	$483,083,784

LIABILITIES AND NET ASSETS

	2018	2017
Current liabilities:		
Accounts payable and accrued expenses	$ 27,822,684	$ 23,269,408
Accrued salaries, wages and related accounts	31,579,177	27,205,884
Accrued interest	1,771,081	1,783,786
Amounts payable to third-party payors (note 3)	16,244,878	12,936,549
Current portion of long-term debt (note 5)	5,403,469	5,186,845
Total current liabilities	82,821,289	70,382,472
Accrued pension (note 7)	72,698,777	83,175,833
Self-insurance reserves and other liabilities (note 2)	37,765,254	30,194,659
Long-term debt, less current portion (note 5)	161,066,094	166,379,893
Total liabilities	354,351,414	350,132,857
Net assets:		
Unrestricted	131,942,786	118,288,372
Temporarily restricted	1,343,852	1,269,569
Permanently restricted	13,461,116	13,392,986
	146,747,754	132,950,927
Total liabilities and net assets	$501,099,168	$483,083,784

See accompanying notes.

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended June 30, 2018 and 2017

	2018	2017
Net patient service revenues (net of contractual allowances and discounts) (notes 2, 3, 9 and 14)	$524,294,391	$503,463,020
Provision for bad debts (notes 2, 3 and 9)	(26,001,597)	(25,910,157)
Net patient service revenues less provision for bad debts	498,292,794	477,552,863
Investment income (note 6)	2,825,813	2,509,700
Other revenues (notes 3 and 8)	26,363,428	22,648,547
Total revenues	527,482,035	502,711,110
Expenses (note 10):		
Salaries, wages and fringe benefits (note 7)	327,557,409	303,051,407
Supplies and other expenses (note 12)	150,805,950	143,402,526
Depreciation and amortization	16,314,595	15,319,510
New Hampshire Medicaid Enhancement Tax (note 14)	22,004,678	21,273,658
Interest	7,160,179	7,601,484
Total expenses	523,842,811	490,648,585
Income from operations	3,639,224	12,062,525
Nonoperating gains (losses), net:		
Loss on bond refunding (note 5)	–	(21,117,864)
Investment return, net (notes 2 and 6)	4,971,431	7,016,113
Other	973,532	906,037
Net periodic pension cost, net of service cost (note 7)	(1,385,079)	(5,883,829)
Nonoperating gains (losses), net	4,559,884	(19,079,543)
Excess (deficiency) of revenues and nonoperating gains (losses) over expenses	8,199,108	(7,017,018)
Pension adjustment (note 7)	11,834,331	20,720,803
Net transfers to affiliates (note 8)	(6,379,025)	(5,623,289)
Net assets released from restrictions for capital purchases	–	20,806
Increase in unrestricted net assets	$ 13,654,414	$ 8,101,302

See accompanying notes.

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended June 30, 2018 and 2017

	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Net Assets	Total
Balances at July 1, 2016	$110,187,070	$1,186,304	$13,000,447	$124,373,821
Deficiency of revenues and nonoperating losses over expenses	(7,017,018)	–	–	(7,017,018)
Investment return, net (note 6)	–	10,151	392,539	402,690
Net unrealized gain (loss) on investments (notes 2 and 6)	–	93,920	–	93,920
Pension adjustment (note 7)	20,720,803	–	–	20,720,803
Net transfers to affiliates (note 8)	(5,623,289)	–	–	(5,623,289)
Net assets released from restrictions for capital purchases	20,806	(20,806)	–	–
Increase in net assets	8,101,302	83,265	392,539	8,577,106
Balances at June 30, 2017	118,288,372	1,269,569	13,392,986	132,950,927
Excess of revenues and nonoperating gains over expenses	8,199,108	–	–	8,199,108
Investment return, net (note 6)	–	26,766	68,130	94,896
Net unrealized gain on investments (notes 2 and 6)	–	47,517	–	47,517
Pension adjustment (note 7)	11,834,331	–	–	11,834,331
Net transfers to affiliates (note 8)	(6,379,025)	–	–	(6,379,025)
Increase in net assets	13,654,414	74,283	68,130	13,796,827
Balances at June 30, 2018	$131,942,786	$1,343,852	$13,461,116	$146,747,754

See accompanying notes.

ELLIOT HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended June 30, 2018 and 2017

	2018	2017
Operating activities and net gains:		
Increase in net assets	$ 13,796,827	$ 8,577,106
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net gains:		
Depreciation and amortization	16,314,595	15,319,510
Loss on disposal of property, plant and equipment	86,262	564,419
Restricted investment income and net gain on investments	(94,896)	(402,690)
Net transfers to affiliates	6,379,025	5,623,289
Pension adjustment	(11,834,331)	(20,720,803)
Net realized and unrealized gains on investments	(4,530,537)	(6,745,446)
Loss on bond refunding	–	21,117,864
Changes in operating assets and liabilities:		
Accounts receivable, net	6,104,014	(1,536,268)
Inventories	(295,515)	(106,871)
Other current and noncurrent assets	(8,160,355)	2,453,015
Accounts payable and accrued expenses	4,553,276	6,857,136
Accrued salaries, wages and related accounts	4,373,293	(60,123)
Accrued interest	(12,705)	811,051
Amounts due to/from affiliates	(80,568)	109,850
Accrued pension	1,357,275	5,895,642
Self-insurance reserves and other liabilities	7,570,595	4,114,820
Amounts payable to third-party payors	3,308,329	4,844,912
Net cash provided by operating activities and net gains	38,834,584	46,716,413
Investing activities:		
Acquisition of property, plant and equipment	(23,031,569)	(17,187,336)
Proceeds from sale of property, plant and equipment	–	3,473,690
Net change in assets whose use is limited	15,732,530	(14,615,727)
Net change in investments	(58,304,112)	–
Net cash used by investing activities	(65,603,151)	(28,329,373)
Financing activities:		
Repayment of long-term debt	(5,186,066)	(139,044,689)
Proceeds from issuance of long-term debt	–	146,509,205
Original issue premium/discount	–	16,616,991
Net cash transfers to affiliates	(6,379,025)	(5,623,289)
Restricted investment income and net gain on investments	94,896	402,690
Deposit to refunding bond escrow	–	(12,229,908)
Net cash (used) provided by financing activities	(11,470,195)	6,631,000
(Decrease) increase in cash and cash equivalents	(38,238,762)	25,018,040
Cash and cash equivalents at beginning of year	102,214,846	77,196,806
Cash and cash equivalents at end of year	$ 63,976,084	$ 102,214,846

See accompanying notes.

