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

129 PLEASANT STREET, CONCORD, NH 03301
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Lori A. Shibinette
Commissioner

Katja S. Fox
Director

January 19, 2021

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, to **Retroactively** amend existing **Sole Source** contracts with the vendors listed in **bold** below to continue a statewide system of Doorways that provide access to substance use disorder treatment and recovery services and supports, by exercising renewal options by increasing the total price limitation by $6,898,532 from $27,125,987to $34,024,519 and by extending the completion dates from September 29, 2020 to September 29, 2021 effective retroactive to September 29, 2020 upon Governor and Council approval. 97.28% Federal and 2.72% Other Funds.

The individual contracts were approved by Governor and Council as specified in the table below.

Vendor Name	Vendor Code	Area Served	Current Amount	Increase/ (Decrease)	New Amount	G&C Approval
Androscoggin Valley Hospital, Inc., Berlin, NH	**177220 -B002**	**Berlin**	**$1,670,051**	**$279,466**	**$1,949,517**	**O: 10/31/18 Item #17A A1: 8/28/19 (Item #10) A2: 6/24/20 (Item #31)**
Concord Hospital, Inc., Concord, NH	**177653 -B003**	**Concord**	**$2,272,793**	**$416,001**	**$2,688,794**	**O: 10/31/18 Item #17A A1: 8/28/19 (Item #10) A2: 6/24/20 (Item #31)**
Granite Pathways, Concord, NH	228900 -B001	Concord	$6,895,879	$0	$6,895,879	O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)
Littleton Regional Hospital, Littleton, NH	**177162 -B011**	**Littleton**	**$1,713,805**	**$446,884**	**$2,160,689**	**O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20) A2: 6/24/20 (Item #31)**

LRGHealthcare Laconia, NH	**177161 -B006**	**Laconia**	**$1,987,673**	**$329,403**	**$2,317,076**	**O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20) A2: 6/24/20 (Item #31)**
Mary Hitchcock Memorial Hospital, Lebanon, NH	177651 -B001	Lebanon	$4,349,314	$0	$4,349,314	O: 10/31/18 Item #17A A1:11/14/19 (Item #11) A2: 9/18/19, (Item #20) A3: 6/24/20 (Item #31)
The Cheshire Medical Center, Keene, NH	**155405 -B001**	**Keene**	**$1,947,690**	**$1,116,050**	**$3,063,740**	**O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20) A2: 6/24/20 (Item #31)**
Wentworth-Douglass, Hospital, Dover, NH	**177187 -B001**	**Dover**	**$2,769,452**	**$1,339,947**	**$4,109,399**	**O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20) A2: 6/24/20 (Item #31)**
Catholic Medical Center, Manchester, NH	**177240 -B003**	**Greater Manchester**	**$1,948,342**	**$2,970,781**	**$4,919,123**	**O: 3/11/20 (Item #9A)**
Southern New Hampshire Health System, Inc., Nashua, NH	177321 -R004	Greater Nashua	$1,570,988	$0	$1,570,988	O: 3/11/20 (Item #9A)
		Total	**$27,125,987**	**$6,898,532**	**$34,024,519**	

Funds are available in the following accounts for State Fiscal Year 2021, and are anticipated to be available in State Fiscal Years 2022, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

See attached fiscal details.

EXPLANATION

This request is **Retroactive** because sufficient funds in State Fiscal Year 2021 were not available in the operating budget considering the grant amount awarded, and due to delay by the Substance Abuse and Mental Health Services Administration in approving New Hampshire's requests for continued State Opioid Response Grant funding the efforts to add the state appropriations were deferred. This request is **Sole Source** because the contracts were originally approved as sole source and MOP 150 requires any subsequent amendments to be labelled as sole source.

The purpose of this request is to continue providing services through the Doorways by utilizing unexpended funds from the first round of State Opioid Response funding, adding funding from the second round of State Opioid Response, and adding funding to address the needs of individuals with substance use disorders not covered under State Opioid Response.

Approximately 2,000 individuals will be served from September 30, 2020 to September 29, 2021.

The contractors will continue providing a network of Doorways to ensure every resident in New Hampshire has access to substance use disorder treatment and recovery services in person during typical business hours. Additionally, telephonic services for screening, assessment, and evaluations for substance use disorders are available through the Doorways 24 hours, seven (7) days a week, to ensure no one in New Hampshire has to travel more than 60 minutes to access services.

The Doorways' services provide resources to strengthen existing prevention, treatment, and recovery programs; ensure access to critical services to decrease the number of opioid-related deaths in New Hampshire; and promote engagement in the recovery process. Individuals with substance use disorders other than opioids or stimulants are also being seen and referred to the appropriate services by the Doorways.

The Department will monitor contracted services using the following methods:

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

As referenced in Exhibit C-1 Revisions to Standard Contract Language, Paragraph 3. Renewals, or Exhibit A, Revisions to Standard Contract Provisions, Subsection 1 – Revisions to Form P-37, General Provisions, in the case of Catholic Medical Center and Southern New Hampshire Health System, Inc., of the original contracts the parties have the option to extend the agreements for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval. The Department is exercising its option to renew services for one (1) of the two (2) years available.

Should the Governor and Council not authorize this request, individuals seeking treatment for opioid use disorder may experience difficulty navigating a complex system; may not receive the supports and clinical services they need; and may experience delays in receiving care that negatively impact recovery and increase the risk of relapse.

Areas served: Statewide.

Source of Funds: CFDA #93.788, FAIN #H79TI081685 and H79TI083326.

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

Respectfully submitted,

Lori A. Weaver

Lori A. Weaver
Deputy Commissioner

DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY MENTAL HEALTH CENTER CONTRACT AMENDMENTS
SFY 2016 FINANCIAL DETAIL

05-95-92-920510-70400000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: BEHAVIORAL HEALTH DIV OF BUREAU OF DRUG & ALCOHOL SERVICES, STATE OPIOID RESPONSE GRANT 100% Federal Funds CFDA #93.788 FAIN H79TI081685 and H79TI083326

Androscoggin Valley — Vendor # 177220

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 619,850.00	$ (385,600.00)	$ 234,250.00
2020	102/500731	Contracts for Program Services	92057040	$ 848,918.00	$ (195,933.00)	$ 652,985.00
2021	102/500731	Contracts for Program Services	92057040	$ 201,283.00	$ -	$ 201,283.00
2021	102/500731	Contracts for Program Services	92057047	$ -	$ 181,000.00	$ 181,000.00
2021	102/500731	Contracts for Program Services	92057048	$ -	$ 436,666.00	$ 436,666.00
2022	102/500731	Contracts for Program Services	92057048	$ -	$ 218,333.00	$ 218,333.00
		Sub Total		*$ 1,670,051.00*	*$ 254,466.00*	*$ 1,924,517.00*

Concord — Vendor # 177653

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 710,746.00	$ (447,973.00)	$ 262,773.00
2020	102/500731	Contracts for Program Services	92057040	$ 1,325,131.00	$ -	$ 1,325,131.00
2021	102/500731	Contracts for Program Services	92057040	$ 236,916.00	$ -	$ 236,916.00
2021	102/500731	Contracts for Program Services	92057047	$ -	$ 166,000.00	$ 166,000.00
2021	102/500731	Contracts for Program Services	92057048	$ -	$ 400,000.00	$ 400,000.00
2022	102/500731	Contracts for Program Services	92057048	$ -	$ 200,000.00	$ 200,000.00
		Sub Total		*$ 2,272,793.00*	*$ 318,027.00*	*$ 2,590,820.00*

Cheshire — Vendor # 155405

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 615,100.00	$ (3,813.00)	$ 611,287.00
2020	102/500731	Contracts for Program Services	92057040	$ 1,127,557.00	$ -	$ 1,127,557.00
2021	102/500731	Contracts for Program Services	92057040	$ 205,033.00	$ -	$ 205,033.00
2021	102/500731	Contracts for Program Services	92057047	$ -	$ 229,925.00	$ 229,925.00
2021	102/500731	Contracts for Program Services	92057048	$ -	$ 532,304.00	$ 532,304.00
2022	102/500731	Contracts for Program Services	92057048	$ -	$ 266,152.00	$ 266,152.00
		Sub Total		*$ 1,947,690.00*	*$ 1,024,568.00*	*$ 2,972,258.00*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY MENTAL HEALTH CENTER CONTRACT AMENDMENTS
SFY 2016 FINANCIAL DETAIL

Granite Pathways Manchester — Vendor #228900

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 1,331,471.00	$ -	$ 1,331,471.00
2020	102/500731	Contracts for Program Services	92057040	$ 2,349,699.00	$ -	$ 2,349,699.00
2021	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2021	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2021	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2022	102/500731	Contracts for Program Services	92057048	$ -	$ -	$ -
		Sub Total		*$ 3,681,170.00*	*$ -*	*$ 3,681,170.00*

Granite Pathways Nashua — Vendor # 228900

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 1,348,973.00	$ -	$ 1,348,973.00
2020	102/500731	Contracts for Program Services	92057040	$ 1,865,736.00	$ -	$ 1,865,736.00
2021	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2021	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2021	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2022	102/500731	Contracts for Program Services	92057048	$ -	$ -	$ -
		Sub Total		*$ 3,214,709.00*	*$ -*	*$ 3,214,709.00*

Littleton Regional — Vendor # 177162

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 627,250.00	$ (388,115.00)	$ 239,135.00
2020	102/500731	Contracts for Program Services	92057040	$ 882,805.00	$ -	$ 882,805.00
2021	102/500731	Contracts for Program Services	92057040	$ 203,750.00	$ -	$ 203,750.00
2021	102/500731	Contracts for Program Services	92057047	$ -	$ 175,000.00	$ 175,000.00
2021	102/500731	Contracts for Program Services	92057048	$ -	$ 423,333.00	$ 423,333.00
2022	102/500731	Contracts for Program Services	92057048	$ -	$ 211,666.00	$ 211,666.00
		Sub Total		*$ 1,713,805.00*	*$ 421,884.00*	*$ 2,135,689.00*

LRGHealthcare — Vendor # 177161

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 615,000.00	$ (115,000.00)	$ 500,000.00
2020	102/500731	Contracts for Program Services	92057040	$ 1,167,673.00	$ (525,559.00)	$ 642,114.00
2021	102/500731	Contracts for Program Services	92057040	$ 205,000.00	$ -	$ 205,000.00
2021	102/500731	Contracts for Program Services	92057047	$ -	$ 178,000.00	$ 178,000.00
2021	102/500731	Contracts for Program Services	92057048	$ -	$ 430,000.00	$ 430,000.00
2022	102/500731	Contracts for Program Services	92057048	$ -	$ 215,000.00	$ 215,000.00
		Sub Total		*$ 1,987,673.00*	*$ 182,441.00*	*$ 2,170,114.00*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY MENTAL HEALTH CENTER CONTRACT AMENDMENTS
SFY 2016 FINANCIAL DETAIL

Mary Hitchcock — Vendor # 177160

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 1,390,247.00		$ 1,390,247.00
2020	102/500731	Contracts for Program Services	92057040	$ 2,575,109.00		$ 2,575,109.00
2021	102/500731	Contracts for Program Services	92057040	$ 383,958.00		$ 383,958.00
2021	102/500731	Contracts for Program Services	92057047	$ -		$ -
2021	102/500731	Contracts for Program Services	92057048	$ -		$ -
2022	102/500731	Contracts for Program Services	92057048	$ -		$ -
		Sub Total		***$ 4,349,314.00***	***$ -***	***$ 4,349,314.00***

Wentworth Douglass — Vendor # 177187

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ 722,025.00	$ (184,962.00)	$ 537,063.00
2020	102/500731	Contracts for Program Services	92057040	$ 1,806,752.00		$ 1,806,752.00
2021	102/500731	Contracts for Program Services	92057040	$ 240,675.00		$ 240,675.00
2021	102/500731	Contracts for Program Services	92057047		$ 299,000.00	$ 299,000.00
2021	102/500731	Contracts for Program Services	92057048		$ 691,360.00	$ 691,360.00
2022	102/500731	Contracts for Program Services	92057048		$ 345,680.00	$ 345,680.00
		Sub Total		***$ 2,769,452.00***	***$ 1,151,078.00***	***$ 3,920,530.00***

Catholic Medical Center — Vendor # 177240

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ -	$ -	$ -
2020	102/500731	Contracts for Program Services	92057040	$ 1,223,728.00	$ (878,709.00)	$ 345,019.00
2021	102/500731	Contracts for Program Services	92057040	$ 724,614.00	$ -	$ 724,614.00
2021	102/500731	Contracts for Program Services	92057047	$ -	$ 802,501.00	$ 802,501.00
2021	102/500731	Contracts for Program Services	92057048	$ -	$ 1,846,000.00	$ 1,846,000.00
2022	102/500731	Contracts for Program Services	92057048	$ -	$ 923,000.00	$ 923,000.00
		Sub Total		***$ 1,948,342.00***	***$ 2,692,792.00***	***$ 4,641,134.00***

Southern New Hampshire Health Systems, Inc. — Vendor # 177321

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2019	102/500731	Contracts for Program Services	92057040	$ -		$ -
2020	102/500731	Contracts for Program Services	92057040	$ 1,048,716.00		$ 1,048,716.00
2021	102/500731	Contracts for Program Services	92057040	$ 522,272.00		$ 522,272.00
2021	102/500731	Contracts for Program Services	92057047	$ -		$ -
2021	102/500731	Contracts for Program Services	92057048	$ -		$ -
2022	102/500731	Contracts for Program Services	92057048	$ -		$ -
		Sub Total		***$ 1,570,988.00***	***$ -***	***$ 1,570,988.00***
		Total SOR		***$ 27,125,987.00***	***$ 6,045,256.00***	***$ 33,171,243.00***

DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY MENTAL HEALTH CENTER CONTRACT AMENDMENTS
SFY 2016 FINANCIAL DETAIL

05-95-92-920510-33820000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV FOR BEHAVORIAL HEALTH, BUREAU OF DRUG & ALCOHOL SVCS, GOVERNOR COMMISSION FUNDS (100% Other Funds)

Vendor # 177220

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 18,750.00	$ 18,750.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 6,250.00	$ 6,250.00
		Sub Total		$ -	$ *25,000.00*	$ *25,000.00*

Concord — Vendor # 177653

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 73,481.00	$ 73,481.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 24,493.00	$ 24,493.00
		Sub Total		$ -	$ *97,974.00*	$ *97,974.00*

Cheshire — Vendor # 155405

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 68,612.00	$ 68,612.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 22,870.00	$ 22,870.00
		Sub Total		$ -	$ *91,482.00*	$ *91,482.00*

Littleton Regional — Vendor # 177162

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 18,750.00	$ 18,750.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 6,250.00	$ 6,250.00
		Sub Total		$ -	$ *25,000.00*	$ *25,000.00*

LRGHealthcare — Vendor # 177161

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 110,222.00	$ 110,222.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 36,740.00	$ 36,740.00
		Sub Total		$ -	$ *146,962.00*	$ *146,962.00*

Mary Hitchcock — Vendor # 177160

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -		$ -
2022	102/500731	Contracts for Program Services	92058501	$ -		$ -
		Sub Total		$ -	$ -	$ -

Wentworth Douglass — Vendor # 177187

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 141,652.00	$ 141,652.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 47,217.00	$ 47,217.00
		Sub Total		$ -	$ *188,869.00*	$ *188,869.00*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY MENTAL HEALTH CENTER CONTRACT AMENDMENTS
SFY 2016 FINANCIAL DETAIL

Catholic Medical Center — Vendor # 177240

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -	$ 208,492.00	$ 208,492.00
2022	102/500731	Contracts for Program Services	92058501	$ -	$ 69,497.00	$ 69,497.00
		Sub Total		$ -	$ *277,989.00*	$ *277,989.00*

Southern New Hampshire Health Systems, Inc. — Vendor # 177321

State Fiscal Year	Class / Account	Class Title	Job Number	Current Amount	Increase (Decrease)	Revised Amount
2021	102/500731	Contracts for Program Services	92058501	$ -		$ -
2022	102/500731	Contracts for Program Services	92058501	$ -		$ -
		Sub Total		$ -	$ -	$ -
		Total Gov Commisison		$ -	$ *853,276.00*	$ *853,276.00*
		Total All		$ *27,125,987.00*	$ *6,898,532.00*	$ *34,024,519.00*

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 3rd Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #3") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Androscoggin Valley Hospital, Inc, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 59 Page Hill Road, Berlin, NH 03570.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 31, 2018 (Item #17A), as amended on August 28, 2019, (Item #10), and on June 24, 2020, (Item #31) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Paragraph 3. Renewal, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement and increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $1,949,517

3. Modify Exhibit A Amendment #1, Scope of Services, by replacing in its entirety with Exhibit A Amendment #3, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.
4. Modify Exhibit B Amendment #1, Methods and Conditions Precedent to Payment, by replacing in its entirety with Exhibit B Amendment #3, Methods and Conditions Precedent to Payment, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein,.
5. Modify Exhibit B-1, Budget by reducing the total budget amount by $385,600, which is identified as unspent funding of which $181,000 is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020), as specified in Exhibit B-4 Amendment #3 NCE; and of which $204,600 is being carried forward to fund the activities in this Agreement for SFY 21 (January 1, 2021 through June 20, 2021), as specified, in part, in Exhibit B-6 Amendment #3 SOR II.
6. Modify Exhibit B-2, Amendment #1 Budget by reducing the total budget amount by $195,933, which is identified as unspent funding that is being carried forward to fund the activities in this Agreement for SFY 21 (January 1, 2021 through June 20, 2021) in the amount of $195,933, as specified, in part, in Exhibit B-6 Amendment #3 SOR II.
7. Add Exhibit B-4 Amendment #3 NCE, which is attached hereto and incorporated by reference herein.
8. Add Exhibit B-5 Amendment #3 GovComm, which is attached hereto and incorporated by

reference herein.