1. Organization

Elliot Hospital is a not-for-profit acute care hospital which serves residents of Southern New Hampshire. Elliot Health System (the System) is the sole member of Elliot Hospital. In the year ending June 30, 2018, the board of the System, accompanied by the board of Southern New Hampshire Health System, Inc., approved an affiliation agreement between the organizations. The sole corporate member of the System became SolutioNHealth, Inc.

Elliot Hospital is the sole corporate member for Elliot Physician Network (EPN), a not-for-profit network of primary care physicians, and Elliot Professional Services (EPS), a not-for-profit network of specialty care physicians. These financial statements reflect the consolidated financial position, results of operations and cash flows of EPN, EPS and Elliot Hospital. These entities are collectively referred to as "the Hospital" in these financial statements.

Elliot Hospital (excluding EPN and EPS) and the System comprise the Obligated Group as defined under a Master Trust Indenture dated November 1, 2016 (as amended) under the 2013 and 2016 bond offerings. See note 5.

The Hospital also participates in certain other strategic affiliation and joint operating agreements with outside entities.

2. Significant Accounting Policies

The accounting policies that affect the more significant elements of the financial statements of the Hospital are summarized below:

Principles of Consolidation

The financial statements include the accounts of Elliot Hospital, EPN and EPS. All significant intercompany balances and transactions have been eliminated in the consolidation.

Charity Care

The Hospital's patient acceptance policy is based on its mission and its community service responsibilities. Accordingly, the Hospital accepts patients in immediate need of care, regardless of their ability to pay. It does not pursue collection of amounts determined to qualify as charity care based on established policies. These policies define charity care as those services for which no payment is due for all or a portion of the patient's bill. For financial reporting purposes, charity care is excluded from net patient service revenue.

In estimating the cost of providing charity care, the Hospital uses the ratio of average patient care cost to gross charges and then applies that ratio to the gross uncompensated charges associated with providing charity care.

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

Cash and Cash Equivalents

Cash and cash equivalents include short-term investments and secured repurchase agreements which have an original maturity of three months or less when purchased.

The Hospital maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Hospital has not experienced any losses on such accounts.

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

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

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

Periodically throughout the year, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience. The results of this review are then used to make any modifications to the provision for bad debts to establish an appropriate allowance for doubtful accounts. The increase in the provision for bad debts in 2018 is driven primarily by an overall increase in self pay revenues. Accounts receivable are written off after collection efforts have been followed in accordance with internal policies.

Income Taxes

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

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

Performance Indicator

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

The statements of operations also include excess (deficiency)of revenues and nonoperating gains (losses) over expenses. Changes in unrestricted net assets which are excluded from excess (deficiency)of revenues and nonoperating gains (losses) over expenses, consistent with industry practice, include net assets released from restrictions for capital purchases, pension adjustments, and transfers to or from affiliates.

Classification of Net Assets

Gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of donated assets. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor restriction expires (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 statements of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions used for capital purchases (capital related items). Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Investments and Investment Income

Investments, including funds held by trustee under revenue bond and note agreements, are measured at fair value in the balance sheets. Interest and dividend income on unlimited use investments and operating cash is reported within operating revenues. Investment income or loss on assets whose use is limited (including realized and unrealized gains and losses on investments, and interest and dividends) is reported as nonoperating gains (losses). The Hospital has elected to reflect changes in the fair value of investments and assets whose use is limited, including both increases and decreases in value whether realized or unrealized in nonoperating gains or losses.

Beneficial Interest in Perpetual Trusts

The Hospital has an irrevocable right to receive income earned on certain trust assets established for its benefit. Distributions received by the Hospital are restricted by the donor for use in nursing education and women's and children's services. The Hospital's interest in the fair value of the trust assets is included in assets whose use is limited. Changes in the market value of beneficial trust assets are reported as increases or decreases to permanently restricted net assets.

2. Significant Accounting Policies (Continued)

Investment Policies

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

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

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

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

Management of these assets is designed to maximize total return while preserving the capital values of the funds, protecting the funds from inflation, and providing liquidity as needed. The objective is to provide a real rate of return that meets inflation, plus 4.5%, over a long-term time horizon (greater than 7 to 10 years).

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

Spending Policy for Appropriation of Assets for Expenditure

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

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

2. Significant Accounting Policies (Continued)

Inventories

Inventories of supplies and pharmaceuticals are carried at the lower of cost, determined on a weighted-average method, or net realizable value.

Bond Issuance Costs/Original Issue Premium or Discount

The bond issuance costs incurred to obtain financing for construction and renovation programs and the original issue premium or discount are being amortized over the life of the bonds. The original issue premium or discount and bond issuance costs are presented as a component of the face amount of bonds payable.

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase, or fair market value at time of donation, less reductions in carrying value based upon impairment and less accumulated depreciation. The Hospital's policy is to capitalize expenditures for major improvements and charge maintenance and repairs for expenditures which do not extend the lives of the related assets. The provision for depreciation is computed on the straight-line method at rates intended to amortize the cost of the related assets over their estimated useful lives. Assets which have been purchased but not yet placed in service are included in construction and projects in progress and no depreciation expense is recorded.

Federal Grant Revenue and Expenditures

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

Advertising Expense

Advertising costs are expensed as incurred and totaled approximately $1,583,000 and $1,669,000 in 2018 and 2017, respectively.

Retirement Benefits

The Hospital participates in a defined benefit pension plan for certain of its employees, the Elliot Health System Pension Plan (the Plan), which is sponsored by the System.

Effective July 1, 2006, the Plan was amended to close the Plan to employees hired after June 30, 2006. Eligible employees hired prior to July 1, 2006 are grandfathered under the Plan and will continue to accrue benefits as long as they remain at a participating System entity and in an eligible status.

The System's funding policy is to contribute amounts to the Plan sufficient to meet minimum funding requirements set forth in the *Employee Retirement Income Security Act of 1974*, plus such additional amounts as might be determined to be appropriate from time to time. The Plan is intended to constitute a plan described in Section 414(k) of the Internal Revenue Code, under which benefits derived from employer contributions are based on the separate account balances of participants in addition to the defined benefits under the Plan.

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

The System provides, and the Hospital participates in, a defined contribution program for all eligible employees hired on or after July 1, 2006. Under this program, eligible employees may receive annual employer contributions to a System 403(b) plan or 401(k) plan up to 3% of annual base pay.

The System also provides matching contributions at the discretion of the System to a 403(b) plan or 401(k) plan for eligible employees hired on or after July 1, 2006 equal to up to one-half of the employee's contribution to a maximum of 4% of their annual base pay. Total expense incurred by the Hospital was $4,138,003 and $3,373,465 under these defined contribution plans for the years ended June 30, 2018 and 2017, respectively.

The System sponsors deferred compensation plans for certain qualifying employees. The amounts ultimately due to employees are to be paid upon the employees attaining certain criteria, including age. At June 30, 2018 and 2017, $17,006,819 and $14,746,583, respectively, is reflected in assets whose use is limited and $17,006,819 and $14,746,583, respectively, in other long-term liabilities related to such agreements.

Workers' Compensation

The System, including the Hospital, is self-insured for workers' compensation. The System has secured its obligation through a surety bond. The System maintains an excess insurance policy to limit its exposure on claims to $650,000 per occurrence. Reserves for claims made and potential unreported claims have been established to provide for incurred but unpaid claims. The amount of the reserve has been determined by an actuarial consultant.

Employee Health and Dental Insurance

The Hospital participates in a self-insurance plan for employee health and dental, sponsored by the System. Under the terms of the plan, employees meeting certain eligibility requirements and their dependents are eligible for participation and, as such, the System is responsible for the administration of the plan and any resultant liability incurred. The System maintains individual stop-loss insurance coverage.

Employee Fringe Benefits

The Hospital has an earned time plan. Under this plan, each qualifying employee earns paid leave for each pay period worked. These hours of paid leave may be used for vacations, holidays or illnesses. Hours earned but not used are vested with the employee and are paid to the employee upon termination subject to certain limits. The Hospital accrues a liability for such paid leave as it is earned, which totaled approximately $13,294,000 and $12,543,000 at June 30, 2018 and 2017, respectively, and is recorded in accrued salaries, wages and related accounts on the accompanying balance sheets.

2. Significant Accounting Policies (Continued)

Malpractice Loss Contingencies

The System, including the Hospital, is insured against malpractice loss contingencies under claims-made insurance policies. A claims-made policy provides specific coverage for claims made during the policy period. The System maintains excess professional and general liability insurance policies to cover claims in excess of liability retention levels. At June 30, 2018, there were no known malpractice claims outstanding for the System which, in the opinion of management, will be settled for amounts in excess of insurance coverage, nor were there any unasserted claims or incidents which required specific loss accruals. The System has established reserves to cover professional liability exposures for incurred but unpaid or unreported claims. The amounts of the reserves have been determined by actuarial consultants. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System.

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24), at June 30, 2018 and 2017, the Hospital recorded a liability of $18,474,188 and $13,924,488, respectively, related to estimated professional liability losses relating to reported cases as well as potentially incurred but not reported claims. At June 30, 2018 and 2017, the Hospital also recorded a receivable of $6,298,613 and $1,685,575, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in self-insurance reserves and other liabilities, and other assets, respectively, on the balance sheets.

Litigation

The Hospital is involved in litigation and regulatory reviews arising in the ordinary course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's financial position, results of operations or cash flows.

Fair Value of Financial Instruments

The fair value of financial instruments is determined by reference to various market data and other valuation techniques as appropriate. Financial instruments consist of cash and cash equivalents, investments, accounts receivable, assets whose use is limited, accounts payable, amounts payable to third-party payors and long-term debt.

The fair value of all financial instruments other than long-term debt approximates their relative book value as these financial instruments have short-term maturities or are recorded at fair value as disclosed in note 13. The fair value of the Hospital's long-term debt is estimated using discounted cash flow analyses, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements, and is disclosed in note 5 to the financial statements.

2. Significant Accounting Policies (Continued)

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities, at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Estimates are used when accounting for the allowance for doubtful accounts, insurance costs, alternative investment funds, employee benefit plans, contractual allowances, amounts payable to third-party payors and contingencies. It is reasonably possible that actual results could differ from those estimates. Adjustments made with respect to the use of estimates often relate to improved information not previously available.

Reclassifications

Certain 2017 amounts have been reclassified to permit comparison with the 2018 consolidated financial statements presentation format.

Subsequent Events

Events occurring after the balance sheet date are evaluated by management to determine whether such events should be recognized or disclosed in the financial statements. Management has evaluated subsequent events through December 11, 2018 which is the date the financial statements were available to be issued.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the Hospital expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the Hospital on July 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The Hospital is evaluating the impact that ASU 2014-09 will have on its financial statements and related disclosures.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842),* which requires that lease arrangements longer than twelve months result in an entity recognizing an asset and liability. The pronouncement is effective for the Hospital beginning July 1, 2020, with early adoption permitted. The guidance may be adopted retrospectively. Management is currently evaluating the impact this guidance will have on the Hospital's financial statements.

2. Significant Accounting Policies (Continued)

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities* (ASU 2016-14). Under ASU 2016-14, there is a change in presentation and disclosure requirements for not-for-profit entities to provide more relevant information about their resources (and the changes in those resources) to donors, grantors, creditors, and other users. These include qualitative and quantitative requirements in net asset classes, investment return, expenses, liquidity and availability of resources and presentation of operating cash flows. ASU 2016-14 is effective for the Hospital on July 1, 2018, with early adoption permitted. The Hospital is currently evaluating the impact of the pending adoption of ASU 2016-14 on its financial statements.

In March 2017, the FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* (ASU 2017-07). ASU 2017-07 requires that an employer report the service cost component of net periodic pension cost in the same line item as other compensation costs arising from services rendered by employees during the period. The other components of net periodic pension cost are required to be presented in the consolidated statement of operations separately and outside a subtotal of income from operations, if one is presented. ASU 2017-07 is effective for the Hospital on July 1, 2019, with early adoption permitted. The Hospital elected the early adoption option and as a result $5,883,829 previously included in salaries, wages and fringe benefits was reclassified to net periodic pension cost, net of service cost on the consolidated statement of operations for the year ended June 30, 2017.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for reporting periods beginning after December 15, 2018, with early adoption permitted. The Hospital is currently evaluating the impact that ASU 2018-08 will have on its consolidated financial statements.