9. Add Exhibit B-6 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.
10. Add Exhibit B-7 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.
11. Add Exhibit B-8 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective September 29, 2020, upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/5/2021
Date

DocuSigned by:
Katja Fox
Name: Katja Fox
Title: Director

Androscoggin Valley Hospital, Inc.

1/4/2021
Date

DocuSigned by:
Michael Peterson
Name: Michael Peterson
Title: President

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

1/15/2021
Date

DocuSigned by:
[signature]
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

EXHIBIT A – Amendment #3

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. All Exhibits B Amendment #3 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Berlin Region with access to referrals to SUD treatment and recovery support services and other health and social services.

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

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

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

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

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

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

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

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

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

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

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

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

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

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

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

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

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

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

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

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

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff, capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

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

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

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

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

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

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

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

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

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

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

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

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

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

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

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

3.1.10.5.4.1.1. A Doorway client;

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

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

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

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

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

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

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service

provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

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

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

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

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

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

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

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

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

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

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

3.1.11.8.3. Upon discharge from the initially referred service.

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

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

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare,

and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

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

3.3. The Contractor shall provide services in accordance with:

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

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

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

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

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

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

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

4. Subcontracting for the Doorways

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

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

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

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

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

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

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

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

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

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

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

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

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

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

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

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

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

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

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

5.7.4.1. The contract requirements.

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

5.8. The Contractor shall provide staff, subcontractors, or end users as defined in Exhibit K with periodic training in practices and procedures to ensure compliance with information

security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (7) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

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

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

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

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

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

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

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

8. **Reporting Requirements**.

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

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

Contractor Initials MP (DS)

Date 1/4/2021

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

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

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

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

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s)

must collect and share data with the Department in a format specified by the Department.

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

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

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

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

11.4. The Contractor and referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal

management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

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

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

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

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

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

13. Termination Report/Transition Plan

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

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

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

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

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

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

14. Credits and Copyright Ownership

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

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

15. Operation of Facilities: Compliance with Laws and Regulations

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

16. Equal Employment Opportunity Plan (EEOP)

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

17. Equipment Purchases

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

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

18. Compliance with Federal and State Laws

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

18.2. Time and Manner of Determination.

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

18.3. Documentation

18.3.1. In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The

Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

18.4. Fair Hearings

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

Methods and Conditions Precedent to Payment

1. This Agreement is funded by:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI083326.
   1.2. 2.72% Other Funds from Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment Funds.
2. Governor Commission Funds
   2.1. The Contractor shall utilize funds in Exhibit B-5 Amendment #3 GovComm and Exhibit B-7 Amendment #3 GovComm for the purpose of providing services and supports to clients whose needs to not make them eliglbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR §200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit B-1, Budget through Exhibit B-8 Amendment #3 SOR II.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or other payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

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

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

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

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

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

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

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported:

6.1.3.1. Unallowable expenses include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

6.1.3.1.7. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference

grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

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

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

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

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

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

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

11. 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.

12. The Contractor must provide the services in Exhibit A-Amendment #3, Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A, Amendment #3, Scope of Services, including failure to submit required monthly and/or quarterly reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

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

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

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

Contractor Name: Androscoggin Valley Hospital, Inc

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-01

Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 1,200.00	$ -	$ 1,200.00	$ -	$ -	$ -	$ 1,200.00	$ -	$ 1,200.00
2. Employee Benefits	$ 120.00	$ -	$ 120.00	$ -	$ -	$ -	$ 120.00	$ -	$ 120.00
3. Consultants	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ 23,750.00	$ -	$ 23,750.00	$ -	$ -	$ -	$ 23,750.00	$ -	$ 23,750.00
6. Travel	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00	$ -	$ 2,000.00
7. Occupancy	$ 15,000.00	$ -	$ 15,000.00	$ -	$ -	$ -	$ 15,000.00	$ -	$ 15,000.00
8. Current Expenses	$ 180.00	$ -	$ 180.00	$ -	$ -	$ -	$ 180.00	$ -	$ 180.00
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 250.00	$ -	$ 250.00	$ -	$ -	$ -	$ 250.00	$ -	$ 250.00
11. Staff Education and Training	$ 8,000.00	$ -	$ 8,000.00	$ -	$ -	$ -	$ 8,000.00	$ -	$ 8,000.00
12. Subcontracts/Agreements	$ 115,000.00	$ -	$ 115,000.00	$ -	$ -	$ -	$ 115,000.00	$ -	$ 115,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FLEX, client travel, shelter, etc	$ 15,000.00	$ -	$ 15,000.00	$ -	$ -	$ -	$ 15,000.00	$ -	$ 15,000.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 181,000.00	$ -	$ 181,000.00	$ -	$ -	$ -	$ 181,000.00	$ -	$ 181,000.00

Indirect As A Percent of Direct 0.0%

DS
MP
Contractor Initials

Date 1/4/2021

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

Contractor Name: Androscoggin Valley Hospital, Inc

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-01

Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ 6,250.00	$ -	$ 6,250.00	$ -	$ -	$ -	$ 6,250.00	$ -	$ 6,250.00
6. Travel	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
10. Marketing/Communications	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
11. Staff Education and Training	$ 7,000.00	$ -	$ 7,000.00	$ -	$ -	$ -	$ 7,000.00	$ -	$ 7,000.00
12. Subcontracts/Agreements	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00	$ -	$ 2,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 18,750.00	$ -	$ 18,750.00	$ -	$ -	$ -	$ 18,750.00	$ -	$ 18,750.00
Indirect As A Percent of Direct		0.0%							

DS
MP
Contractor Initials

Date 1/4/2021

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

Contractor Name: Androscoggin Valley Hospital, Inc

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-01

Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 3,800.00	$ -	$ 3,800.00	$ -	$ -	$ -	$ 3,800.00	$ -	$ 3,800.00
2. Employee Benefits	$ 380.00	$ -	$ 380.00	$ -	$ -	$ -	$ 380.00	$ -	$ 380.00
3. Consultants	$ 1,000.00	$ -	$ 1,000.00	$ -	$ -	$ -	$ 1,000.00	$ -	$ 1,000.00
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ 40,000.00	$ -	$ 40,000.00	$ -	$ -	$ -	$ 40,000.00	$ -	$ 40,000.00
6. Travel	$ 5,486.00	$ -	$ 5,486.00	$ -	$ -	$ -	$ 5,486.00	$ -	$ 5,486.00
7. Occupancy	$ 40,000.00	$ -	$ 40,000.00	$ -	$ -	$ -	$ 40,000.00	$ -	$ 40,000.00
8. Current Expenses	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
11. Staff Education and Training	$ 20,000.00	$ -	$ 20,000.00	$ -	$ -	$ -	$ 20,000.00	$ -	$ 20,000.00
12. Subcontracts/Agreements	$ 285,000.00	$ -	$ 285,000.00	$ -	$ -	$ -	$ 285,000.00	$ -	$ 285,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FLEX, client travel, shelter,etc	$ 40,000.00	$ -	$ 40,000.00	$ -	$ -	$ -	$ 40,000.00	$ -	$ 40,000.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 436,666.00	$ -	$ 436,666.00	$ -	$ -	$ -	$ 436,666.00	$ -	$ 436,666.00
Indirect As A Percent of Direct		0.0%							

DS
MP
Contractor Initials

Date 1/4/2021

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

Contractor Name: Androscoggin Valley Hospital, Inc

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-01

Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ 3,250.00	$ -	$ 3,250.00	$ -	$ -	$ -	$ 3,250.00	$ -	$ 3,250.00
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00	$ -	$ 2,000.00
11. Staff Education and Training	$ 1,000.00	$ -	$ 1,000.00	$ -	$ -	$ -	$ 1,000.00	$ -	$ 1,000.00
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):		$ -	$ -	$ -	$ -	$ -		$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 6,250.00	$ -	$ 6,250.00	$ -	$ -	$ -	$ 6,250.00	$ -	$ 6,250.00

Indirect As A Percent of Direct 0.0%

DS
MP
Contractor Initials

Date 1/4/2021

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

Contractor Name: Androscoggin Valley Hospital, Inc

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-01

Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00	$ -	$ 2,000.00
2. Employee Benefits	$ 200.00	$ -	$ 200.00	$ -	$ -	$ -	$ 200.00	$ -	$ 200.00
3. Consultants	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ 20,000.00	$ -	$ 20,000.00	$ -	$ -	$ -	$ 20,000.00	$ -	$ 20,000.00
6. Travel	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00	$ -	$ 2,000.00
7. Occupancy	$ 16,000.00	$ -	$ 16,000.00	$ -	$ -	$ -	$ 16,000.00	$ -	$ 16,000.00
8. Current Expenses	$ 133.00	$ -	$ 133.00	$ -	$ -	$ -	$ 133.00	$ -	$ 133.00
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
11. Staff Education and Training	$ 8,000.00	$ -	$ 8,000.00	$ -	$ -	$ -	$ 8,000.00	$ -	$ 8,000.00
12. Subcontracts/Agreements	$ 149,000.00	$ -	$ 149,000.00	$ -	$ -	$ -	$ 149,000.00	$ -	$ 149,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FLEX, client travel, shelter,etc	$ 20,000.00	$ -	$ 20,000.00	$ -	$ -	$ -	$ 20,000.00	$ -	$ 20,000.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 218,333.00	$ -	$ 218,333.00	$ -	$ -	$ -	$ 218,333.00	$ -	$ 218,333.00

Indirect As A Percent of Direct 0.0%

DS
MP
Contractor Initials
Date 1/4/2021

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 ANDROSCOGGIN VALLEY HOSPITAL, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on November 28, 1969. 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: **61184**

Certificate Number: **0005062311**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 29th day of December A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Martha Laflamme, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of Androscoggin Valley Hospital
(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 December 17, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Michael Peterson (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Androscoggin Valley Hosp to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

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

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: Dec 17, 2020

Martha P. Laflamme
Martha P. Laflamme (Dec 17, 2020 08:37 EST)
Signature of Elected Officer
Name:
Title:

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/06/2021

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

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must 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.
c/o 26 Century Blvd
P.O. Box 305191
Nashville, TN 372305191 USA

CONTACT NAME: Willis Towers Watson Certificate Center
PHONE (A/C, No, Ext): 1-877-945-7378 FAX (A/C, No): 1-888-467-2378
E-MAIL ADDRESS: certificates@willis.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: ProSelect Insurance Company	10638
INSURER B: New Hampshire Employers Insurance Company	13083
INSURER C: Associated Industries of Massachusetts Mut	33758
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
North Country Healthcare, Inc
8 Clover Lane
Whitefield, NH 03598

COVERAGES CERTIFICATE NUMBER: W19776561 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: POLICY [ ] PRO-JECT [ ] LOC OTHER:			002NH000032947	10/01/2020	10/01/2021	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ $ 1,000 $ 1,000,000 $ 3,000,000 $
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
A	UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED RETENTION $			002NH000032947	10/01/2020	10/01/2021	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 10,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WM2-800-8007765-2020A	10/01/2020	10/01/2021	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
A	Professional Liability Claims Made & Reported			002NH000032947	10/01/2020	10/01/2021	Claim Limits Aggregate	1,000,000 3,000,000

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

SEE ATTACHED

CERTIFICATE HOLDER

DHHS, State of NH
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

AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

AGENCY		NAMED INSURED
Willis Towers Watson Northeast, Inc.		North Country Healthcare, Inc 8 Clover Lane Whitefield, NH 03598
POLICY NUMBER See Page 1		
CARRIER See Page 1	NAIC CODE See Page 1	EFFECTIVE DATE: See Page 1

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

North Country Healthcare, Inc, Androscoggin Valley Hospital, North Country Home Health & Hospice Agency, Upper Connecticut Valley Hospital, Weeks Medical Center are named insured with respect to the coverage referenced herein.

INSURER AFFORDING COVERAGE: Associated Industries of Massachusetts Mutual Ins Co AIM NAIC#: 33758
POLICY NUMBER: WMZ-800-8007737-2020B EFF DATE: 10/01/2020 EXP DATE: 10/01/2021

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Workers Compensation - NCH	E.L. EACH ACCIDENT	$500,000
	EL DISEASE - EACH EMP	$500,000
Per Statute	E.L. DISEASE - LIMITS	$500,000

INSURER AFFORDING COVERAGE: Associated Industries of Massachusetts Mutual Ins Co AIM NAIC#: 33758
POLICY NUMBER: WMZ-800-8007357-2020A EFF DATE: 10/01/2020 EXP DATE: 10/01/2021

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Workers Compensation- AVH	E.L. EACH ACCIDENT	500,000.00
	EL DISEASE - EACH EMP	500,000.00
Per Statute	E.L. DISEASE - LIMITS	500,000.00

INSURER AFFORDING COVERAGE: New Hampshire Employers Insurance Company NAIC#: 13083
POLICY NUMBER: WMZ-800-8007763-2020A EFF DATE: 10/01/2020 EXP DATE: 10/01/2021

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Workers Compensation-UCVH	E.L. EACH ACCIDENT	500,000.00
	E.L. DISEASE-EACH EMP	500,000.00
Per Statute	E.L. DISEASE - LIMITS	500,000.00

ANDROSCOGGIN VALLEY HOSPITAL
A CRITICAL ACCESS HOSPITAL
BOARD OF DIRECTORS

Vision, Mission, and Organizational Values

August 29, 2019

Purpose

To describe the vision, mission, and organizational values of Androscoggin Valley Hospital.

General

MISSION STATEMENT

Our Mission: To deliver the best healthcare experience for every patient, every day.

VISION STATEMENT

Our Vision: Working TOGETHER, we will be one of the top ten Critical Access Hospitals in the Country, by providing the most compassionate, highest quality care to OUR community.

ORGANIZATIONAL VALUES

The following organizational values support the Vision and Mission Statements:

1. Sense of Ownership: Investing in our work place and culture, as a reflection of ourselves, promoting a safe environment.
2. Collaboration: Working together, encouraging teamwork.
3. Quality: High quality patient-centered holistic care, delivered with compassion and empathy.
4. Integrity: Always doing the right thing; respecting patients and staff. Honesty and transparency; kindness.
5. Flexibility: Accepting change as an opportunity to grow while honoring our past and creating our new legacy.
6. Communication: Listen attentively to understand needs and deliver with courtesy, clarity, and compassion.
7. Service: Exceeding expectations while meeting the changing needs of our community.
8. Accountability: Accepting and taking responsibility for our own actions and feelings, and taking initiative to ensure a safe and supportive workplace.

Rescission

This document rescinds and replaces the Hospital Document, Vision, Mission, and Organizational Values, dated October 26, 2017.

Michael D. Peterson, FACHE
President

Donna Goodrich
Chair, Board of Directors

Review Year	2020		2021		2022		2023	
	Initials	Date	Initials	Date	Initials	Date	Initials	Date
President/CEO								
Chair, Board of Directors								

BerryDunn

[redacted]

NCH north country healthcare | Androscoggin Valley Hospital

CONSOLIDATED FINANCIAL STATEMENTS

and

SUPPLEMENTARY INFORMATION

September 30, 2019 and 2018

With Independent Auditor's Report

[redacted]

BerryDunn

INDEPENDENT AUDITOR'S REPORT

The Board of Directors
Androscoggin Valley Hospital, Inc. and Subsidiaries

We have audited the accompanying consolidated financial statements of Androscoggin Valley Hospital, Inc. and Subsidiaries, which comprise the consolidated balance sheets as of September 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.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Androscoggin Valley Hospital, Inc. and Subsidiaries as of September 30, 2019 and 2018, and the results of their operations, changes in their net assets, and their cash flows for the years ended September 30, 2019 and 2018, in accordance with U.S. generally accepted accounting principles.

The Board of Directors
Androscoggin Valley Hospital, Inc. and Subsidiaries

Change in Accounting Principle

As discussed in Note 1 to the financial statements, in 2019 Androscoggin Valley Hospital, Inc. and Subsidiaries adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2016-14, Not-for-Profit Entities (Topic 958), *Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to this matter.

Other Matter

Other Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. Schedules 1 and 2 are presented for purposes of additional analysis, rather than to present the financial position and results of operations of the individual organizations, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The 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 U.S. generally accepted auditing standards. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
December 10, 2019

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets		
Cash and cash equivalents	$ 9,284,798	$ 8,561,673
Patient accounts receivable, net	4,387,575	5,054,706
Other accounts receivable	2,180,380	2,781,678
Supplies	821,516	724,365
Prepaid expenses and other current assets	742,798	648,621
Total current assets	17,417,067	17,771,043
Assets limited as to use	26,371,048	27,044,488
Property and equipment, net	15,969,243	14,672,211
Other assets	5,734,807	5,379,427
Total assets	$ 65,492,165	$ 64,867,169

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

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities		
Current portion of long-term debt	$ 886,288	$ 1,003,635
Accounts payable and accrued expenses	2,771,568	2,924,682
Accrued salaries and related amounts	2,976,931	3,184,691
Estimated third-party payor settlements	1,066,054	1,058,096
Total current liabilities	7,700,841	8,171,104
Estimated third-party payor settlements	19,023,322	16,978,825
Long-term debt, excluding current portion	6,253,978	7,131,462
Deferred compensation	5,727,618	5,379,427
Total liabilities	38,705,759	37,660,818
Net assets		
Without donor restrictions	26,742,644	27,162,589
With donor restrictions	43,762	43,762
Total net assets	26,786,406	27,206,351
Total liabilities and net assets	$ 65,492,165	$ 64,867,169

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years Ended September 30, 2019 and 2018

	2019	2018
Revenues and gains without donor restrictions		
Patient service revenue (net of contractual allowances and discounts)	$ 59,533,412	$ 60,192,553
Less provision for bad debts	3,314,818	1,722,160
Net patient service revenue	56,218,594	58,470,393
Other revenues	3,335,885	3,285,142
Total revenues and gains without donor restrictions	59,554,479	61,755,535
Operating expenses		
Salaries, wages, and fringe benefits	32,198,252	31,131,790
Contract labor	4,853,994	4,724,051
Supplies and other	17,145,700	15,562,944
Medicaid enhancement tax	2,578,281	2,645,534
Depreciation	2,351,301	2,397,405
Interest	264,321	397,535
Total operating expenses	59,391,849	56,859,259
Operating income	162,630	4,896,276
Nonoperating gains (losses)		
Investment income, net	415,739	1,508,651
Contributions, net	(246,300)	(270,230)
Community benefit grant expense	(440,418)	(1,010,900)
Gain on investment in Great Northwoods Community Foundation	7,189	-
Nonoperating (losses) gains, net	(263,790)	227,521
(Deficiency) excess of revenues and gains over expenses and losses	(101,160)	5,123,797
Net unrealized losses on investments	(318,785)	(1,110,339)
(Decrease) increase in net assets without donor restrictions	$ (419,945)	$ 4,013,458

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

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years Ended September 30, 2019 and 2018

	Net Assets without Donor Restrictions	Net Assets with Donor Restrictions	Total
Balances, October 1, 2017	$ 23,149,131	$ 43,762	$ 23,192,893
Excess of revenues and gains over expenses and losses	5,123,797	-	5,123,797
Net unrealized losses on investments	(1,110,339)	-	(1,110,339)
Net increase in net assets	4,013,458	-	4,013,458
Balances, September 30, 2018	27,162,589	43,762	27,206,351
Deficiency of revenues and gains over expenses and losses	(101,160)	-	(101,160)
Net unrealized losses on investments	(318,785)	-	(318,785)
Net decrease in net assets	(419,945)	-	(419,945)
Balances, September 30, 2019	$ 26,742,644	$ 43,762	$ 26,786,406

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

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years Ended September 30, 2019 and 2018

	2019	2018
Cash flows from operating activities		
(Decrease) increase in net assets	$ (419,945)	$ 4,013,458
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities		
Depreciation and amortization	2,363,841	2,409,945
Net realized and unrealized losses (gains) on investments	115,562	(302,188)
Provision for bad debts	3,314,818	1,722,160
Gain on equity investment	(7,189)	-
(Increase) decrease in		
Patient accounts receivable	(2,647,687)	(1,597,176)
Other accounts receivable	601,298	(1,205,187)
Supplies	(97,151)	(146,111)
Prepaid expenses and other current assets	(94,177)	533,528
Increase (decrease) in		
Accounts payable and accrued expenses	(153,114)	369,880
Accrued salaries and related amounts	(207,760)	1,175,569
Estimated third-party payor settlements	2,052,455	3,909,326
Net cash provided by operating activities	4,820,951	10,883,204
Cash flows from investing activities		
Proceeds from sale of investments	8,619,943	11,623,663
Purchases of investments	(8,062,065)	(11,509,732)
Purchases of property and equipment	(3,648,333)	(2,937,247)
Net cash used by investing activities	(3,090,455)	(2,823,316)
Cash flows from financing activities		
Payments on long-term debt	(1,007,371)	(5,281,757)
Proceeds from issuance of long-term debt	-	185,436
Net cash used by financing activities	(1,007,371)	(5,096,321)
Net increase in cash and cash equivalents	723,125	2,963,567
Cash and cash equivalents, beginning of year	8,561,673	5,598,106
Cash and cash equivalents, end of year	$ 9,284,798	$ 8,561,673
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 253,318	$ 361,150

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

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

September 30, 2019 and 2018

Nature of Business

Androscoggin Valley Hospital, Inc. is a critical access hospital (CAH) providing inpatient, outpatient, emergency care, specialty care and physician/provider services to residents of Berlin, New Hampshire and the surrounding communities. The Hospital's subsidiaries include Northcare, the former parent of the Hospital, an inactive entity, Androscoggin Valley Hospital Foundation, Inc. (Foundation), a company formed to conduct fund-raising activities and manage trusteed investments that support health-related community programs, and Mountain Health Services, Inc. (MHS), which ceased existence during 2019. Androscoggin Valley Hospital, Inc. and Subsidiaries are collectively referred to herein as the "Hospital."

On June 30, 2015, the Hospital along with three other hospitals in the North Country region of New Hampshire, Littleton Regional Hospital, Upper Connecticut Valley Hospital, and Weeks Medical Center, signed an Affiliation Agreement. The Boards of each of the hospitals approved the affiliation documents which consist of an Affiliation Agreement, Management Services Agreement, and proposed Bylaw changes. The application to the New Hampshire Attorney General's office and Charitable Trust Unit was approved in December 2015. On April 1, 2016, the hospitals closed on the formation of the new parent organization, North Country Healthcare. North Country Healthcare was established to coordinate activities of the four hospitals and an affiliated home health operating company. As a result of the affiliation, North Country Healthcare is the parent of the Hospital. Effective September 30, 2019, Littleton Regional Hospital ended its participation in the affiliation.

1. Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of Androscoggin Valley Hospital Inc., Northcare, the Foundation, and MHS. All significant intercompany accounts and transactions have been eliminated in consolidation.

Newly Adopted Accounting Pronouncement

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities (Topic 958)*, which makes targeted changes to the not-for-profit financial reporting model. The ASU marks the completion of the first phase of a larger project aimed at improving not-for-profit financial reporting. Under the ASU, net asset reporting is streamlined and clarified. The previous three category classification of net assets is replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property and equipment has also been simplified and clarified. New disclosures highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. The ASU also imposes several new requirements related to reporting expenses. The ASU is effective for the Hospital for the year ended September 30, 2019. Required disclosures for 2018 are also included in these financial statements.

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

September 30, 2019 and 2018

Basis of Presentation

The financial statements of the Hospital have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which require the Hospital to report information regarding its financial position and activities according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Hospital. These net assets may be used at the discretion of the Hospital's management and the Board of Directors (Board).

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by the actions of the Hospital or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Donor-restricted contributions are reported as increases in net assets with donor restrictions. When a restriction expires, net assets are reclassified from net assets with donor restrictions to net assets without donor restrictions in the consolidated statements of operations and changes in net assets.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash equivalents include short-term investments which have a maturity of three months or less when purchased, and exclude amounts limited as to use by Board designation.

Patient Accounts Receivable

Patient accounts receivable are carried at the amount management expects to collect from outstanding balances.

Patient receivables are periodically evaluated for collectibility based on credit history and current financial condition. Provisions for losses on receivables are determined on the basis of loss experience, known and inherent risks, estimated value of collateral and current economic conditions. The Hospital uses the allowance method to account for uncollectible accounts receivable.

In evaluating the collectibility of accounts receivable, the Hospital analyzes past results and identified trends for each major payor source of revenue for the purpose of estimating the appropriate amounts of the allowance for doubtful accounts and the provision for bad debts. Data in each major payor source are regularly reviewed to evaluate the adequacy of the allowance for doubtful accounts. Specifically, for receivables relating to services provided to patients having third-party coverage, an allowance for doubtful accounts and a corresponding provision for bad debts are established at varying levels based on the age of the receivables and the payor source. For receivables relating to self-pay patients, a provision for bad debts is made in the period services are rendered based on experience indicating the inability or unwillingness of patients to pay amounts for which they are financially responsible. Actual write-offs after management has used reasonable collection efforts are charged against the allowance for doubtful accounts.

Supplies

Supplies are carried at the lower of cost (determined by the first-in, first-out method) or market.

Assets Limited as to Use

Assets limited as to use include designated assets set aside by the Board for future capital improvements over which the Board retains control, and which it may at its discretion subsequently use for other purposes.

Investments and Investment Income

Investments are reported as assets limited as to use and deferred compensation investments. Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the (deficiency) excess of revenues and gains over expenses and losses unless the income or loss is restricted by donor or law. Unrealized gains and temporary unrealized losses on investments are excluded from this measure.

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

Property and Equipment

Property and equipment acquisitions are recorded at cost or, if contributed, at fair value determined at the date of donation, less accumulated depreciation. The Hospital's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the useful lives of the related assets. The provision for depreciation has been computed using the straight-line method at rates which are intended to amortize the cost of assets over their estimated useful lives.

Bond Issuance Costs

The costs incurred to obtain long-term financing are being amortized by the straight-line method over the repayment period of the related debt. The costs are included in long-term debt in the balance sheets.

Employee Fringe Benefits

The Hospital has an "earned time" plan which provides benefits to employees for paid leave hours. Under this plan, each employee earns paid leave for each period worked. These hours of paid leave may be used for vacations, holidays, or illnesses. Hours earned, but not used, are vested with the employee. The Hospital accrues a liability for such paid leave as it is earned. The earned time plan does not cover the providers.

Net Patient Service Revenue

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

Charity Care

The Hospital provides care to patients who meet certain criteria under its community care policy without charge or amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Medicaid Enhancement Tax

The Hospital pays a healthcare provider tax of 5.45% on certain net patient service revenue, which is reported as Medicaid enhancement tax in the statements of operations.

Operating Income

For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported in operating income. Gain or (loss) on disposal of property and equipment and investment income used to fund interest expense and other operating expenses are also included in operating income. Peripheral or incidental transactions and community benefit grants are reported as nonoperating gains (losses), which primarily include certain investment income (losses), contributions and support of community programs and community benefit grants.

Excess (Deficiency) of Revenues and Gains Over Expenses and Losses

The consolidated statements of operations include the excess (deficiency) of revenues and gains over expenses and losses. Changes in unrestricted net assets which are excluded from this measure, consistent with industry practice, include unrealized gains and temporary unrealized losses on investments other than trading securities.

Income Taxes

Androscoggin Valley Hospital, Inc. and Subsidiaries are non-profit organizations as described in Section 501(c)(3) of the Internal Revenue Code and therefore are exempt from federal income taxes on related income.

Subsequent Events

For purposes of the preparation of these financial statements in conformity with U.S. GAAP, management has considered transactions or events occurring through December 10, 2019, which was the date the financial statements were available to be issued.

In November 2019, the Hospital entered into a purchase and sale agreement for the acquisition of a building in Gorham, New Hampshire. The purchase price is $700,000, which management expects to fund through operations. In addition, the Hospital entered into a construction contract to renovate the building with a maximum contract cost of $1,173,000. The project is anticipated to be completed by the end of April 2020.

2. Net Patient Service Revenue and Patient Accounts Receivable

Net Patient Service Revenue

Patient service revenue is reported net of contractual allowances and other discounts as follows for the years ended September 30:

	2019	2018
Patient services		
Inpatient	$ 16,312,754	$ 16,777,686
Outpatient	66,577,468	62,364,452
Provider services	12,310,426	11,793,256
Gross patient service revenue	95,200,648	90,935,394
Less contractual allowances	34,774,213	29,737,655
Less charity care	893,023	1,005,186
Patient service revenue (net of contractual allowances and discounts)	59,533,412	60,192,553
Less provision for bad debts	3,314,818	1,722,160
Net patient service revenue	$ 56,218,594	$ 58,470,393

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

Medicare

The Hospital was granted CAH status. Under CAH status, the Hospital is reimbursed 101% of allowable costs for its inpatient, outpatient, and swing-bed services provided to Medicare beneficiaries. The 101% is currently reduced by a federal sequestration of 2%. For providers and certain lab services, the Hospital is paid on a fee schedule.

The Hospital is reimbursed for cost reimbursable items at tentative rates, with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been settled by the Medicare fiscal intermediary through December 31, 2014.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively-determined rates per day of hospitalization. The prospectively-determined per-diem rates are not subject to retroactive adjustment. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a prior year tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the fiscal intermediary. The Hospital's Medicaid cost reports have been settled by the fiscal intermediary through December 31, 2013.

Provider services are paid based on a fee schedule.

Anthem

Inpatient and outpatient services rendered to Anthem subscribers are reimbursed based on standard charges less a negotiated discount, except for lab, radiology, and physician services which are reimbursed on fee schedules.

The Hospital has also entered into payment agreements with certain other commercial insurance carriers and health maintenance organizations. The basis for payment to the Hospital under these agreements includes prospectively-determined rates, discount from charges and prospectively-determined daily rates.

Revenues from Medicare and Medicaid programs accounted for approximately 50% and 9%, respectively, of the Hospital's net patient revenue for the year ended September 30, 2019 and 48% and 8%, respectively, of the Hospital's net patient revenue for the year ended September 30, 2018. Laws and regulations governing the Medicare and Medicaid programs are extremely

complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. In 2019 and 2018, net patient service revenue increased by approximately $1,141,000 and $1,236,000, respectively, due to changes in prior year estimates and the favorable results of Medicare cost report reopenings and disproportionate share hospital program audits.

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the years ended September 30, 2019 and 2018 totaled $59,533,412 and $27,044,488, respectively, of which $58,710,598 and $26,565,183, respectively, were revenues from third-party payors and $822,814 and $479,305, respectively, were revenues from self-pay patients.

Under the State of New Hampshire's Medicaid program, the Hospital recognizes disproportionate share payment revenue which amounted to $5,028,832 and $8,147,706 for 2019 and 2018, respectively, and is recorded in net patient service revenue. Because the methodologies used to determine disproportionate share payments remain unsettled, the Hospital has reserved a portion of the amounts received.

Long-term estimated third-party payor settlements consist of estimates related to Medicare's potential disallowance of Medicaid enhancement tax as an allowable cost and state disproportionate share pending settlements. Due to unresolved issues at the federal and state levels for both matters, the Hospital has classified the balances as long-term.

Charity Care

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for the services and supplies furnished under its charity care policy, the estimated cost of those services and supplies and equivalent services statistics. For the years ended September 30, 2019 and 2018, 1% of all services, as defined by percentage of gross revenue, was provided on a charity care basis.

The estimated expense incurred to provide charity care for the years ended September 30, 2019 and 2018 was approximately $557,000 and $629,000, respectively. The Hospital estimates its cost of charity care by applying an overall cost to charge ratio to the gross charges foregone.

Patient Accounts Receivable

Patient accounts receivable is stated net of estimated contractual allowances and allowances for doubtful accounts as follows as of September 30:

	2019	2018
Gross patient accounts receivable	**$14,537,293**	$12,982,987
Less: Estimated contractual allowances	**5,982,782**	4,868,634
Estimated allowance for doubtful accounts	**4,166,936**	3,059,647
Net patient accounts receivable	**$ 4,387,575**	$ 5,054,706

The portion representing the estimated allowance for doubtful accounts at September 30 is as follows, with the increase in the allowance attributed to the increase in self-pay accounts receivable:

	2019	2018
Self-pay patients	$ 2,657,582	$ 1,702,704
All other payors	1,509,354	1,356,943
	$ 4,166,936	$ 3,059,647

Self-pay write-offs decreased from $2,145,043 in 2018 to $1,906,792 in 2019. The change resulted from trends experienced in the collection of amounts from self-pay patients and third-party payors and the clean-up of account balances in 2018.