3. Patient Service and Other Revenues

An estimated breakdown of patient service revenue, net of contractual allowances, discounts and provision for bad debts recognized in 2018 and 2017 from major payor sources, is as follows:

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Bad Debts	Net Patient Service Revenues Less Provision for Bad Debts
2018				
Private payors (includes coinsurance and deductibles)	$ 545,726,283	$208,669,434	$17,345,372	$ 319,711,477
Medicaid	148,963,909	108,446,357	575,827	39,941,725
Medicare	466,022,727	329,450,707	1,939,799	134,632,221
Self-pay	25,275,236	15,127,266	6,140,599	4,007,371
	$1,185,988,155	$661,693,764	$26,001,597	$ 498,292,794

3. **Patient Service and Other Revenues (Continued)**

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Bad Debts	Net Patient Service Revenues Less Provision for Bad Debts
2017				
Private payors (includes coinsurance and deductibles)	$ 506,959,407	$185,744,111	$18,111,567	$303,103,729
Medicaid	147,028,757	102,124,787	569,862	44,334,108
Medicare	423,891,455	297,329,656	2,028,831	124,532,968
Self-pay	20,548,691	9,766,736	5,199,897	5,582,058
	$1,098,428,310	$594,965,290	$25,910,157	$477,552,863

The Hospital maintains contracts with the Social Security Administration (Medicare) and the State of New Hampshire Department of Health and Human Services (Medicaid). The Hospital is paid a prospectively determined fixed price for Medicare and Medicaid inpatient acute care services depending on the type of illness or the patient's diagnostic related group classification. Reimbursement for Medicare for outpatient services is based upon a prospective standard rate for procedures performed or services rendered. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed rate. The Hospital receives payment for other Medicare and Medicaid inpatient and outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports. The percentage of net patient service revenue earned from the Medicare and Medicaid programs was 26% and 8%, respectively, in 2018 and 25% and 9%, respectively, in 2017.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. The Hospital believes that it is in substantial compliance with all applicable laws and regulations. However, there is at least a reasonable possibility that recorded estimates could change by a material amount in the near term. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known. The differences between amounts previously estimated and amounts subsequently determined to be recoverable from third-party payors increased net patient service revenues by approximately $1,400,000 and $2,762,000 in 2018 and 2017, respectively.

The Hospital also maintains contracts with Anthem Blue Cross, Cigna, Harvard Pilgrim Health Care, certain commercial carriers, managed care plans and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge and per day, discounts from established charges and fee schedules.

4. Property, Plant and Equipment

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

	2018	2017
Operating properties:		
Land and land improvements	$ 8,807,619	$ 8,807,619
Buildings and fixed equipment	205,167,985	205,183,904
Major movable equipment	181,063,652	171,609,169
Construction and projects in progress	16,968,967	6,830,831
	412,008,223	392,431,523
Less accumulated depreciation	(261,116,148)	(248,085,317)
	150,892,075	144,346,206
Rental properties:		
Major movable equipment	71,420	75,197
Buildings and fixed equipment	13,066,417	12,273,894
	13,137,837	12,349,091
Less accumulated depreciation	(3,686,143)	(3,071,131)
	9,451,694	9,277,960
Net property, plant and equipment	$ 160,343,769	$ 153,624,166

5. Debt

Long-term debt of the Hospital consists of the following at June 30:

	2018	2017
New Hampshire Health and Education Facilities Authority - Revenue Bonds:		
Elliot Hospital Obligated Group Series 2016 Bonds with interest ranging from 2.00% to 5.00% per year. Principal payments commenced in October 2017 and are payable in annual installments ranging from $2,720,000 to $10,915,000 through October 2038	$144,465,000	$147,020,000
Plus unamortized original issue premium/discount	16,555,500	16,638,511
	161,020,500	163,658,511
Elliot Hospital Obligated Group Series 2013 Bonds with a fixed interest rate of 2.05% per year and a total monthly payment of principal and interest of $217,925 through October 1, 2020	5,953,148	8,415,888
Capital lease obligations – see note 12	11,248	49,839
	166,984,896	172,124,238
Less current portion	(5,403,469)	(5,186,845)
Less net unamortized bond issuance costs	(515,333)	(557,500)
	$161,066,094	$166,379,893

5. **Debt (Continued)**

On November 15, 2016, the Hospital refunded its existing 2009 Series Bonds outstanding of $126,470,000 through the issuance of $147,020,000 in fixed rate New Hampshire Health and Education Facilities Authority Revenue Bonds with interest rates ranging from 2.00% to 5.00%. Although the refunding transaction will reduce the Hospital's total interest costs through the maturity of the refunded bonds, the Hospital has realized an accounting loss in the accompanying 2017 financial statements primarily as a result of establishing the refunding escrow for the 2009 Series Bonds, as well as the write-off of certain prior deferred financing costs and the remaining original issue discount. The loss on bond refunding recognized for the year ended September 30, 2017 was $21,117,864. As of June 30, 2018 and 2017, the balance of defeased 2009 Series Bonds payable not included in the accompanying balance sheets was $125,455,000 and $126,470,000, respectively.

The Obligated Group's agreement with the New Hampshire Health and Education Facilities Authority for the 2016 and 2013 Bonds grants the Authority a security interest in the Hospital's gross receipts and a mortgage on the Hospital's existing and future facilities and equipment. In addition, under the terms of the master indenture, the Obligated Group is required to meet certain covenants requirements. For the years ended June 30, 2018 and 2017, the Hospital was in compliance with all required financial covenants.

Interest paid totaled $7,172,884 and $7,739,726 for the years ended June 30, 2018 and 2017, respectively. There was no interest capitalized for the years ended June 30, 2018 and 2017.

Aggregate annual principal payments required under the bonds and capital lease agreements for each of the five years ending June 30 are approximately: 2019 - $5,403,000; 2020 - $5,701,000; 2021 - $6,235,000; 2022 - $6,772,000; and 2023 - $5,583,000.

The fair value, based on current market rates, of the Hospital's long-term debt was approximately $167,900,000 and $174,100,000 as of June 30, 2018 and 2017, respectively.

During 2012, the System entered into a $15,000,000 unsecured line of credit agreement with a bank which is due on demand. The line of credit agreement bears interest at LIBOR plus 1.15% (3.25% at June 30, 2018). At June 30, 2018 and 2017, there were no borrowings outstanding under this agreement. The agreement grants the bank a security interest in the System's securities, cash and deposit account balances to collateralize any future outstanding advances. Subsequent to June 30, 2018, the line of credit was increased to $25,000,000.

6. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited at fair value are comprised of the following at June 30:

	2018	2017
Cash and equivalents	$ 14,165,627	$ 32,068,321
Marketable equity securities	60,393,079	58,029,532
Fixed income securities	58,304,112	–
U.S. Government obligations and corporate bonds	40,123,159	38,032,614
Employee benefit plans and other	17,006,819	14,746,583
Beneficial interest in perpetual trusts	7,233,609	7,152,232
Alternative investments	7,216,263	7,311,267
	$204,442,668	$157,340,549

Board designated and donor restricted investments of the Hospital are pooled with other System entities into the Elliot Common Trust Fund LLC. The Hospital's allocation of this pool, along with self-insured trust funds, is comprised of the following at June 30:

	2018	2017
Board designated:		
Capital, working capital and community service	$ 89,216,140	$ 84,851,691
Self-insurance	11,486,480	12,756,557
	100,702,620	97,608,248
Donor restricted and other	9,365,267	9,491,189
	$110,067,887	$107,099,437

Funds held by trustee under revenue bond and note agreements are comprised of the following at June 30:

	2018	2017
Construction funds	$11,828,769	$28,341,560
Debt service funds	1,472	737
	$11,830,241	$28,342,297

6. Investments and Assets Whose Use is Limited (Continued)

Investment income, and realized and unrealized gains (losses) on investments are summarized as follows for the years ended June 30:

	2018	2017
Unrestricted investment income and net gains on investments are summarized as follows:		
Investment income	$ 2,825,813	$ 2,509,700
Nonoperating investment income	488,411	364,587
Realized gains on sale of investments	1,980,278	739,874
Net unrealized gains on investments	2,502,742	5,911,652
	7,797,244	9,525,813
Restricted investment income and net gains on investments are summarized as follows:		
Investment income and net income on investments	94,896	402,690
Net unrealized gains on investments	47,517	93,920
	142,413	496,610
Total restricted and unrestricted	$ 7,939,657	$10,022,423

7. Retirement Benefits

A reconciliation of the changes in the Elliot Health System Pension Plan's projected benefit obligation and the fair value of plan assets and a statement of funded status of the plan are as follows as of and for the years ended June 30:

	2018	2017
Changes in benefit obligation:		
Projected benefit obligations, beginning of year	$(363,896,351)	$(362,478,770)
Service cost	(9,958,934)	(10,045,166)
Interest cost	(14,072,056)	(13,349,618)
Benefits paid	22,463,260	5,679,552
Actuarial gain	17,992,287	14,820,849
Administrative expenses paid	1,511,478	1,476,802
Projected benefit obligations, end of year	$(345,960,316)	$(363,896,351)
Changes in plan assets:		
Fair value of plan assets, beginning of year	$ 277,929,739	$ 261,107,658
Actual return on plan assets	6,963,071	13,978,435
Contributions by plan sponsor	10,000,000	10,000,000
Benefits paid	(22,463,260)	(5,679,552)
Actual administrative expense paid	(1,511,478)	(1,476,802)
Fair value of plan assets, end of year	$ 270,918,072	$ 277,929,739

7. **Retirement Benefits (Continued)**

	2018	2017
Funded status:		
Fair value of plan assets	$ 270,918,072	$ 277,929,739
Projected benefit obligations	(345,960,316)	(363,896,351)
Funded status of the plan	$ (75,042,244)	$ (85,966,612)

The accumulated benefit obligation at June 30, 2018 and 2017 was $329,167,274 and $343,923,589, respectively.

Amounts recognized in the statements of financial position consist of the following at June 30:

	2018	2017
Net liability recognized by the System	$(75,042,244)	$ (85,966,612)
Amounts recognized by the Hospital	$(72,698,777)	$ (83,175,833)

The weighted-average assumptions used to develop the projected benefit obligation are as follows as of June 30:

	2018	2017
Discount rate	4.19%	3.91%
Rate of compensation	3.75	3.75

In 2018, the System began using the MP-2017 mortality improvement scale which also had an impact on the projected benefit obligation.

Amounts recognized in unrestricted net assets consist of the following at June 30:

	2018	2017
Net actuarial loss	$62,382,598	$74,687,978
Prior service cost	–	7,551
Total amount recognized by the System	$62,382,598	$74,695,529
Amounts recognized by the Hospital	$60,382,864	$72,217,195

7. **Retirement Benefits (Continued)**

Pension Plan Assets

The fair values of the System's pension plan assets and target allocations as of June 30, 2018, by asset category are as follows (see note 13 for level definitions):

	Target Allocation 2018	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Short-term investments:	5%				
Money market fund		$ 3,477,343	$ 3,477,343	$ –	$ –
Equity securities:	40%				
Common stocks		39,385,395	39,385,395	–	–
Mutual funds		10,460,924	10,460,924	–	–
Other equities		32,231,459	32,231,459	–	–
Fixed income securities:	55%				
U.S. Government and agency obligations		48,784,888	–	48,784,888	–
Municipal bonds		7,140,866	–	7,140,866	–
Mutual funds - balanced		4,006,743	–	4,006,743	–
Corporate and foreign bonds		124,443,830	–	124,443,830	–
		269,931,448	$85,555,121	$184,376,327	$ –
Unallocated insurance contract		986,624			
		$270,918,072			

7. **Retirement Benefits (Continued)**

The fair values of the System's pension plan assets and target allocations as of June 30, 2017, by asset category are as follows (see note 13 for level definitions):

	Target Allocation 2017	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Short-term investments:	5%				
Money market fund		$ 3,333,849	$ 3,333,849	$ –	$ –
Equity securities:	40%				
Common stocks		42,206,812	42,206,812	–	–
Mutual funds		10,990,323	10,990,323	–	–
Other equities		30,306,319	30,306,319	–	–
Fixed income securities:	55%				
U.S. Government and agency obligations		49,409,932	–	49,409,932	–
Municipal bonds		9,037,831	–	9,037,831	–
Mutual funds - balanced		4,073,053	–	4,073,053	–
Corporate and foreign bonds		127,549,274	–	127,549,274	–
		276,907,393	$86,837,303	$190,070,090	$ –
Unallocated insurance contract		1,022,346			
		$277,929,739			

Management of the assets is designed to maximize total return while preserving the capital values of the fund, protecting the fund from inflation, and providing liquidity as needed for plan benefits. The objective is to provide a rate of return that meets inflation, plus 5.5%, over a long-term horizon.

In addition to the total return goal, the portfolio is constructed to hedge a portion of the interest rate risk of the Plan's liability. The portion of the interest rate risk hedged is the percent of assets allocated to fixed income investments multiplied by the Plan's funded status. The fixed income asset class is structured to reduce the volatility of the funded status by matching the duration of the Plan's liability which is currently approximately 15 years. The current strategic asset allocation target for the fixed income portfolio is 55% of total plan assets, which is designed to hedge approximately 35% of the plan liability.

These funds are managed as permanent funds with disciplined longer term investment objectives and strategies designed to meet cash flow requirements of the plan. Funds are managed in accordance with ERISA and all other regulatory requirements.