3. Assets Limited as to Use

Assets limited as to use consisted of the following as of September 30:

	2019	2018
Cash, cash equivalents, and short-term investments	$ 1,413,850	$ 4,866,871
U.S. Treasury securities and government-sponsored enterprises	208,892	398,614
Corporate bonds	1,475,029	1,841,708
Exchange traded funds	8,603,963	4,343,163
Mutual funds	14,669,314	15,594,132
	$26,371,048	$27,044,488

Investment income and gains (losses) for assets limited as to use, cash equivalents, and other investments are comprised of the following for the years ended September 30:

	2019	2018
Income		
Interest and dividend income	$ 628,967	$ 533,425
Realized gains on sales of securities	203,223	1,412,527
Management fees	(95,080)	(93,442)
	$ 737,110	$ 1,852,510
Other changes in unrestricted net assets		
Change in net unrealized losses	$ (318,785)	$ (1,110,339)

Investment income is included in the statement of operations as follows:

	2019	2018
Other operating revenue	321,371	343,859
Nonoperating gains	415,739	1,508,651
	$ 737,110	$ 1,852,510

Total gross unrealized losses sustained for less than twelve months and twelve months or longer were approximately $84,500 and $221,100, respectively, on investments held at September 30, 2019. In the opinion of management, no individual unrealized loss as of September 30, 2019 represents an other-than-temporary impairment. The Hospital has both the intent and the ability to hold these securities for the time necessary to recover its cost.

4. Availability and Liquidity of Financial Assets

As of September 30, 2019 and 2018, the Hospital has working capital of $9,716,226 and $9,599,939, respectively, and average days (based on normal expenditures) cash and cash equivalents on hand of 59 and 57, respectively.

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, were as follows as of September 30:

	2019	2018
Cash and cash equivalents	$ 9,284,798	$ 8,561,673
Patient accounts receivable, net	4,387,575	5,054,706
Other receivables, net	2,180,380	2,781,678
Financial assets available at year end for current use	$ 15,852,753	$ 16,398,057

The Hospital has $26,371,048 and $27,044,488 at September 30, 2019 and 2018, respectively, that are designated assets set aside by the Board for future capital improvements. These assets limited as to use are not available for general expenditure within the next year; however, the internally designated amounts could be made available, if necessary. As of fiscal yearend, the Hospital's goal is to maintain cash and assets limited as to use balances to meet 192 days of operating expenses.

5. Fair Value Measurement

FASB Accounting Standards Codification Topic (ASC) 820, *Fair Value Measurement,* defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. FASB ASC 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

Assets and liabilities measured at fair value on a recurring basis, and reconciliations to related amounts reported in the balance sheet, are summarized below.

		Fair Value Measurements at September 30, 2019 Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash, cash equivalents, and short-term investments	$ 1,413,850	$ 1,413,850	$ -	$ -
U.S. Treasury securities and government-sponsored enterprises	208,892	208,892	-	-
Corporate bonds	1,475,029	-	1,475,029	-
Exchange traded funds	8,603,963	8,603,963	-	-
Mutual funds	14,669,314	14,669,314	-	-
Total assets limited as to use reported at fair value	$ 26,371,048	$ 24,896,019	$ 1,475,029	$ -
Investments to fund deferred compensation Mutual funds	$ 5,727,618	$ 5,727,618	$ -	$ -
Total investments to fund deferred compensation	$ 5,727,618	$ 5,727,618	$ -	$ -

	Total	Fair Value Measurements at September 30, 2018 Using Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 4,866,871	$ 4,866,871	$ -	$ -
U.S. Treasury securities and government-sponsored enterprises	398,614	398,614	-	-
Corporate bonds	1,841,708	-	1,841,708	-
Exchange traded funds	4,343,163	4,343,163	-	-
Mutual funds	15,594,132	15,594,132	-	-
Total assets limited as to use measured at fair value	$27,044,488	$25,202,780	$1,841,708	$ -
Investments to fund deferred compensation Mutual funds	$ 5,379,427	$ 5,379,427	$ -	$ -
Total investments to fund deferred compensation	$ 5,379,427	$ 5,379,427	$ -	$ -

The fair value for Level 2 assets is primarily based on quoted prices for similar assets.

6. Property and Equipment

The major categories of property and equipment were as follows as of September 30:

	2019	2018
Land	$ 77,592	$ 77,592
Land improvements	1,520,204	1,523,507
Buildings and fixtures	22,740,345	22,452,111
Fixed equipment	8,204,706	7,482,827
Major moveable equipment	15,662,494	16,852,464
	48,205,341	48,388,501
Less accumulated depreciation	34,993,718	35,056,159
	13,211,623	13,332,342
Construction in progress	2,757,620	1,339,869
	$15,969,243	$14,672,211

The Hospital has various projects included in construction in progress. As of September 30, 2019 there was approximately $1,760,000 related to upgrading of the Hospital's electronic health records reporting system and server. The projects are expected to be completed by November 2020 with an estimated cost to complete of approximately $556,000. All projects are being funded through operations.

7. Other Assets

Other assets consist of the following at September 30:

	2019	2018
Deferred compensation assets	$ 5,727,618	$ 5,379,427
Equity interest in Great Northwoods Community Foundation	7,189	-
	$ 5,734,807	$ 5,379,427

The Hospital owns a 50% interest in Great Northwoods Community Foundation (GNCF). The investment in GNCF is reported in accordance with the equity method.

8. Long-Term Debt

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

	2019	2018
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds, Androscoggin Valley Hospital Issue, Series 2012.		
Term bond, $12,500,000, maturing on April 1, 2022, payable in equal monthly installments of $88,530, including interest at 3.312%.	$ 7,065,519	$ 8,028,123
Capital lease obligation payable in equal monthly installments of $4,272, including interest at 5.20%, through November 2021; collateralized by leased equipment.	105,040	149,807
Total long-term debt, before unamortized bond issuance costs	7,170,559	8,177,930
Unamortized bond issuance costs	(30,293)	(42,833)
	7,140,266	8,135,097
Less current portion	886,288	1,003,635
Long-term debt, excluding current portion	$ 6,253,978	$ 7,131,462

The NHHEFA Revenue Bonds (Androscoggin Valley Hospital Issue, Series 2012) in the amount of $14,500,000 were issued in March 2012 for the purpose of refinancing existing indebtedness and retiring the Hospital's interest rate swap contract. The Revenue Bonds consist of two term bonds in the amounts of $2,000,000 and $12,500,000. The $2,000,000 term bond was paid off in 2019. The term of the remaining bond is ten years (with a five-year renewal option). A negative-negative pledge agreement was provided as security.

The Series 2012 Revenue Bond Agreement contains various restrictive covenants, which include compliance with certain financial ratios and a detail of events constituting defaults. The Hospital is in compliance with these requirements at September 30, 2019.

Scheduled principal repayments on long-term debt are as follows:

Year ending September 30,	Bonds Payable	Capital Lease Obligations
2020 (included in current liabilities)	$ 839,222	$ 51,266
2021	868,472	51,266
2022	5,357,825	8,542
	$ 7,065,519	111,074
Less amount representing interest under capital lease obligations		6,034
		$ 105,040

9. Retirement Plans

The Hospital sponsors a 403(b) retirement plan for their employees. To be eligible to participate in the 403(b) plan, an employee must meet certain requirements as specified in the Plan documents. The amount charged to expense for the 403(b) plan totaled $411,546 and $372,418 for 2019 and 2018, respectively.

In addition, the Hospital maintains a 457(b) deferred compensation plan for certain employees. An asset and liability of $5,727,618 and $5,379,427, respectively, have been recorded related to this plan for 2019 and 2018.

10. Commitments and Contingencies

Malpractice Loss Contingencies

The Hospital insures its medical malpractice risks on a claims-made basis under a policy which covers all employees of the Hospital. A claims-made policy provides specified coverage for claims reported during the policy term. The policy contains a provision which allows the Hospital to purchase "tail" coverage for an indefinite period of time to avoid any lapse in insurance coverage. The Hospital is subject to complaints, claims and litigation due to potential claims which arise in the normal course of doing business. U.S. GAAP require the Hospital to accrue the ultimate cost of malpractice claims when the incident that gives rise to the claim occurs, without consideration of insurance recoveries. Expected recoveries are presented as a separate asset. Amounts accrued under this provision are included in other current accounts receivable and accounts payable and accrued expenses in the balance sheet. The Hospital has evaluated its exposure to losses arising from potential claims and determined necessary accruals. The Hospital has obtained coverage on a claims-made basis and anticipates that such coverage will be available going forward.

Asset Retirement Obligation

FASB ASC 410, *Asset Retirement and Environmental Obligations*, requires entities to record asset retirement obligations at fair value if they can be reasonably estimated. The State of New Hampshire requires special disposal procedures relating to building materials containing asbestos. The Hospital building contains some encapsulated asbestos, but a liability has not been recognized. This is because there are no current plans to renovate or dispose of the building that would require the removal of the asbestos; accordingly, the liability has an indeterminate settlement date and its fair value cannot be reasonably estimated.

Community Benefit Grant

The Hospital and Coos County Family Health Services (CCFHS) have entered into an agreement whereby the Hospital will provide funding in the form of a community benefit grant to CCFHS for the purpose of supporting a portion of the otherwise uncompensated costs incurred by CCFHS for provider services. The terms of the agreement require that the Hospital provide CCFHS with the agreed-upon community benefit grant funds on July 1 of the appropriate grant year. The amount of the community benefit grant to be awarded is determined on an annual basis in accordance with the terms of the agreement. The initial term of the community benefit grant agreement expires July 31, 2023. Grant expense of $440,418 and $1,010,900 was incurred for the years ended September 30, 2019 and 2018, respectively.

The community benefit grant has been negotiated to the following payment schedule, contingent upon CCFHS achieving certain annual encounter levels:

On July 1	Not to Exceed
2019 - 2023	$475,000

In addition, as part of this agreement, the Hospital will establish a Community Initiative Grant Fund that will be used to fund community initiatives designed to provide or enhance healthcare services to the medically underserved residents of Coos County.

11. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients. The mix of receivables from patients and third-party payors was as follows as of September 30:

	2019	2018
Medicare	30 %	30 %
Medicaid	21	17
Commercial insurances and other	31	42
Patients	18	11
	100 %	100 %

The Hospital maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Hospital has not experienced any losses in such accounts. Hospital management believes it is not exposed to any significant risk on cash and cash equivalents.

12. Functional Expenses

The Hospital provides general healthcare services to residents within their geographic locations. Expenses related to providing these services are as follows for the year ended September 30, 2019:

	Program Services	General and Administrative	Total
Salaries, wages, and fringe benefits	$ 26,647,408	$ 5,550,844	$ 32,198,252
Contract labor	4,804,159	49,835	4,853,994
Supplies and other	12,583,775	4,561,925	17,145,700
Medicaid enhancement tax	2,578,281	-	2,578,281
Depreciation	2,168,880	182,421	2,351,301
Interest	264,321	-	264,321
	$ 49,046,824	$ 10,345,025	$ 59,391,849

13. Related Party Transactions

As a member of North Country Healthcare, the Hospital shares in various services with the other member hospitals and the parent. For the years ended September 30, 2019 and 2018, the Hospital billed other member hospitals $2,408,269 and $2,050,190, respectively, and expensed $1,634,077 and $1,726,553, respectively, for shared services. At September 30, 2019 and 2018, the following amounts were due from (to) the affiliates and the parent and are included in other accounts receivable:

	2019	2018
Upper Connecticut Valley Hospital	$ 110,678	$ 137,799
Weeks Medical Center	44,668	98,290
North Country Home Health & Hospice Agency, Inc.	202,333	196,000
North Country Healthcare	215,177	383,695
Total	$ 572,856	$ 815,784

SUPPLEMENTARY INFORMATION

Schedule 1
ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Consolidating Balance Sheets

September 30, 2019
(with comparative totals for September 30, 2018)

ASSETS

	Androscoggin Valley Hospital, Inc.	Northcare	Androscoggin Valley Hospital Foundation, Inc.	Eliminations	**2019 Consolidated**	2018 Consolidated
Current assets						
Cash and cash equivalents	$ 9,284,798	$ -	$ -	$ -	**$ 9,284,798**	$ 8,561,673
Patient accounts receivable, net	4,387,575	-	-	-	**4,387,575**	5,054,706
Other accounts receivable	2,180,380	-	-	-	**2,180,380**	2,781,678
Supplies	821,516	-	-	-	**821,516**	724,365
Prepaid expenses and other current assets	742,798	-	-	-	**742,798**	648,621
Total current assets	17,417,067	-	-	-	**17,417,067**	17,771,043
Due from affiliates	564,005	-	-	564,005	**-**	-
Assets limited as to use	23,683,314	-	2,687,734	-	**26,371,048**	27,044,488
Property and equipment, net	15,969,243	-	-	-	**15,969,243**	14,672,211
Other assets	5,734,807	-	-	-	**5,734,807**	5,379,427
Total assets	$ 63,368,436	$ -	$ 2,687,734	$ 564,005	**$ 65,492,165**	$ 64,867,169

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Consolidating Balance Sheets

September 30, 2019
(with comparative totals for September 30, 2018)

LIABILITIES AND NET ASSETS (DEFICIT)

	Androscoggin Valley Hospital, Inc	Northcare	Androscoggin Valley Hospital Foundation, Inc.	Eliminations	2019 Consolidated	2018 Consolidated
Current liabilities						
Current portion of long-term debt	$ 886,288	$ -	$ -	$ -	**$ 886,288**	$ 1,003,635
Accounts payable and accrued expenses	2,771,568	-	-	-	**2,771,568**	2,924,682
Accrued salaries and related amounts	2,976,931	-	-	-	**2,976,931**	3,184,691
Estimated third-party payor settlements	1,066,054	-	-	-	**1,066,054**	1,058,096
Total current liabilities	7,700,841	-	-	-	**7,700,841**	8,171,104
Estimated third-party payor settlements	19,023,322	-	-	-	**19,023,322**	16,978,825
Long-term debt, excluding current portion	6,253,978	-	-	-	**6,253,978**	7,131,462
Due to affiliates	-	518,580	45,425	564,005	**-**	-
Deferred compensation	5,727,618	-	-	-	**5,727,618**	5,379,427
Total liabilities	38,705,759	518,580	45,425	564,005	**38,705,759**	37,660,818
Net assets (deficit)						
Without donor restrictions	24,662,677	(518,580)	2,598,547	-	**26,742,644**	27,162,589
With donor restrictions	-	-	43,762	-	**43,762**	43,762
Total net assets (deficit)	24,662,677	(518,580)	2,642,309	-	**26,786,406**	27,206,351
Total liabilities and net assets (deficit)	$ 63,368,436	$ -	$ 2,687,734	$ 564,005	**$ 65,492,165**	$ 64,867,169

ANDROSCOGGIN VALLEY HOSPITAL, INC. AND SUBSIDIARIES

Schedule 2

Consolidating Statements of Operations

Year Ended September 30, 2019
(with comparative totals for the year ended September 30, 2018)

	Androscoggin Valley Hospital, Inc.	Androscoggin Valley Hospital Foundation, Inc.	Mountain Health Services, Inc.	Eliminations	2019 Consolidated	2018 Consolidated
Revenues and gains without donor restrictions						
Patient service revenue (net of contractual allowances and discounts)	$ 59,533,412	$ -	$ -	$ -	**$ 59,533,412**	$ 60,192,553
Less provision for bad debts	3,314,818	-	-	-	**3,314,818**	1,722,160
Net patient service revenue	56,218,594	-	-	-	**56,218,594**	58,470,393
Other revenues	3,272,351	63,534	-	-	**3,335,885**	3,285,142
Revenues and gains without donor restrictions	59,490,945	63,534	-	-	**59,554,479**	61,755,535
Operating expenses						
Salaries, wages, and fringe benefits	32,198,252	-	-	-	**32,198,252**	31,131,790
Contract labor	4,853,994	-	-	-	**4,853,994**	4,724,051
Supplies and other	17,145,700	-	-	-	**17,145,700**	15,562,944
Medicaid enhancement tax	2,578,281	-	-	-	**2,578,281**	2,645,534
Depreciation and amortization	2,351,301	-	-	-	**2,351,301**	2,397,405
Interest	264,321	-	-	-	**264,321**	397,535
Total operating expenses	59,391,849	-	-	-	**59,391,849**	56,859,259
Operating income	99,096	63,534	-	-	**162,630**	4,896,276
Nonoperating gains (losses)						
Investment income, net	372,929	42,810	-	-	**415,739**	1,508,651
Contributions, net	(191,826)	(54,474)	-	-	**(246,300)**	(270,230)
Community benefit grant expense	(440,418)	-	-	-	**(440,418)**	(1,010,900)
Gain on investment in Greater Northwoods Community Foundation	7,189	-	-	-	**7,189**	-
Nonoperating (losses) gains, net	(252,126)	(11,664)	-	-	**(263,790)**	227,521
(Deficiency) excess of revenues and gains over expenses and losses	(153,030)	51,870	-	-	**(101,160)**	5,123,797
Net unrealized losses on investments	(233,129)	(85,656)	-	-	**(318,785)**	(1,110,339)
Equity transfer	70,688	-	(70,688)	-	**-**	-
(Decrease) increase in net assets without donor restrictions	$ (315,471)	$ (33,786)	$ (70,688)	$ -	**$ (419,945)**	$ 4,013,458

NCH north country healthcare | Androscoggin Valley Hospital

COMPOSITION OF AVH BOARD of Trustees
2020-2021

AVH Board of Directors

Donna Goodrich, *Chair* (Independent) - 2023

Jay Poulin, *Vice-Chair* (Independent) - 2021

Max Makaitis, *Treasurer* (Independent) - 2023

Martha Laflamme, *Secretary* (Independent) - 2022

Louise Belanger (Independent) - 2021

Javier Cardenas, MD (Dependent) - 2022

Jerry Rittenhouse, MD (Dependent, *Med Staff Pres*.)

Eric Johnson (Independent) - 2021

Randall Labnon (Independent) - 2021

Thomas McCue (Independent) - 2021

Michael Peterson (Dependent, *Hospital President/CEO*)

Daniel van Buren, MD (Dependent) - 2023

Tim Godin (Independent) - 2022

Joan Merrill (Independent) - 2023

Sarah Verney Frechette (Independent) - 2023

EFFECTIVE DATE: September 17, 2020

Christine Fortin

[redacted]

Objective

Achieve a high level of performance in billing for both hospital and professional services through directing and managing the entire billing process to maximize revenue and decrease denials.

Education

JOHNSON STATE COLLEGE, JOHNSON, VERMONT

- Major: Accounting
- Practice Management Certification
- CPC, COC

Experience

Weeks Medical Center , Lancaster NH August 2018 to Current
Practice manager
Behavioral Health and North Country Recovery Center

Provide direct oversight and leadership to Behavioral Health multiple sites

North Country Hospital , Newport VT September 1993 – August 2018
Director Patient Financial Services and Patient Access 1999 - 2018
Practice Management 1993 – 1999

Responsible for developing and maintaining controls within Patient Financial Services. Continually reviewed processes to improve revenue cycle outcomes relative to increased efficiencies, proper payment per contracts, decreased denials, and coordination between departments to capture revenue. Provided leadership and operational oversight for Patient Access Staff including Emergency Department. Prior to 1999 managed medical practices including the following OB/Gyn, Orthopaedics, Urology, Behavioral Health, Neurology and Primary care. Assigned Practices as needed on interim bases as well.

North Country Ob/GYN Services, Newport VT July 1989 – September 1993
Practice Manager

Skills & Abilities

PROBLEM SOLVING

- Combine patience, determination, and persistence to troubleshoot issues
- Dynamic, results-oriented problem solver
- Handling complaints from patients regarding services/ billing.
- Skilled at evaluating options and generating solutions
- Strong problem-solving and analytic skills

National Medical Services

Lydia McKenzie, PMHNP

[redacted]

• Obtain a full-time position as a Psychiatric Mental Health Nurse Practitioner in the outpatient and/or inpatient setting.

Work Experience

Specialist in Poison Information

Banner Poison and Drug Information Center - Phoenix, AZ January 2014 to Present

Manage poison and drug exposure calls from the public and health care facilities by telephone. Recommend treatment modalities to physicians and nurses based upon reported history, physical assessment, vital signs and laboratory results. Determine criteria for medical clearance for Emergency Department and hospitalized patients Also receive intake calls for occupational health post-exposure prophylaxis as well as calls for the Health Department disease reporting line and assisting with calls on current public health issues. Critical thinking and autonomy in decision-making is expected. Protocols are not used.

Adjunct Faculty

Phoenix College School of Nursing - Phoenix, AZ August 2013 to May 2015

Adjunct faculty for associate degree nursing program, working primarily with senior nursing students in the ICU setting, skills lab and simulation hospital.

Staff nurse

Banner Good Samaritan Medical Center - Phoenix, AZ Jan 2011 to Jan 2014

in Level 1 Trauma Center teaching facility. Primary care, assessment and evaluation of adult critical care patients in the medical/surgical, neurological, cardiovascular and trauma intensive care setting. Provided relief staffing for the ICU SWAT position as an expert critical care nurse, including troubleshooting of lines and equipment, post-cardiac arrest hypothermia protocol, RN leader of Rapid Response Team, IV insertion using ultrasound, external jugular IV insertion and difficult IV insertions in both the ICU and medical/surgical floor.

Travel nurse

Fastaff Travel Nursing - Greenwood Village, CO Jan 2003 to Oct2010

in both emergency and critical care. Diverse settings including small rural critical access hospitals to large urban tertiary care facilities across the United States. Worked in all ICU specialty units including Burn ICU. Provided high-level care with a minimum of orientation time and limited familiarity with equipment.

Staff nurse

Iowa Methodist Medical Center - Des Moines, IA Dec 2005 to Dec 2007

in Level 1 Trauma center in the critical care setting. Provided care to adult medical/surgical, neurological, cardiovascular and trauma patients in a family focused environment. Completed a critical care nursing course as part of the orientation process. Functioned in both full-time and per diem capacity.

Travel nurse

American Mobile Healthcare - San Diego, CA Feb2000 to Dec 2002

in emergency nursing in a variety of settings ranging from small critical access hospitals to high volume inner city emergency departments. High-functioning with minimal orientation and limited

familiarity with equipment. Provided care to both adult and pediatric patients.

Staff nurse in busy community based emergency department
Lakeland Medical Center - Niles, MI Jan 1997 to March 2000
Provided care to both adult and pediatric patients. Class on cardiac rhythm identification completed as part of the orientation process.

Education

DNP in Psychiatric Mental Health Nurse Practitioner
University of Arizona - Tucson, AZ Aug 2015 to Aug 2018

M.S. in Law Enforcement
Grand Canyon University - Phoenix, AZ 2014

BSN
Grand Canyon University - Phoenix, AZ 2011 to Nov 2012

AAS in Registered Nursing
Southwestern Michigan College - Dowagiac, MI Dec 1996

A.A. in Law Enforcement
Kalamazoo Valley Community College - Kalamazoo, MI 1994

Skills

Certified Specialist in Poison Information

Certifications/Licenses

Registered Nurse State of Arizona

Laurie Collins

[redacted]

Education

WHITE MOUNTAIN COMMUNITY COLLEGE, Littleton NH
2017-2018
White Mountain Community College
Medical Assistant Program

PLYMOUTH STATE UNIVERSITY, Plymouth NH
2012-2013
Master of Education Curriculum and Instruction with a Concentration in K-12 Education

GRANITE STATE COLLEGE, Concord NH
2009-2011
Advanced Endorsements
Learning Disabilities
Emotional Behavioral Disorders
Intellectual and Developmental Disabilities
Certification for Early Childhood Special Education

OFFICE OF EDUCATION PROGRAMS, Concord NH
2007-2008
Special Education Teacher Training (SETT) Program

GRANITE STATE COLLEGE, Concord NH
2007
Bachelors in Child and Family Studies
Summa Cum Laude

HESSER COLLEGE, Manchester NH
1995
Associates in Criminal Justice
Magna Cum Laude
Phi Theta Kappa Honor Society

Experience

Weeks Medical Center, Lancaster, NH
NCRC Team Leader
Doorway At Androscoggin Valley Hospital Team Leader
December 2017- Current

- The MAT/Behavioral Health Team Leader will work full time and is responsible for clinical quality, oversight, coordination, and standardization of the MAT and Behavioral Health Teams.
- The MAT/Behavioral Health Team Leader is responsible for optimizing work flow, improving efficiency as well as overseeing clinical issues and ensuring day-to-day functions within the teams is well maintained.
- The MAT/Behavioral Health Team Leader also works as a member of the clinical team and is responsible for utilizing the Nursing Process to ensure that quality care is provided to patients of the Behavioral Health Team as well as those patients enrolled in the North Country Recovery Center program.
- She/he will oversee other non-provider team members in the provision of care to patients with behavioral health and substance misuse/addiction.

- Follows and promotes best practices in the treatment of healthcare and addiction.

Weeks Medical Center, Lancaster, NH
Behavioral Health Case Manager
November 2017-December 2017

- Perform appropriate interviews and case management assessments
- Identify related client specific plans, goals and methodology
- Develop and facilitate client specific services
- Monitor in various community based settings while working with a wide range of ages, and with individuals, groups and families, from diverse backgrounds and cultural orientations
- Conduct and record as assigned, face-to-face interviews with collateral and networking contacts, maintaining correspondence and case records in accordance with agency and regulatory standards and requirements
- Participate in inter- and intra-agency planning and service coordination to improve and enhance service continuity and effectiveness
- Medication monitoring in the community, where and when relevant and approved by medical staff, and documenting all relevant information
- Participate in regular interdisciplinary staff meetings and provide reports as assigned
- Possess knowledge of consumer rights, confidentiality laws and related policy and procedure
- Document and chart professionally
- Maintain effective community and interagency relations

Indian Stream Health Center, Colebrook, NH
Behavioral Health Case Manager
June 2016-November 2017

- Perform appropriate interviews and case management assessments
- Identify related client specific plans, goals and methodology
- Develop and facilitate client specific services
- Monitor in various community based settings while working with a wide range of ages, and with individuals, groups and families, from diverse backgrounds and cultural orientations
- Conduct and record as assigned, face-to-face interviews with collateral and networking contacts, maintaining correspondence and case records in accordance with agency and regulatory standards and requirements
- Participate in inter- and intra-agency planning and service coordination to improve and enhance service continuity and effectiveness
- Medication monitoring in the community, where and when relevant and approved by medical staff, and documenting all relevant information
- Participate in regular interdisciplinary staff meetings and provide reports as assigned
- Possess knowledge of consumer rights, confidentiality laws and related policy and procedure
- Document and chart professionally
- Maintain effective community and interagency relations

Colebrook Elementary School, Colebrook, NH
Pre-School Teacher/Special Educator/Case Manager
September 2011-June 2016

- Planning and implementing Preschool Curriculum
- Supervision of paraprofessionals
- Working with and developing curriculum for children with special needs within the preschool setting

Teacher, Case Manager
March 21, 2006-June 2016

- Planned curriculums
- Supervised of Paraprofessionals
- Provided resources for children with special needs
- Managed IEP meetings with all accompanying paperwork
- Collaborated with regular education teachers to develop and implement Individual Education Plans and 504 Plan

Paraprofessional
December 2, 2003-March 20, 2006

- Assisted students with activities initiated by the teachers.
- Supervised students during special activities as well as lunch, recess and hallway duties as requested by the supervisor
- Reinforced learning in small groups
- Assisted the teacher with everyday tasks such as observing, recording or charting behavior
- Carried out instructional programs

Special Training and Certifications

- Certified Medical Assistant
- MOAB (Management of Aggressive Behavior)
- Certified CPR/1st Aid
- Certified Nonviolent Crisis Intervention
- Master of Education degree
- Certification in Early Childhood Special Education
- Advanced Endorsement Certification for Emotional Behavioral Disorders
- Advanced Endorsement Certification for Learning Disabilities
- Advanced Endorsement for Intellectual and Developmental Disabilities
- Certified Trainer for Suicide Prevention
- Certified Teacher Elementary Education K-6
- Certified General Special Education Teacher

References furnished upon request

Rona Glines

Experience

1994-Present Weeks Medical Center Lancaster, NH

Vice President of Physician and Administrative Services

- Responsible for Physician Services, Case Management, Health Information Management and Admitting/Communications.
- Integrated the functions of physician offices and other departments within the organization.
- Responsible for implementation of clinical and financial computer applications for the physician offices and Health Information Management.
- Responsible for implementing an enterprise-wide Department of Case Management.

1985–1994 Weeks Memorial Hospital Lancaster, NH

Patient Accounts Manager/Assistant Director of Fiscal Services

- Responsible for the day-to-day operation of the patient accounting department.
- Ensured adequate cash flow to meet organizational needs.
- Responsible for implementation and upgrade of computerized financial system.
- Assisted managers with completion of departmental budgets.

1980-1985 M&R Glines Auctions Lancaster, NH

Auctioneer/Appraiser

- Responsible for business management functions.
- Set-up and conducted auction sales.
- Performed estate and insurance appraisals for clients.

Education

1985 Plymouth State University Plymouth, NH

- B.S., Business Administration and Computer Science.
- Graduated Summa Cum Laude.

Interests

Antiques, Camping

References

Available upon request.

Scott Parent, BS, LADC, CCS (State of Maine)

[redacted]

OBJECTIVE:

To obtain a full time position treating people negatively impacted by Substance Use/ Co-Occurring Disorders, by assisting them in developing healthier skills and supports they can use to improve their stability, functioning and lives.

EXPERIENCE:

Crisis & Counseling Centers

10 Caldwell Road, Augusta, ME 04330

March 2019 - Present

Substance Abuse/ MEPP Clinician (Outpatient SA Program)

Position responsibilities include:

*Providing Assessment, Screening, Referral and Treatment Services for Substance Use Disorder Patients in the Outpatient/ MEPP program.

*Completing Bio-Psycho Social Assessment to determine appropriateness for treatment for patients referred by DEEP, DHHS/ CPS & Criminal Justice.

*Providing Motivational Interviewing, Person Centered and Behavioral Techniques for patients receiving Individual, Group and/ or IOP services.

*Competently completing agency paperwork to document patient's needs, goals and progress to provide quality care, while meeting administrative targets.

*Providing Comprehensive Patient Care through Coordinating with Internal/ External providers, supports and resources.

Scott Parent, BS, LADC, CCS

[redacted]

EXPERIENCE:

Acadia Health Care – Discovery House

400 Western Avenue, South Portland, ME 04106

August 2016 – March 2019

LADC – Lead Substance Abuse Counselor (Suboxone Program)

Position responsibilities include:

*Providing Treatment for Opioid and Other Substance Use Disorder Patients in the Methadone Maintenance & Suboxone Opioid Health Home programs.

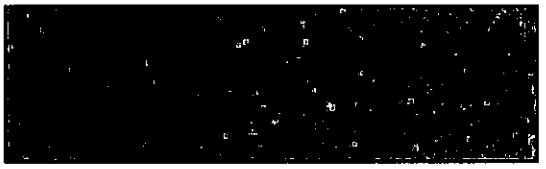
*Completing Bio-Psycho Social Assessment to determine appropriateness for Patients seeking admission to the Suboxone/ Methadone MAT programs.

*Providing Motivational Interviewing, Person Centered and Behavioral Techniques for patients receiving Individual, Group and/ or IOP services.

*Collaborating as part of the care team to provide services in the Suboxone Program and in development of the Opioid Health Homes Program.

*Providing Comprehensive Patient Care through Coordinating with Internal/ External providers, supports and resources.

Scott Parent, BS, LADC, CCS



EXPERIENCE:

Northern Human Services/ White Mountain Mental Health

29 Maple Street, PO Box 599, Littleton, NH 03561

December 2012 – August 2016

LADC - Case Manager / MH Court / Substance Use Disorder Counselor

Position responsibilities include:

*Providing Assessment, Planning, Monitoring and Referral services for Community Support/ MH Court clients to assist them in meeting identified goals.

*Completing Comprehensive Bio-Psycho Social Assessments and Co-Occurring Treatment for clients referred by the MH Court Program.

*Providing Case Management, MH Functional Support and Substance Abuse Treatment for clients in the Community Support and MH Court programs.

*Completing Court Ordered Alcohol and Drug Assessments to determine appropriateness for Substance Abuse and/ or Mental Health Services.

*Competently completing agency paperwork to document client's needs, goals and progress in order to provide quality of care and meet administrative targets.

*Providing Emergency and Crisis Stabilization Services as part of the Clinical Crisis Team to support clients in addressing acute Mental Health crisis needs.

Scott Parent, BS, LADC, CCS

[redacted]

EXPERIENCE:

Aroostook Mental Health Center

PO Box 1018, Caribou, ME 04736

January 1999 - September 2012

LADC - Substance Use Disorder / Community Integration Counselor

Position responsibilities included:

*Providing Assessment and Treatment for clients in the Suboxone clinic to assist them in addressing their Co-Occurring needs.

*Utilizing Motivational Interviewing, 12 Step, Strengths based and Behavioral approaches to assist clients to meet their identified treatment and recovery goals.

*Providing Treatment through use of Individual, Group & IOP services.

*Providing DEEP Assessments and Substance Disorder Treatment to address identified problems and meet DEEP Treatment requirements.

*Providing Community Support Services to assist clients with Chronic/ Severe Mental Illness to improve their functioning at home, work and in the community.

*Completing and Maintaining accurate clinical records and documentation.

*Completing Emergency Services Evaluations and Crisis Stabilization Services for clients experiencing acute Mental Health Crisis.

CONTRACTOR NAME

Key Personnel

Androscoggin Valley Hospital
2020 12

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Christine Fortin	Program Director	126297.00	75%	94723.00
Lydia McKenzie	Psych Nurse Practitioner	214500.00	50%	107250.00
Scott Parent	Licensed Alcohol Counselor	78021.00	100%	78021.00
Laurie Collins	MA, Team Leader	67142.00	66 %	40285.44

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 3rd Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #3") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Concord Hospital, Inc., (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 250 Pleasant Street, Concord, NH 03301.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 31, 2018 (Item #17A), as amended on August 28, 2019, (Item #10), and on June 24, 2020, (Item #31) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Paragraph 3. Renewal, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement and increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $2,688,794.

3. Modify Exhibit A Amendment #2, Scope of Services, by replacing in its entirety with Exhibit A Amendment #3, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.

4. Modify Exhibit B Amendment #2, Methods and Conditions Precedent to Payment, by replacing in its entirety with Exhibit B Amendment #4, Methods and Conditions Precedent to Payment, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein.