7. Retirement Benefits (Continued)

Net periodic pension cost includes the following components at June 30:

	2018	2017
Service cost	$ 9,958,934	$ 10,045,166
Interest cost	14,072,056	13,349,618
Expected return on plan assets	(18,711,959)	(17,251,991)
Amortization:		
Actuarial loss	6,061,981	9,917,237
Prior service cost	7,551	30,049
Net periodic pension cost - System	$ 11,388,563	$ 16,090,079
Amount recognized by the Hospital	$ 11,121,707	$ 15,657,776

The weighted-average assumptions used to develop net periodic pension cost were as follows for the years ended June 30:

	2018	2017
Discount rate	3.91%	3.71%
Expected return on plan assets	6.75	6.75
Rate of compensation	3.75	3.75

In selecting the long-term rate of return on assets, the System considered the average rate of earnings expected on the funds invested or to be invested to provide for the benefits of the plan. This included considering the trust's asset allocation and the expected returns likely to be earned over the life of the plan, as well as the historical returns on the types of assets held and the current economic environment.

The loss amount expected to be recognized in net periodic benefit cost in 2019 totals $2,689,725.

Contributions

The System expects to contribute $10 million to its pension plan in 2019.

7. Retirement Benefits (Continued)

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid by the System:

Fiscal Year	Pension Benefits
2019	$ 8,571,500
2020	10,201,700
2021	11,621,300
2022	13,063,700
2023	14,376,900
Years 2024 – 2028	88,815,600

8. Related Party Transactions

Elliot Health System

The Hospital transferred cash and certain assets to and received certain assets from Elliot Health System and its affiliates for the following purposes during the years ended June 30:

	2018	2017
40 Buttrick Road	$ 1,000,000	$ (3,569,693)
Tarrytown Real Estate Holdings	(4,600,000)	(2,026,490)
Mary and John Elliot Charitable Foundation	(1,790,025)	(71,000)
Elliot Health System	(989,000)	43,894
Net transfers to Elliot Health System and affiliates	$ (6,379,025)	$ (5,623,289)

In addition, for the years ended June 30, 2018 and 2017, the Hospital provided professional services for affiliates of the System. Included in other operating revenues for the years ended June 30, 2018 and 2017 is $3,029,544 and $3,836,965, respectively, which management has determined to be the cost of services incurred by the Hospital and provided and allocated to these affiliates. At June 30, 2018 and 2017, amounts due from affiliates related to these services are $278,164 and $197,596, respectively. These amounts are eliminated upon consolidation in the System financial statements.

Leases

The Hospital leases various spaces that it owns under operating lease arrangements primarily to related parties. Rental income for the years ended June 30, 2018 and 2017 was $2,109,353 and $1,894,432, respectively. These amounts are included in other nonoperating gains (losses) in the accompanying statements of operations.

9. Community Benefits (Unaudited)

The mission of the Hospital is to provide quality, accessible healthcare services to patients regardless of their ability to pay. The Hospital subsidizes certain health care services, supports community-based healthcare providers, and provides outreach and educational programs.

Charity Care

The Hospital provides services to patients who are uninsured or underinsured under its charity care policy at no charge or at amounts less than its established charges. The estimated costs of providing charity care services are determined using the ratio of average patient care costs to gross charges, and then applying that ratio to the gross charges associated with providing such services.

Community Programs and Subsidized Services

The Hospital provides community health programs, health professional education through partnerships with local post-secondary organizations, health screenings, health publications and other health information services. Many of these services are provided at a financial loss and are subsidized by the Hospital in order to meet important community needs that otherwise would not be available. In addition, supporting contributions and in-kind services are made to a number of community organizations for the promotion of health-related activities.

Government-Sponsored Programs

The Hospital provided services to Medicare and Medicaid recipients. Reimbursement for such services is at rates substantially below cost.

The estimated cost of providing community benefits for the years ended June 30, 2018 and 2017 are summarized below:

	2018	2017
Charity care	$ 6,657,705	$ 6,361,032
Community programs and subsidized services	1,978,480	1,385,899
Government-sponsored programs	109,961,931	93,948,417
	$118,598,116	$101,695,348

In addition, the Hospital provides a significant amount of uncompensated care to patients that are reported as bad debts. For the years ended June 30, 2018 and 2017, the Hospital reported provisions for bad debts of $26,001,597 and $25,910,157, respectively.

10. Functional Expenses

The Hospital provides general health care services to residents within its geographic location including inpatient, outpatient, physician and emergency care. Expenses related to providing these services are as follows for the years ended June 30:

	2018	2017
Health care services	$346,124,231	$315,985,248
General and administrative	177,718,580	174,663,337
	$523,842,811	$490,648,585

11. Concentration of Credit Risk

The Hospital grants credit without requiring collateral from its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows for the years ended June 30:

	2018	2017
Medicare	30%	30%
Medicaid	9	11
Managed care and other	25	25
Patients (self-pay)	23	21
Anthem Blue Cross	13	13
	100%	100%

12. Leases

The Hospital leases various office facilities and equipment from unrelated parties under noncancelable operating leases. Total rental expense for the years ended June 30, 2018 and 2017 was $7,276,968 and $7,581,449, respectively. The Hospital also leases equipment under lease agreements that are classified as capital leases. The cost of equipment under capital leases was $370,956 at both June 30, 2018 and 2017. Accumulated amortization of the leased equipment at June 30, 2017 was $323,815. The equipment became fully amortized during 2018. Amortization of assets under capital leases is included in depreciation and amortization expense.

12. Leases (Continued)

Future minimum lease payments required under operating and capital leases and the present value of the net minimum lease payments are as follows as of June 30, 2018:

	Operating Leases	Capital Leases	Total
Year Ending June 30:			
2019	$2,574,045	$ 11,333	$2,585,378
2020	2,109,241	–	2,109,241
2021	286,114	–	286,114
2022	144,351	–	144,351
2023	15,592	–	15,592
Thereafter	15,592	–	15,592
Total minimum lease payments	$5,144,935	11,333	$5,156,268
Less amount representing interest		(85)	
Present value of minimum lease payments		11,248	
Less current maturities of capital lease obligations		(11,248)	
Long-term capital lease obligations		$ –	

See also note 8 for certain related party lease arrangements.

13. Fair Value Measurements

Fair value of a financial instrument is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Hospital uses various methods including market, income and cost approaches. Based on these approaches, the Hospital often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Hospital utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the Hospital is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

13. Fair Value Measurements (Continued)

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

In determining the appropriate levels, the Hospital performs a detailed analysis of the assets and liabilities that are subject to fair value measurements. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3. The following is a description of the valuation methodologies used:

Marketable Equity Securities

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

Fixed Income Securities

The fair value for debt instruments is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The Hospital holds U.S. governmental and federal agency debt instruments, municipal bonds, corporate bonds and foreign bonds, which are primarily classified as Level 2 within the fair value hierarchy.

Alternative Investments

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

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

13. Fair Value Measurements (Continued)

Beneficial Interests in Perpetual Trusts

The Hospital is the beneficiary of two perpetual trusts held by a third party. Under the terms of the trusts, the Hospital has the irrevocable right to receive the income earned on the assets of the trusts in perpetuity, but never receives the assets held in the trusts. The Hospital has transparency into the holdings of the trusts. These investments are generally classified as Level 1 within the fair value hierarchy.

Employee Benefit Plan and Other

Underlying plan investments within these funds are stated at quoted market prices. These investments are generally classified as Level 1 within the fair value hierarchy.

Fair Value on a Recurring Basis

The System invests certain assets on behalf of the Hospital. The System invests the amount in a pooled investment fund and allocates the return from the investment pool to the hospital, of which the Hospital is entitled to the majority of the pooled investment fund. The investment pool is invested in a variety of investments and amounts are available to the Hospital on demand.

The following presents the balances of assets measured at fair value on a recurring basis at June 30:

	Total	Level 1	Level 2	Level 3
2018:				
Investments and assets whose use is limited:				
Cash and equivalents	$ 14,165,627	$ 14,165,627	$ –	$ –
Marketable equity securities:				
Common stocks	60,393,079	60,393,079	–	–
Fixed income securities:				
U.S. Government obligations	18,672,864	–	18,672,864	–
Municipal bonds	2,687,768	–	2,687,768	–
Corporate bonds	74,782,883	–	74,782,883	–
Foreign bonds	2,283,756	–	2,283,756	–
Beneficial interest in perpetual trusts	7,233,609	7,233,609	–	–
Employee benefit plans and other	17,006,819	17,006,819	–	–
Investments and assets whose use is limited	197,226,405	$ 98,799,134	$98,427,271	$ –
Alternative investment funds measured at net asset value	7,216,263			
Total assets	$204,442,668			

13. Fair Value Measurements (Continued)

	Total	Level 1	Level 2	Level 3
2017:				
Assets whose use is limited:				
Cash and equivalents	$ 32,068,321	$ 32,068,321	$ –	$ –
Marketable equity securities:				
Common stocks	58,029,532	58,029,532	–	–
Fixed income securities:				
U.S. Government obligations	7,098,926	–	7,098,926	–
Municipal bonds	274,435	–	274,435	–
Corporate bonds	29,338,681	–	29,338,681	–
Foreign bonds	1,320,572	–	1,320,572	–
Beneficial interest in perpetual trusts	7,152,232	7,152,232	–	–
Employee benefit plans and other	14,746,583	14,746,583	–	–
Assets whose use is limited	150,029,282	$111,996,668	$38,032,614	$ –
Alternative investment funds measured at net asset value	7,311,267			
Total assets	$157,340,549			

The alternative investments consist of interests in six funds at both June 30, 2018 and 2017 that are not actively traded.

Net Assets Value Per Share

In accordance with ASU 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, the table below sets forth additional disclosures for alternative investments valued based on net asset value to further demonstrate the nature and risk of the investments by category at June 30:

Investment	Net Asset Value	Unfunded Commitment of the System	Redemption Frequency	Redemption Notice Period
2018				
Equity fund	$2,357,334	$ –	Monthly	90 days
Multi-strategy hedge fund	620,983	–	Illiquid	N/A
Global equity fund	78,934	91,462	Liquid	N/A
Commingled REIT fund	366,118	1,635,708	Liquid	N/A
Multi-strategy hedge fund	1,142,546	–	Annually	N/A
Multi-strategy hedge fund	2,650,348	–	Quarterly	65 days

13. **Fair Value Measurements (Continued)**

Investment	Net Asset Value	Unfunded Commitment of the System	Redemption Frequency	Redemption Notice Period
2017				
Equity fund	$2,156,454	$ –	Monthly	90 days
Multi-strategy hedge fund	506,235	–	Illiquid	N/A
Global equity fund	218,490	203,044	Liquid	N/A
Commingled REIT fund	412,138	1,971,361	Liquid	N/A
Multi-strategy hedge fund	1,325,040	–	Closed Until 2018	N/A
Multi-strategy hedge fund	2,692,910	–	Quarterly	65 days

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

Investment Strategies

Fixed Income Securities (Debt Instruments)

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

Marketable Equity Securities

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

Alternative Investments

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

14. Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.4% of net patient service revenues, with certain exclusions. The amount of tax incurred by the Hospital for fiscal 2018 and 2017 was $22,004,678 and $21,273,658, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. The Hospital recorded $17,472,570 and $18,631,257 in disproportionate share revenue for the years ended June 30, 2018 and 2017, respectively, which is recorded in net patient service revenues.

CMS has completed the audits of the State's program and the disproportionate share payments made by the State from 2011 to 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The Hospital has recorded reserves to address its exposure based on the audit results to date.

Elliot Hospital Board of Trustees &
Elliot Health System Board of Directors
2019

Greg Baxter, MD, President
Loretta Brady, PhD
Rev. John A. Cerrato, Jr.
Susan Critz, MS, RN
David Cuzzi
Mathew Dayno, MD
Sherry Hausmann
John A. Hession
Paul W. Hoff, Ph.D
James C. Hood, Esq
Joseph T. Hyatt, MD
Dottie Kelley, President, Elliot Hospital Associates
Linda Kornfeld, MD
Stephen Loosigian, DO, President, Medical Staff
John Mercier
Daniel M. Monfried
Charles F. Rolecek
Elizabeth Soukup, MD
Philip Taub, Esquire
James J. Tenn, Jr., Esq.
Peter can der Meer, MD

CAROL J. FURLONG, LCMHC, MAC, MBA

SKILLS / ABILITIES / ACHIEVEMENTS PROFILE

Administration: Seasoned professional with progressive experience in diverse healthcare and educational environments, including operations, budget control, marketing, quality assurance, risk management, utilization review, facility design and management, human resources, and strategic planning.

Management: Self-starter with strong planning, controlling, organizing and leadership skills. Effectively manages resources and ensures compliance with established policies and procedures. Skilled in identifying and troubleshooting problem areas and implementing solutions. Developed comprehensive Quality Management program. Restructured billing, triage and customer service systems resulting in improved productivity and efficiency. Extensive managed care experience.

Human Resources: Skilled in recruiting, interviewing and selecting top personnel. Effective trainer, develops staff abilities to full potential. Motivates and retains employees using the mentor approach. Managed and supervised training and development of personnel. Knowledgeable regarding multicultural issues. Effectively trained and prepared counseling professionals.