5. Modify Exhibit B-1, Budget by reducing the total budget amount by $447,973, which is identified as unspent funding of which $166,000 is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020) of which . specified in Exhibit B-4 Amendment #3 NCE; and of which $281,973 is being carried forward to fund the activities in this Agreement for SFY 21 (January 1, 2021 through June 20, 2021) as specified, in part, in Exhibit B-6 Amendment #3 SOR II.

6. Add Exhibit B-4 Amendment #3 NCE, which is attached hereto and incorporated by reference herein.

7. Add Exhibit B-5 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.

8. Add Exhibit B-6 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

9. Add Exhibit B-7 Amendment #3 GovComm, which is attached hereto and incorporated by

reference herein.

10. Add Exhibit B-8 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective retroactive to September 29, 2020, upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/29/2020
Date

DocuSigned by:
Katja Fox
ED0D05B04C83442...
Name: Katja Fox
Title: Director

Concord Hospital, Inc.

12/28/2020
Date

DocuSigned by:
Robert P. Steigmeyer
8DD5DBFF8EA8426...
Name: Robert P. Steigmeyer
Title: President & CEO

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/30/2020
Date

DocuSigned by:
D5CA9202E32C4AE...
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. All Exhibits B Amendment #3 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Concord Region with access to referrals to SUD treatment and recovery support services and other health and social services.

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

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

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

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

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

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

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

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

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

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

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

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

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

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

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

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

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

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

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

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

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff, capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

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

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

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

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

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

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

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

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

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

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

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

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

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

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

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

3.1.10.5.4.1.1. A Doorway client;

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

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

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

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

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

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

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service

provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

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

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

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

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

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

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

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

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

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

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

3.1.11.8.3. Upon discharge from the initially referred service.

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

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

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare,

and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

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

3.3. The Contractor shall provide services in accordance with:

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

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

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

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

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

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

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

4. Subcontracting for the Doorways

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

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

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

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

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

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

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

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

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

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

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

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

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

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

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

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

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

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

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

5.7.4.1. The contract requirements.

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

5.8. The Contractor shall provide staff, subcontractors, or end users as defined in Exhibit K with periodic training in practices and procedures to ensure compliance with information

security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (7) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

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

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

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

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

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

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

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

8. **Reporting Requirements.**

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

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

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

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

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

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

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s)

must collect and share data with the Department in a format specified by the Department.

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

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

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

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

11.4. The Contractor and referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal

management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

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

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

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

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

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

13. Termination Report/Transition Plan

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

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

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

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

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

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

14. Credits and Copyright Ownership

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

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

15. Operation of Facilities: Compliance with Laws and Regulations

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

16. Equal Employment Opportunity Plan (EEOP)

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

17. Equipment Purchases

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

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

18. Compliance with Federal and State Laws

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

18.2. Time and Manner of Determination.

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

18.3. Documentation

18.3.1. In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The

Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

18.4. Fair Hearings

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

Methods and Conditions Precedent to Payment

1. This Agreement is funded by:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN TI083326..
   1.2. 2.72% Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery Funds.
2. Governor Commission Funds
   2.1. The Contractor shall utilze funds in Exhibit B-5 Amendment #3 GovComm and Exhibit B-7 Amendment #3 GovComm for the purpose of providing services and supports to clients whose needs to not make them eliglbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit B-1, Budget through Exhibit B-8 Amendment #3 SOR II.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or other payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.
      5.3.2. Medicaid Fee for Service: The Contractor shall bill Medicaid for services on the Fee for Service (FFS) schedule.

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

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

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

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

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

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported:

6.1.3.1. Unallowable expenses include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

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

exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

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

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

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

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

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

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

11. 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.

12. The Contractor must provide the services in Exhibit A – Amendment #3, Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A, Amendment #3, Scope of Services, including failure to submit required monthly and/or quartery reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years

and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

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

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

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

Contractor Name: Concord Hospital, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-03

Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	86,923	8,892	95,815				86,923	8,892	95,815
2. Employee Benefits	29,879	2,988	32,867				29,879	2,988	32,867
3. Consultants									
4. Equipment:	1,198	120	1,318				1,198	120	1,318
5. Supplies:	777	78	855				777	78	855
6. Travel	436	44	479				436	44	479
7. Occupancy	14,161	1,416	15,577				14,161	1,416	15,577
8. Current Expenses	9,651	985	10,636				9,651	985	10,636
9. Software	545	54	599				545	54	599
10. Marketing/Communications	1,089	109	1,198				1,089	109	1,198
11. Staff Education and Training	381	38	419				381	38	419
12. Subcontracts/Agreements	436	44	479				436	44	479
13. Other (specific details mandatory):									
Naloxone	100	10	110				100	10	110
Flex funds	2,284	228	2,513				2,284	228	2,513
Shelter Respite Vouchers	3,050	305	3,355				3,050	305	3,355
TOTAL	$ 150,909	$ 15,091	$ 166,000				$ 150,909	$ 15,091	$ 166,000
Indirect As A Percent of Direct		10.0%							

Contractor Initials RPS

Date 12/28/2020

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

Contractor Name: Concord Hospital, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-03
Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	34,592	3,459	38,051				34,592	3,459	38,051
2. Employee Benefits	11,891	1,189	13,080				11,891	1,189	13,080
3. Consultants									
4. Equipment:	477	48	525				477	48	525
5. Supplies:	309	31	340				309	31	340
6. Travel	173	17	191				173	17	191
7. Occupancy	5,635	564	6,199				5,635	564	6,199
8. Current Expenses	2,728	273	3,001				2,728	273	3,001
9. Software	217	22	238				217	22	238
10. Marketing/Communications	433	43	477				433	43	477
11. Staff Education and Training	152	15	167				152	15	167
12. Subcontracts/Agreements	173	17	191				173	17	191
13. Other (specific details mandatory):									
Naloxone									
Flex funds	8,806	881	9,687				8,806	881	9,687
Shelter Respite Vouchers	1,214	121	1,335				1,214	121	1,335
TOTAL	$ 66,801	$ 6,680	$ 73,481				$ 66,801	$ 6,680	$ 73,481
Indirect As A Percent of Direct		10.0%							

Contractor Initials RPS
Date 12/28/2020

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

Contractor Name: Concord Hospital, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-03
Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	177,730	17,773	195,503				177,730.18	17,773	195,503
2. Employee Benefits	61,093	6,109	67,202				61,092.73	6,109	67,202
3. Consultants									
4. Equipment:	2,450	245	2,695				2,449.96	245	2,695
5. Supplies:	1,589	159	1,748				1,589.32	159	1,748
6. Travel	891	89	980				890.89	89	980
7. Occupancy	28,954	2,895	31,849				28,954.05	2,895	31,849
8. Current Expenses	10,648	1,065	11,711				10,646.18	1,065	11,711
9. Software	1,114	111	1,225				1,113.62	111	1,225
10. Marketing/Communications	2,227	223	2,450				2,227.23	223	2,450
11. Staff Education and Training	780	78	857				779.53	78	857
12. Subcontracts/Agreements	891	89	980				890.89	89	980
13. Other (specific details mandatory):									
Naloxone	55,598	5,560	61,158				55,598.04	5,560	61,158
Flex funds	13,437	1,344	14,781				13,437.49	1,344	14,781
Shelter Respite Vouchers	6,236	624	6,860				6,236.26	624	6,860
TOTAL	$ 363,636	$ 36,364	$ 400,000				$ 363,636	$ 36,364	$ 400,000
Indirect As A Percent of Direct		10.0%							

Contractor Initials RPS

Date 12/28/2020

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

Contractor Name: Concord Hospital, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-03
Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	11,530	1,153	12,684				11,530	1,153	12,684
2. Employee Benefits	3,964	396	4,360				3,964	396	4,360
3. Consultants									
4. Equipment:	159	16	175				159	16	175
5. Supplies:	103	10	113				103	10	113
6. Travel	58	6	64				58	6	64
7. Occupancy	1,878	188	2,066				1,878	188	2,066
8. Current Expenses	909	91	1,000				909	91	1,000
9. Software	72	7	79				72	7	79
10. Marketing/Communications	144	14	159				144	14	159
11. Staff Education and Training	51	5	56				51	5	56
12. Subcontracts/Agreements	58	6	64				58	6	64
13. Other (specific details mandatory):									
Naloxone			-						-
Flex funds	2,935	294	3,229				2,935	294	3,229
Shelter Respite Vouchers	405	40	445				405	40	445
TOTAL	22,266	2,227	24,493				$ 22,266	$ 2,227	$ 24,493
Indirect As A Percent of Direct		10.0%							

Contractor Initials RPS
Date 12/28/2020

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

Contractor Name: Concord Hospital, Inc.

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-03
Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	88,865	8,887	97,752				88,865	8,887	97,752
2. Employee Benefits	30,546	3,055	33,601				30,546	3,055	33,601
3. Consultants									
4. Equipment:	1,225	122	1,347				1,225	122	1,347
5. Supplies:	795	79	874				795	79	874
6. Travel	445	45	490				445	45	490
7. Occupancy	14,477	1,448	15,925				14,477	1,448	15,925
8. Current Expenses	5,323	532	5,855				5,323	532	5,855
9. Software	557	56	612				557	56	612
10. Marketing/Communications	1,114	111	1,225				1,114	111	1,225
11. Staff Education and Training	390	39	429				390	39	429
12. Subcontracts/Agreements	445	45	490				445	45	490
13. Other (specific details mandatory):									
Naloxone	26,299	2,630	28,929				26,299	2,630	28,929
Flex funds	8,219	822	9,041				8,219	822	9,041
Shelter Respite Vouchers	3,118	312	3,430				3,118	312	3,430
TOTAL	$ 181,818	$ 18,182	$ 200,000				$ 181,818	$ 18,182	$ 200,000
Indirect As A Percent of Direct		10.0%							

Contractor Initials RPS

Date 12/28/2020

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 CONCORD HOSPITAL, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on January 29, 1985. 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: 74948

Certificate Number : 0004893926

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 13th day of April A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE

I, William Chapman, Secretary of Concord Hospital, Inc. do hereby certify:

1) I maintain and have custody of and am familiar with the seal and minute books of the corporation;
2) I am authorized to issue certificates with respect to the contents of such books and to affix such seal to such certificates;
3) The following is a true and complete copy of the resolution adopted by the board of trustees of the corporation at a meeting of that board on March 21, 2005 which meeting was held in accordance with the law of the state of incorporation and the bylaws of the corporation:

   The motion was made, seconded and the Board unanimously voted that the powers and duties of the President shall include the execution of all contracts and other legal documents on behalf of the corporation, unless some other person is specifically so designated by the Board, by law, or pursuant to the administrative policy addressing contract and expenditure approval levels.

4) the foregoing resolution is in full force and effect, unamended, as of the date hereof; and
5) the following persons lawfully occupy the offices indicated below:

   Robert P. Steigmeyer, President
   Scott W. Sloane, Chief Financial Officer

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the Corporation this 16 day of December, 2020.

(Corporate seal)

William Chapman
Secretary

State of:

County of:

On this, the 16 *day of* December, 2020, *before me a notary public, the undersigned officer, personally appeared* William Chapman, *known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.*
In witness hereof, I hereunto set my hand and official seal.

SUSANNE M. BOLDUC
MY COMMISSION EXPIRES MAY 3, 2022
NOTARY PUBLIC NEW HAMPSHIRE

(Seal)

Susanne M Bolduc
Notary Public

My Commission expires: 5/3/2022

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/28/2020

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
MARSH USA, INC.
99 HIGH STREET
BOSTON, MA 02110
Attn: Boston.certrequest@Marsh.com

CN107277064-CHS-gener-21-22

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

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Granite Shield Insurance Exchange	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
CAPITAL REGION HEALTHCARE CORPORATION
& CONCORD HOSPITAL, INC.
ATTN: KATHY LAMONTAGNE, ADMINISTRATION
250 PLEASANT STREET
CONCORD, NH 03301

COVERAGES **CERTIFICATE NUMBER:** NYC-010805475-02 **REVISION NUMBER:** 3

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			GSIE-PRIM-2021-101	01/01/2021	01/01/2022	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 12,000,000
	POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			GSIE-PRIM-2021-101	01/01/2021	01/01/2022		SEE ABOVE

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
GENERAL LIABILITY AND PROFESSIONAL LIABILITY SHARE A COMBINED LIMIT OF 2,000,000/12,000,000. HOSPITAL PROFESSIONAL LIABILITY RETRO ACTIVE DATE 06/24/1985. EACH OCCURRENCE AND AGGREGATE LIMITS ARE SHARED AMONGST THE GRANITE SHIELD EXCHANGE HOSPITALS.

CERTIFICATE HOLDER

STATE OF NH DEPT OF HEALTH
& HUMAN SERVICES
129 PLEASANT STREET
CONCORD, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Elizabeth Stapleton

CAPIREG-01 AZIDOW

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/8/2020

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.

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PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: PHONE (A/C, No, Ext): (207) 829-3450 FAX (A/C, No): (207) 829-6350 E-MAIL ADDRESS:
INSURED Capital Region Healthcare Corporation 250 Pleasant Street Concord, NH 03301	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Hanover Insurance Company — 22292 INSURER B : Safety National Casualty Corporation — 15105 INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	[ ] CLAIMS-MADE [ ] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	[ ] POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$
	[ ] OTHER:							$
A	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[ ] ANY AUTO			AWPH38382700	10/1/2020	10/1/2021	BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [X] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						[ ] PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$
B	Excess Worker's Comp			SP4063844	10/1/2020	10/1/2021	$500,000 retention	1,000,000

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

CERTIFICATE HOLDER

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

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Concord Hospital Mission Statement

Concord Hospital is a charitable organization which exists to meet the health needs of individuals within the communities it serves.

It is the established policy of Concord Hospital to provide services on the sole basis of the medical necessity of such services as determined by the medical staff without reference to race, color, ethnicity, national origin, sexual orientation, marital status, religion, age, gender, disability, or inability to pay for such services.

Approved by Board of Trustees 10-21-02; Reaffirmed by Board 11-23-03, 11-15-04, 11-21-05, 11-20-06, 11-19-07, 11-17-08, 11-16-09, 10-18-10, 9-19-11, 9-24-12, 9-23-13, 9-22-14, 9-28-15, 9-26-16, 9-25-17, 9-24-18, 9-23-19, 9-28-20

BAKER NEWMAN NOYES

Concord Hospital, Inc. and Subsidiaries

Audited Consolidated Financial Statements

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

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

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

Audited Consolidated Financial Statements

Years Ended September 30, 2019 and 2018

CONTENTS

BAKER NEWMAN NOYES

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INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Concord Hospital, Inc.

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

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

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

The Board of Trustees
Concord Hospital, Inc.

Opinion

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

Emphasis of Matter

As discussed in Note 1 to the consolidated financial statements, in 2019, the System adopted Financial Accounting Standards Board Accounting Standards Update 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities*, and applied the guidance retrospectively to all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
December 10, 2019

The Board of Trustees
Concord Hospital, Inc.