Communication: Articulate speaker and effective negotiator. Writes with strength, clarity and style. Natural ability to work with others. Consistently develops good rapport with staff, professionals, staff managers and community. Works well as part of a team or independently. Wrote and published several training and procedural manuals.

PROFESSIONAL EXPERIENCE

DIRECTOR OF SUBSTANCE USE SERVICES **2017 - present**
Developing and managing four SUD programs – Hillsborough County North Drug Court, a co-occurring Partial Hospitalization Program, a primary care practice MAT program and SUD services in the Emergency Room.

VICE PRESIDENT OF OPERATIONS **2005-2017**
Harbor Homes, Inc. Nashua, NH
Managed over 250 clinical, residential and administrative staff and coordinated a continuum of service delivery for those experiencing physical illness, mental illness, homelessness and other populations. Continuously expanded a fully integrated FQHC for homeless adding dental, MAT, and Medical Respite services along with primary care and Behavioral Health services. Developed Mobile Crisis Response Team for Greater Nashua area. Have successfully completed three HRSA site reviews and a CARF accreditation.

DIRECTOR OF COMMUNITY SUPPORT SERVICES DEPARTMENT **2003 – 2005**
Community Council of Nashua Nashua, NH
Developed and updated program plans, assured monitoring of implementation and implemented corrective actions as indicated. Provided education/consultation to staff, other agencies or community groups. Provided supervision to a clinical staff of approximately 40 therapists, case managers and MIMS workers. Developed Regional Planning of adult services. Assured quality/appropriateness of critical aspects of care through ongoing monitoring.

DIRECTOR OF OUTCOMES & SYSTEM IMPROVEMENT **1999-2003**
Community Council of Nashua Nashua, NH
Developed and maintained a Quality Management Program complying with NCQA and JCAHO standards. Monitored utilization review, evaluated medical necessity, and continuation of care services. Developed effective medical records protocols. Directed training for the agency. Coordinated efforts resulting in highly successful JCAHO survey, (among the top 5% in the country). Coordinated Customer Service and complaints process.

ADJUNCT FACULTY **1990-2005**
Rivier College Nashua, NH
Graduate Counseling Program – Instruct graduate counseling students in a variety of courses to include Group Therapy, Counseling Techniques, Substance Abuse Counseling, Clinical Assessment, Marriage & Family Therapy, and Prescriptive Behavioral Management Techniques.

DIRECTOR OF REGIONAL BEHAVIORAL HEALTH QM **1997-1999**
The Hitchcock Clinic **Bedford, NH**
Developed and maintained a Quality Management Program complying with NCQA standards for four Behavioral Health sites. Developed and implemented program expansion. Identified staffing requirements and facilitated subsequent downsizing to ensure cost effectiveness. Liaison between the Clinic and insurance plans. Monitored and supervised utilization review for the Southern Region, evaluating the medical necessity, case management and continuation of care. Recommended by insurance reviewers to other organizations for consultation services in order to assist these agencies in their compliance processes. Developed effective medical records protocols.

COORDINATOR OF MULTICULTURAL COUNSELING PROGRAM **1998-1999**
Rivier College Nashua, NH
Coordinated the Bilingual/Multicultural Counseling Program in both guidance counseling and mental health fields. Recruited and advised professional students from local multicultural agencies. Developed a diversity-training program for use in area schools and businesses to enhance multicultural awareness. Instructor in Graduate Counseling Program.

CLINICAL DIRECTOR **1990-1997**
The Hitchcock Clinic Nashua, NH
Developed and implemented program policies and procedures. Managed FTE and budgetary control while providing effective leadership to the staff. Improved out-referral system, while reducing out-referral expenditures. Developed cooperative collaboration measures with insurers' UM Departments. Supervised a staff of thirty employees. Senior member of the Regional Management Team and a member of the Nashua Medical Group Board of Governors.

PROGRAM DIRECTOR **1988-1990**
Partial Hospitalization Program, Brookside Hospital Nashua, NH
Developed program components, structure, policies and procedures. Implemented FTE and budgetary control and supervised treatment staff. Initiated referral network and maintained marketing and referral relationships within the Greater Nashua community. Facilitated groups provided case management and individual counseling including initial assessments. Monitored case management and utilization review processes with insurers.

PROGRAM DIRECTOR – SUBSTANCE ABUSE CLINIC **1985-1988**
Department of the Army West Germany
Developed comprehensive preventive substance abuse program. Coordinated efforts with schools, civic organizations, civilian agencies and military organizations in order to integrate preventive education efforts. Supervised clinical and support staff of two treatment clinics. Maintained referral relationships with commanders.

ARMY COMMUNITY SERVICE DIRECTOR **1983-1985**
Department of the Army West Germany
Developed comprehensive community support agency. Responsible for staffing and budgetary concerns. Composed informational publications, prepared financial and statistical reports and submitted budget requests to the U. S. government for agency funding. Responsible for FAP (Family Advocacy Program).

EDUCATION

MASTERS OF BUSINESS ADMINISTRATION DEGREE
IN HEALTHCARE ADMINISTRATION - 2001
Rivier College, Nashua

MASTERS OF SCIENCE IN EDUCATION (COUNSELING) - 1986
University of Southern California

BACHELORS IN EDUCATION (SPECIAL EDUCATION)
Westfield State College, Westfield, MA

LICENSES AND CERTIFICATIONS

LICENSED CLINICAL MENTAL HEALTH COUNSELOR
New Hampshire License #100 – 1998

MASTERS ADDICTION COUNSELOR CERTIFICATION
1997

Project Manager Job Description

The Program Manager is responsible for community planning and implementation of the MOM model within Elliot and across community providers. This position will coordinate with the State's Administrator to ensure the ongoing planning and implementation efforts for a person-centered model, including development of workflows and standard approaches and obtain input and support from community-based organizations. The Manager will work collaboratively with the key partner organizations in the Greater Manchester Area to finalize model development and implement interventions throughout the health care system. Additionally, the Program Manager will lead meetings with the Executive Committee made up of partners across the health care continua.

Project Analyst Job Description

The Project Analyst will support the Project Manager in community planning and program implementation. The Project Analyst will be responsible for coordinating the implementation of the MOM model across community partners, and to support partners in their efforts to report on MOM model interventions on a monthly basis, and in support of any additional data needed for CMMI evaluation of the MOM model

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Carol Furlong	Director, Substance Use Services	128,910	20%	26,208
Not Hired	Project Manager	70,000	100%	70,000
Not Hired	Project Analyst*	9,500	100%	9,500

- Numbers above for first full year
- anticipate that Project Analyst will start towards end of first year