Opinion

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

Emphasis of Matter

As discussed in Note 1 to the consolidated financial statements, in 2019, the System adopted Financial Accounting Standards Board Accounting Standards Update 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities*, and applied the guidance retrospectively to all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
December 10, 2019

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

September 30, 2019 and 2018

ASSETS
(In thousands)

	2019	2018
Current assets:		
Cash and cash equivalents	$ 6,404	$ 4,691
Short-term investments	23,228	30,553
Accounts receivable, less allowance for doubtful accounts of $14,635 in 2019 and $15,037 in 2018	68,614	70,261
Due from affiliates	492	659
Supplies	2,396	2,079
Prepaid expenses and other current assets	6,662	5,262
Total current assets	107,796	113,505
Assets whose use is limited or restricted:		
Board designated	284,668	297,243
Funds held by trustee for workers' compensation reserves, self-insurance escrows and construction funds	38,141	55,978
Donor-restricted funds and restricted grants	39,656	40,431
Total assets whose use is limited or restricted	362,465	393,652
Other noncurrent assets:		
Due from affiliates, net of current portion	708	768
Other assets	18,340	13,344
Total other noncurrent assets	19,048	14,112
Property and equipment:		
Land and land improvements	6,338	6,942
Buildings	194,301	195,301
Equipment	244,834	292,694
Construction in progress	38,734	7,044
	484,207	501,981
Less accumulated depreciation	(302,519)	(332,923)
Net property and equipment	181,688	169,058
	$ 670,997	$ 690,327

LIABILITIES AND NET ASSETS
(In thousands)

	2019	2018
Current liabilities:		
Accounts payable and accrued expenses	$ 34,354	$ 36,190
Accrued compensation and related expenses	28,174	26,646
Accrual for estimated third-party payor settlements	34,569	35,378
Current portion of long-term debt	7,385	9,061
Total current liabilities	104,482	107,275
Long-term debt, net of current portion	120,713	128,463
Accrued pension and other long-term liabilities	74,718	48,302
Total liabilities	299,913	284,040
Net assets:		
Without donor restrictions	333,022	368,060
With donor restrictions	38,062	38,227
Total net assets	371,084	406,287
	$ 670,997	$ 690,327

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018
(In thousands)

	2019	2018
Revenue and other support without donor restrictions:		
Net patient service revenue, net of contractual allowances and discounts	$510,098	$492,647
Provision for doubtful accounts	(23,826)	(29,329)
Net patient service revenue less provision for doubtful accounts	486,272	463,318
Other revenue	21,887	20,496
Disproportionate share revenue	19,215	14,327
Net assets released from restrictions for operations	1,453	2,112
Total revenue and other support without donor restrictions	528,827	500,253
Operating expenses:		
Salaries and wages	250,359	233,356
Employee benefits	61,887	52,130
Supplies and other	106,095	98,713
Purchased services	32,865	43,352
Professional fees	7,681	6,531
Depreciation and amortization	26,150	27,574
Medicaid enhancement tax	22,442	20,975
Interest expense	4,729	4,873
Total operating expenses	512,208	487,504
Income from operations	16,619	12,749
Nonoperating income:		
Gifts and bequests without donor restrictions	304	317
Investment (loss) income and other	(4,906)	12,878
Net periodic benefits cost, other than service cost	(2,626)	(2,880)
Total nonoperating (loss) income	(7,228)	10,315
Excess of revenues and nonoperating income over expenses	$ 9,391	$ 23,064

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2019 and 2018
(In thousands)

	2019	2018
Net assets without donor restrictions:		
Excess of revenues and nonoperating income over expenses	$ 9,391	$ 23,064
Net unrealized gains on investments	4,979	1,805
Net transfers from (to) affiliates	388	(35)
Net assets released from restrictions used for purchases of property and equipment	188	479
Pension adjustment	(49,984)	7,599
(Decrease) increase in net assets without donor restrictions	(35,038)	32,912
Net assets with donor restrictions:		
Contributions and pledges with donor restrictions	1,912	1,554
Net investment (loss) return	(103)	1,236
Contributions to affiliates and other community organizations	(186)	(222)
Unrealized (losses) gains on trusts administered by others	(147)	48
Net assets released from restrictions for operations	(1,453)	(2,112)
Net assets released from restrictions used for purchases of property and equipment	(188)	(479)
(Decrease) increase in net assets with donor restrictions	(165)	25
(Decrease) increase in net assets	(35,203)	32,937
Net assets, beginning of year	406,287	373,350
Net assets, end of year	$371,084	$406,287

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018
(In thousands)

	2019	2018
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (35,203)	$ 32,937
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Contributions and pledges with donor restrictions	(1,912)	(1,554)
Depreciation and amortization	26,150	27,574
Net realized and unrealized losses (gains) on investments	5,483	(12,762)
Bond premium and issuance cost amortization	(368)	(317)
Provision for doubtful accounts	23,826	29,329
Equity in earnings of affiliates, net	(7,345)	(5,539)
Loss (gain) on disposal of property and equipment	35	(84)
Pension adjustment	49,984	(7,599)
Changes in operating assets and liabilities:		
Accounts receivable	(22,179)	(48,246)
Supplies, prepaid expenses and other current assets	(1,717)	291
Other assets	(4,087)	2,495
Due from affiliates	227	430
Accounts payable and accrued expenses	(8,826)	7,497
Accrued compensation and related expenses	1,528	1,066
Accrual for estimated third-party payor settlements	(809)	7,996
Accrued pension and other long-term liabilities	(23,568)	(4,635)
Net cash provided by operating activities	1,219	28,879
Cash flows from investing activities:		
Increase in property and equipment, net	(31,698)	(30,456)
Purchases of investments	(43,333)	(87,949)
Proceeds from sales of investments	76,304	31,793
Equity distributions from affiliates	6,309	4,752
Net cash provided (used) by investing activities	7,582	(81,860)
Cash flows from financing activities:		
Payments on long-term debt	(9,058)	(8,816)
Proceeds from issuance of long-term debt	–	62,004
Bond issuance costs	–	(670)
Change in short-term notes payable	–	(15)
Contributions and pledges with donor restrictions	1,970	1,370
Net cash (used) provided by financing activities	(7,088)	53,873
Net increase in cash and cash equivalents	1,713	892
Cash and cash equivalents at beginning of year	4,691	3,799
Cash and cash equivalents at end of year	$ 6,404	$ 4,691

Supplemental disclosure:
At September 30, 2019, amounts totaling $6,990 related to the purchase of property and equipment were included in accounts payable and accrued expenses.

See accompanying notes.

1. Description of Organization and Summary of Significant Accounting Policies

Organization

Concord Hospital, Inc., (the Hospital) located in Concord, New Hampshire, is a not-for-profit acute care hospital. The Hospital provides inpatient, outpatient, emergency care and physician services for residents within its geographic region. Admitting physicians are primarily practitioners in the local area. The Hospital is controlled by Capital Region Health Care Corporation (CRHC).

In 1985, the then Concord Hospital underwent a corporate reorganization in which it was renamed and became CRHC. At the same time, the Hospital was formed as a new entity. All assets and liabilities of the former hospital, now CRHC, with the exception of its endowments and restricted funds, were conveyed to the new entity. The endowments were held by CRHC for the benefit of the Hospital, which is the true party in interest. Effective October 1, 1999, CRHC transferred these funds to the Hospital.

In March 2009, the Hospital created The Concord Hospital Trust (the Trust), a separately incorporated, not-for-profit organization to serve as the Hospital's philanthropic arm. In establishing the Trust, the Hospital transferred philanthropic funds with donor restrictions, including board designated funds, endowments, indigent care funds and specific purpose funds, to the newly formed organization together with the stewardship responsibility to direct monies available to support the Hospital's charitable mission and reflect the specific intentions of the donors who made these gifts. Concord Hospital and the Trust constitute the Obligated Group at September 30, 2019 and 2018 to certain debt described in Note 6.

Subsidiaries of the Hospital include:

Capital Region Health Care Development Corporation (CRHCDC) is a not-for-profit real estate corporation that owns and operates medical office buildings and other properties.

Capital Region Health Ventures Corporation (CRHVC) is a not-for-profit corporation that engages in health care delivery partnerships and joint ventures. It operates ambulatory surgery and diagnostic facilities independently and in cooperation with other entities.

NH Cares ACO, LLC (NHC) is a single member limited liability company that engages in providing medical services to Medicare beneficiaries as an accountable care organization. NHC has a perpetual life and is subject to termination in certain events.

The Hospital, its subsidiaries and the Trust are collectively referred to as the System. The consolidated financial statements include the accounts of the Hospital, the Trust, CRHCDC, CRHVC and NHC. All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Concentration of Credit Risk

Financial instruments which subject the Hospital to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Hospital's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The Hospital's accounts receivable are primarily due from third-party payors and amounts are presented net of expected contractual allowances and uncollectible amounts, including estimated uncollectible amounts from uninsured patients. The Hospital's investment portfolio consists of diversified investments, which are subject to market risk. The Hospital's investment in one fund, the Vanguard Institutional Index Fund, exceeded 10% of total Hospital investments as of September 30, 2019 and 2018.

Cash and Cash Equivalents

Cash and cash equivalents include money market funds with original maturities of three months or less, excluding assets whose use is limited or restricted.

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.

Supplies

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

Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted include assets held by trustees for workers' compensation reserves, self-insurance escrows, construction funds, designated assets set aside by the Board of Trustees (over which the Board retains control and may, at its discretion, subsequently use for other purposes), and donor-restricted investments.

Investments and Investment Income

Investments are carried at fair value in the accompanying consolidated balance sheets. Investment income (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues and nonoperating income over expenses unless the income is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions. Gains and losses on investments are computed on a specific identification basis. Unrealized gains and losses on investments are excluded from the excess of revenues and nonoperating income over expenses unless the investments are classified as trading securities or losses are considered other-than-temporary. Periodically, management reviews investments for which the market value has fallen significantly below cost and recognizes impairment losses where they believe the declines are other-than-temporary.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Beneficial Interest in Perpetual Trusts

The System has an irrevocable right to receive income earned on certain trust assets established for its benefit. Distributions received by the System are without donor restrictions. The System's interest in the fair value of the trust assets is included in assets whose use is limited or restricted and as net assets with donor restrictions. Changes in the fair value of beneficial trust assets are reported as increases or decreases to net assets with donor restrictions.

Investment Policies

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

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

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

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

Management of these assets is designed to increase, with minimum risk, the inflation adjusted principal and income of the endowment funds over the long term. The System 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 System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

Spending policies may be adopted by the System, 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 System has a current spending policy on various funds currently equivalent to 5% of twelve-quarter moving average of the funds' total market value.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Accounts Receivable and the Allowance for Doubtful Accounts

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for doubtful accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for doubtful accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the System records a provision for doubtful accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The System's allowance for doubtful accounts for self-pay patients represented 68% and 82% of self-pay accounts receivable at September 30, 2019 and 2018, respectively. The total provision for the allowance for doubtful accounts was $23,826 and $29,329 for the years ended September 30, 2019 and 2018, respectively. The System also provides charity care to patients, which is not recorded as revenue. The System's self-pay bad debt writeoffs decreased $4,246, from $27,430 in 2018 to $23,184 in 2019. The decrease in bad debt writeoffs between 2018 and 2019 was primarily a result of certain shifts in payor mix.

Property and Equipment

Property and equipment is stated at cost at time of purchase, or at fair value at time of donation for assets contributed, less any reductions in carrying value for impairment and less accumulated depreciation. The System's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. Depreciation is computed using the straight-line method in a manner intended to amortize the cost of the related assets over their estimated useful lives. For the years ended September 30, 2019 and 2018, depreciation expense was $26,150 and $27,574, respectively.

The System has also capitalized certain costs associated with property and equipment not yet in service. Construction in progress includes amounts incurred related to major construction projects, other renovations, and other capital equipment purchased but not yet placed in service. During 2019 and 2018, the Hospital capitalized $652 and $167, respectively, of interest expense relating to various construction projects. At September 30, 2019, the Hospital has outstanding construction commitments totaling approximately $18.8 million for a new medical office building. Construction commenced in the summer of 2018 and is anticipated to be completed in June 2020.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Gifts of long-lived assets such as land, buildings or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues and nonoperating income over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used, and gifts of cash or other assets that must be used to acquire long-lived assets, are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Federal Grant Revenue and Expenditures

Revenues and expenses under federal grant programs are recognized as the grant expenditures are incurred.

Bond Issuance Costs/Original Issue Discount or Premium

Bond issuance costs incurred to obtain financing for construction and renovation projects and the original issue discount or premium are amortized to interest expense using the straight-line method, which approximates the effective interest method, over the life of the respective bonds. The original issue discount or premium and bond issuance costs are presented as a component of bonds payable.

Charity Care

The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates (Note 11). Because the System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The System uses an industry standard approach in calculating the costs associated with providing charity care. Funds received from gifts and grants to subsidize charity services provided for the years ended September 30, 2019 and 2018 were approximately $88 and $452, respectively.

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of receipt of the promise. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statement of operations as either net assets released from restrictions for operations (for noncapital related items) or as net assets released from restrictions used for purchases of property and equipment (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the System in perpetuity.

Donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions without donor restrictions in the accompanying consolidated financial statements.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Net Patient Service Revenue

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, 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. For the years ended September 30, 2019 and 2018, net patient service revenue in the accompanying consolidated statements of operations increased by approximately $5,600 and $2,900, respectively, due to actual settlements and changes in assumptions underlying estimated future third-party settlements.

Revenues from the Medicare and Medicaid programs accounted for approximately 34% and 4% and 34% and 5% of the Hospital's net patient service revenue for the years ended September 30, 2019 and 2018, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation.

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. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for doubtful accounts related to uninsured patients in the period the services are provided.

Excess of Revenues and Nonoperating Income Over Expenses

The System has deemed all activities as ongoing, major or central to the provision of health care services and, accordingly, they are reported as operating revenue and expenses, except for contributions and pledges without donor restrictions, the related philanthropy expenses and investment income which are recorded as nonoperating income.

The consolidated statements of operations also include excess of revenues and nonoperating income over expenses. Changes in net assets without donor restrictions which are excluded from excess of revenues and nonoperating income over expenses, consistent with industry practice, include the change in net unrealized gains and losses on investments other than trading securities or losses considered other than temporary, permanent transfers of assets to and from affiliates for other than goods and services, pension liability adjustments and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Estimated Workers' Compensation and Health Care Claims

The provision for estimated workers' compensation and health care claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in Note 10. Accordingly, costs have been allocated among program services and supporting services benefitted.

Income Taxes

The Hospital, CRHCDC, CRHVC, and the Trust 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. NHC is organized as a single member limited liability company and has elected to be treated as a disregarded entity for federal and state income tax reporting purposes. Accordingly, all income or losses and applicable tax credits are reported on the member's income tax returns, with the exception of taxes due to the State of New Hampshire. Management evaluated the System's tax positions and concluded the System has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to or disclosure in the accompanying consolidated financial statements.

Advertising Costs

The System expenses advertising costs as incurred, and such costs totaled approximately $251 and $201 for the years ended September 30, 2019 and 2018, respectively.

Recent Accounting Pronouncements

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

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

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

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

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

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash (a consensus of the FASB Emerging Issues Task Force)* (ASU 2016-18), which provides guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. ASU 2016-18 will be effective for the System's fiscal year ended September 30, 2020, and early adoption is permitted. ASU 2016-18 must be applied using a retrospective transition method. The System is currently evaluating the impact of the adoption of this guidance on its consolidated 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 System on October 1, 2019, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-08 will have on its consolidated financial statements.

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

Reclassifications

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

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Subsequent Events

Management of the System evaluated events occurring between the end of the System's fiscal year and December 10, 2019, the date the consolidated financial statements were available to be issued.

2. **Transactions With Affiliates**

The System provides funds to CRHC and its affiliates which are used for a variety of purposes. The System records the transfer of funds to CRHC and the other affiliates as either receivables or directly against net assets, depending on the intended use and repayment requirements of the funds. Generally, funds transferred for start-up costs of new ventures or capital related expenditures are recorded as charges against net assets. For the years ended September 30, 2019 and 2018, transfers made to CRHC were $(214) and $(157), respectively, and transfers received from Capital Region Health Services Corporation (CRHSC) were $602 and $122, respectively.

A brief description of affiliated entities is as follows:

- CRHSC is a for-profit provider of health care services, including an eye surgery center and assisted living facility.
- Concord Regional Visiting Nurse Association, Inc. and Subsidiary (CRVNA) provides home health care services.
- Riverbend, Inc. provides behavioral health services.

Amounts due the System, primarily from joint ventures, totaled $1,200 and $1,427 at September 30, 2019 and 2018, respectively. Amounts have been classified as current or long-term depending on the intentions of the parties involved. Beginning in 1999, the Hospital began charging interest on a portion of the receivables ($708 and $759 at September 30, 2019 and 2018, respectively) with principal and interest (6.75% at September 30, 2019) payments due monthly. Interest income amounted to $50 and $58 for the years ended September 30, 2019 and 2018, respectively.

Contributions to affiliates and other community organizations from net assets with donor restrictions were $186 and $222 in 2019 and 2018, respectively.

(In thousands)

3. Investments and Assets Whose Use is Limited or Restricted

Short-term investments totaling $23,228 and $30,553 at September 30, 2019 and 2018, respectively, are comprised primarily of cash and cash equivalents. Assets whose use is limited or restricted are carried at fair value and consist of the following at September 30:

	2019	2018
Board designated funds:		
Cash and cash equivalents	$ 7,762	$ 6,651
Fixed income securities	23,592	22,555
Marketable equity and other securities	242,088	248,760
Inflation-protected securities	11,226	19,277
	284,668	297,243
Held by trustee for workers' compensation reserves:		
Fixed income securities	3,140	2,937
Self-insurance escrows and construction funds:		
Cash and cash equivalents	10,568	10,912
Fixed income securities	14,816	33,593
Marketable equity securities	9,617	8,536
	35,001	53,041
Donor-restricted funds and restricted grants:		
Cash and cash equivalents	5,930	5,459
Fixed income securities	1,771	1,832
Marketable equity securities	19,865	20,200
Inflation-protected securities	921	1,565
Trust funds administered by others	10,903	11,051
Other	266	324
	39,656	40,431
	$362,465	$393,652

Included in marketable equity and other securities above are $175,251 and $172,826 at September 30, 2019 and 2018, respectively, in so called alternative investments and collective trust funds. See also Note 14.

(In thousands)

3. **Investments and Assets Whose Use is Limited or Restricted (Continued)**

Investment income, net realized gains and losses and net unrealized gains and losses on assets whose use is limited or restricted, cash and cash equivalents, and other investments are as follows at September 30:

	2019	2018
Net assets without donor restrictions:		
Interest and dividends	$ 5,606	$ 4,344
Investment income from trust funds administered by others	530	541
Net realized (losses) gains on sales of investments	(9,863)	9,996
	(3,727)	14,881
Net assets with donor restrictions:		
Interest and dividends	349	323
Net realized (losses) gains on sales of investments	(779)	755
	(430)	1,078
	$ (4,157)	$ 15,959
Net unrealized gains on investments:		
Net assets without donor restrictions	$ 4,979	$ 1,805
Net assets with donor restrictions	180	206
	$ 5,159	$ 2,011

In compliance with the System's spending policy, portions of investment income and related fees are recognized in other operating revenue on the accompanying consolidated statements of operations. Investment income reflected in other operating revenue was $1,710 and $1,779 in 2019 and 2018, respectively.

Investment management fees expensed and reflected in nonoperating income were $863 and $917 for the years ended September 30, 2019 and 2018, respectively.

(In thousands)

3. Investments and Assets Whose Use is Limited or Restricted (Continued)

The following summarizes the Hospital's gross unrealized losses and fair values, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at September 30, 2019 and 2018:

	Less Than 12 Months		12 Months or Longer		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
2019						
Marketable equity securities	$ 1,173	$ (432)	$13,650	$ (1,029)	$14,823	$ (1,461)
Fund-of-funds	10,322	(747)	–	–	10,322	(747)
Collective trust funds	13,226	(490)	30,814	(2,497)	44,040	(2,987)
	$24,721	$(1,669)	$44,464	$ (3,526)	$69,185	$ (5,195)
2018						
Marketable equity securities	$ 1,743	$ (234)	$46,828	$ (9,261)	$48,571	$ (9,495)
Fund-of-funds	10,300	(446)	–	–	10,300	(446)
Collective trust funds	16,894	(471)	14,062	(897)	30,956	(1,368)
	$28,937	$(1,151)	$60,890	$(10,158)	$89,827	$(11,309)

In evaluating whether investments have suffered an other-than-temporary decline, based on input from outside investment advisors, management evaluated the amount of the decline compared to cost, the length of time and extent to which fair value has been less than cost, the underlying creditworthiness of the issuer, the fair values exhibited during the year, estimated future fair values and the System's intent and ability to hold the security until a recovery in fair value or maturity. Based on evaluations of the underlying issuers' financial condition, current trends and economic conditions, management believes there are no securities that have suffered an other-than-temporary decline in value at September 30, 2019 and 2018.

4. Defined Benefit Pension Plan

The System has a noncontributory defined benefit pension plan (the Plan), covering all eligible employees of the System and subsidiaries. The Plan provides benefits based on an employee's years of service, age and the employee's compensation over those years. The System's funding policy is to contribute annually the amount needed to meet or exceed actuarially determined minimum funding requirements of the *Employee Retirement Income Security Act of 1974* (ERISA).

The System accounts for its defined benefit pension plan under ASC 715, *Compensation Retirement Benefits*. This Statement requires entities to recognize an asset or liability for the overfunded or underfunded status of their benefit plans in their financial statements.

(In thousands)

4. Defined Benefit Pension Plan (Continued)

The following table summarizes the Plan's funded status at September 30, 2019 and 2018:

	2019	2018
Funded status:		
Fair value of plan assets	$ 251,574	$ 235,752
Projected benefit obligation	(304,836)	(267,072)
	$ (53,262)	$ (31,320)
Activities for the year consist of:		
Benefit payments and administrative expenses paid	$ 26,475	$ 26,584
Net periodic benefit cost	12,958	11,582

The table below presents details about the System's defined benefit pension plan, including its funded status, components of net periodic benefit cost, and certain assumptions used in determining the funded status and cost:

	2019	2018
Change in benefit obligation:		
Projected benefit obligation at beginning of year	$267,072	$277,075
Service cost	10,332	8,702
Interest cost	12,096	11,991
Actuarial loss (gain)	40,111	(5,612)
Benefit payments and administrative expenses paid	(26,475)	(26,584)
Other adjustments to benefit cost	1,700	1,500
Projected benefit obligation at end of year	$304,836	$267,072
Change in plan assets:		
Fair value of plan assets at beginning of year	$235,752	$233,739
Actual return on plan assets	1,297	12,597
Employer contributions	41,000	16,000
Benefit payments and administrative expenses	(26,475)	(26,584)
Fair value of plan assets at end of year	$251,574	$235,752
Funded status and amount recognized in noncurrent liabilities at September 30	$ (53,262)	$ (31,320)

(In thousands)

4. Defined Benefit Pension Plan (Continued)

Amounts recognized as a change in net assets without donor restrictions during the years ended September 30, 2019 and 2018 consist of:

	2019	2018
Net actuarial loss	$56,890	$ 121
Net amortized loss	(7,153)	(7,996)
Prior service credit amortization	247	276
Total amount recognized	$49,984	$(7,599)

Pension Plan Assets

The fair values of the System's pension plan assets as of September 30, 2019 and 2018, by asset category are as follows (see Note 14 for level definitions). In accordance with ASU 2015-07, certain investments that are measured using the net value per share practical expedient have not been classified in the fair value hierarchy.

	2019 Level 1	2018 Level 1
Short-term investments:		
Money market funds	$ 5,111	$ 31,447
Equity securities:		
Common stocks	9,356	10,188
Mutual funds – international	9,835	7,923
Mutual funds – domestic	64,805	49,090
Mutual funds – natural resources	–	4,478
Mutual funds – inflation hedge	8,919	8,325
Fixed income securities:		
Mutual funds – REIT	986	890
Mutual funds – fixed income	22,944	15,522
	121,956	127,863
Funds measured at net asset value:		
Equity securities:		
Funds-of-funds	77,700	71,202
Collective trust funds:		
Equities	42,325	27,427
Fixed income	9,593	9,260
	129,618	107,889
Total investments at fair value	$251,574	$235,752

(In thousands)

4. **Defined Benefit Pension Plan (Continued)**

The target allocation for the System's pension plan assets as of September 30, 2019 and 2018, by asset category are as follows:

	2019		2018	
	Target Allocation	Percentage of Plan Assets	Target Allocation	Percentage of Plan Assets
Short-term investments	0-20%	2%	0-20%	13%
Equity securities	40-80%	68	40-80%	64
Fixed income securities	5-80%	13	5-80%	7
Other	0-30%	17	0-30%	16

The funds-of-funds are invested with ten investment managers and have various restrictions on redemptions. One manager holding amounts totaling approximately $13 million at September 30, 2019 allows for semi-monthly redemptions, with 5 days' notice. One manager holding approximately $7 million at September 30, 2019 allows for monthly redemptions, with 15 days' notice. Five managers holding amounts totaling approximately $43 million at September 30, 2019 allow for quarterly redemptions, with notices ranging from 45 to 65 days. Two of the managers holding amounts of approximately $8 million at September 30, 2019 allow for annual redemptions, with notice ranging from 60 to 90 days. One of the managers holding amounts of approximately $6 million at September 30, 2019 allows for redemptions on a semi-annual basis, with a notice of 60 days. The redemption is further limited to 25% of the investment balance at each redemption period. The collective trust funds allow for daily or monthly redemptions, with notices ranging from 6 to 10 days. Certain funds also may include a fee estimated to be equal to the cost the fund incurs in converting investments to cash (ranging from 0.5% to 1.5%) or are subject to certain lock periods.

The System considers various factors in estimating the expected long-term rate of return on plan assets. Among the factors considered include the historical long-term returns on plan assets, the current and expected allocation of plan assets, input from the System's actuaries and investment consultants, and long-term inflation assumptions. The System's expected allocation of plan assets is based on a diversified portfolio consisting of domestic and international equity securities, fixed income securities, and real estate.

The System's investment policy for its pension plan is to balance risk and returns using a diversified portfolio consisting primarily of high quality equity and fixed income securities. To accomplish this goal, plan assets are actively managed by outside investment managers with the objective of optimizing long-term return while maintaining a high standard of portfolio quality and proper diversification. The System monitors the maturities of fixed income securities so that there is sufficient liquidity to meet current benefit payment obligations. The System's Investment Committee provides oversight of the plan investments and the performance of the investment managers.

(In thousands)

4. Defined Benefit Pension Plan (Continued)

Amounts included in expense during fiscal 2019 and 2018 consist of:

	2019	2018
Components of net periodic benefit cost:		
Service cost	$ 10,332	$ 8,702
Interest cost	12,096	11,991
Expected return on plan assets	(18,076)	(18,331)
Amortization of prior service credit and loss	6,906	7,720
Other adjustments to benefits cost	1,700	1,500
Net periodic benefit cost	$ 12,958	$ 11,582

The accumulated benefit obligations for the plan at September 30, 2019 and 2018 were $288,126 and $251,736, respectively.

	2019	2018
Weighted average assumptions to determine benefit obligation:		
Discount rate	3.59%	4.63%
Rate of compensation increase	2.50% for the next three years; 3.00% thereafter	3.00
Weighted average assumptions to determine net periodic benefit cost:		
Discount rate	4.63%	4.29%
Expected return on plan assets	7.75	7.75
Cash balance credit rate	5.00	5.00
Rate of compensation increase	3.00	3.00

In selecting the long-term rate of return on plan 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 plan'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 and prior service credit amount expected to be recognized in net periodic benefit cost in 2020 are as follows:

Actuarial loss	$11,420
Prior service credit	(243)
	$11,177

The System funds the pension plan and no contributions are made by employees. The System funds the plan annually by making a contribution of at least the minimum amount required by applicable regulations and as recommended by the System's actuary. However, the System may also fund the plan in excess of the minimum required amount.

(In thousands)

4. Defined Benefit Pension Plan (Continued)

Cash contributions in subsequent years will depend on a number of factors including performance of plan assets. However, the System expects to fund $16,000 in cash contributions to the plan for the 2020 plan year.

Benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

Year Ended September 30	Pension Benefits
2020	$ 15,820
2021	16,452
2022	17,476
2023	18,590
2024	19,221
2025 – 2029	105,566

Effective September 26, 2018, the Plan entered into a group annuity contract with Pacific Life Insurance Company. The contract was purchased for certain retirees of the Plan. A total of 354 participants were entitled to receive benefits purchased under the contract. Annuity payments for participants commenced on January 1, 2019 and Pacific Life Insurance Company will assume the risk for participants entitled to receive benefits purchased under this contract. The Plan paid premiums totaling $9,135 and $9,241 in September 2018 and October 2018, respectively, relating to the purchase of the contract.

5. Estimated Third-Party Payor Settlements

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

Medicare

Inpatient and outpatient services rendered to Medicare program beneficiaries are primarily paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical diagnosis and other factors. In addition to this, the System is also reimbursed for medical education and other items which require cost settlement and retrospective review by the fiscal intermediary. Accordingly, the System files an annual cost report with the Medicare program after the completion of each fiscal year to report activity applicable to the Medicare program and to determine any final settlements.

The physician practices are reimbursed on a fee schedule basis.

5. **Estimated Third-Party Payor Settlements (Continued)**

Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of net patient service revenues in State fiscal years 2019 and 2018. The amount of tax incurred by the System for 2019 and 2018 was $22,442 and $20,975, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded within revenue without donor restrictions and other support and amounted to $19,215 in 2019 and $14,327 in 2018, net of reserves referenced below.

The Centers for Medicare and Medicaid Services (CMS) has completed audits of the State's program and the disproportionate share payments made by the State from 2011 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 System has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under fee schedules and cost reimbursement methodologies subject to various limitations or discounts. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid program.

The physician practices are reimbursed on a fee schedule basis.

Other

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

The accrual for estimated third-party payor settlements reflected on the accompanying consolidated balance sheets represents the estimated net amounts to be paid under reimbursement contracts with the Centers for Medicare and Medicaid Services (Medicare), the New Hampshire Department of Welfare (Medicaid) and any commercial payors with settlement provision. Settlements for the Hospital have been finalized through 2015 for Medicare and Medicaid.

(In thousands)

6. Long-Term Debt and Notes Payable

Long-term debt consists of the following at September 30, 2019 and 2018:

	2019	2018
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds, Concord Hospital Issue, Series 2017; interest of 5.0% per year and principal payable in annual installments. Installments ranging from $2,010 to $5,965 beginning October 2032, including unamortized original issue premium of $7,215 in 2019 and $7,530 in 2018	$ 61,425	$ 61,740
3.38% to 5.0% NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2013A; due in annual installments, including principal and interest ranging from $1,543 to $3,555 through 2043, including unamortized original issue premium of $2,824 in 2019 and $2,945 in 2018	40,469	41,805
1.71% fixed rate NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2013B; due in annual installments, including principal and interest ranging from $1,860 to $2,038 through 2024	9,341	13,079
4.25% to 5.5% NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2011; due in annual installments, including principal and interest ranging from $2,737 to $5,192 through 2026, including unamortized original issue premium of $136 in 2019 and $155 in 2018	18,201	22,325
	129,436	138,949
Less unamortized bond issuance costs	(1,338)	(1,425)
Less current portion	(7,385)	(9,061)
	$120,713	$128,463

In December 2017, $62,004 (including an original issue premium of $7,794) of NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2017, were issued to pay for the construction of a new medical office building. In addition, the Series 2017 Bonds reimbursed the Hospital for capital expenditures incurred in association with the construction of a parking garage and the construction of a medical office building, as well as routine capital expenditures.

In February 2013, $48,631 (including an original issue premium of $3,631) of NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2013A, were issued to assist in the funding of a significant facility improvement project and to advance refund the Series 2001 NHHEFA Hospital Revenue Bonds. The facility improvement project included enhancements to the System's power plant, renovation of certain nursing units, expansion of the parking capacity at the main campus and various other routine capital expenditures and miscellaneous construction, renovation and improvements of the System's facilities.

In March 2011, $49,795 of NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2011, were issued to assist in the funding of a significant facility improvement project and pay off the Series 1996 Revenue Bonds. The project included expansion and renovation of various Hospital departments, infrastructure upgrades, and acquisition of capital equipment.

(In thousands)

6. Long-Term Debt and Notes Payable (Continued)

Substantially all the property and equipment relating to the aforementioned construction and renovation projects, as well as subsequent property and equipment additions thereto, and a mortgage lien on the facility, are pledged as collateral for the Series 2011, 2013A and B and 2017 Revenue Bonds. In addition, the gross receipts of the Hospital are pledged as collateral for the Series 2011, 2013A and B and 2017 Revenue Bonds. The most restrictive financial covenants require a 1.10 to 1.0 ratio of aggregate income available for debt service to total annual debt service and a day's cash on hand ratio of 75 days. The Hospital was in compliance with its debt covenants at September 30, 2019 and 2018.

The obligations of the Hospital under the Series 2017, Series 2013A and B and Series 2011 Revenue Bond Indentures are not guaranteed by any of the subsidiaries or affiliated entities.

Interest paid on long-term debt amounted to $6,350 (including capitalized interest of $652) and $5,530 (including capitalized interest of $167) for the years ended September 30, 2019 and 2018, respectively.

The aggregate principal payments on long-term debt for the next five fiscal years ending September 30 and thereafter are as follows:

2020	$ 7,385
2021	5,186
2022	5,340
2023	5,485
2024	5,645
Thereafter	90,220
	$119,261

7. Commitments and Contingencies

Malpractice Loss Contingencies

Effective February 1, 2011, the System insures its medical malpractice risks through a multiprovider captive insurance company under a claims-made insurance policy. Premiums paid are based upon actuarially determined amounts to adequately fund for expected losses. At September 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 require loss accruals. The System has established reserves for unpaid claim amounts for Hospital and Physician Professional Liability and General Liability reported claims and for unreported claims for incidents that have been incurred but not reported. The amounts of the reserves total $3,834 and $3,341 at September 30, 2019 and 2018, respectively and are reflected in the accompanying consolidated balance sheets within accrued pension and other long-term liabilities. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System.

7. **Commitments and Contingencies (Continued)**

The captive retains and funds up to actuarial expected loss amounts, and obtains reinsurance at various attachment points for individual and aggregate claims in excess of funding in accordance with industry practices. At September 30, 2019, the System's interest in the captive represents approximately 80% of the captive. The System accounts for its investments in the captive under the equity method since control of the captive is shared equally between the participating hospitals. The System has recorded its interest in the captive's equity, totaling approximately $7,270 and $6,363 at September 30, 2019 and 2018, respectively, in other noncurrent assets on the accompanying consolidated balance sheets. Changes in the System's interest are included in nonoperating income on the accompanying consolidated statements of operations

In accordance with ASU No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2019 and 2018, the Hospital recorded a liability of approximately $4,100 and $1,000, respectively, related to estimated professional liability losses. At September 30, 2019 and 2018, the Hospital also recorded a receivable of $4,100 and $1,000, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other long-term liabilities and other assets, respectively, on the consolidated balance sheets.

Workers' Compensation

The Hospital maintains workers' compensation insurance under a self-insurance plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the Hospital against excessive losses. The Hospital has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $2,797 and $2,523 at September 30, 2019 and 2018, respectively, are recorded within accounts payable and accrued expenses on the accompanying consolidated balance sheets and have been discounted at 3% (both years) and, in management's opinion, provide an adequate reserve for loss contingencies. A trustee held fund has been established as a reserve under the plan. Assets held in trust totaled $3,140 and $2,937 at September 30, 2019 and 2018, respectively, and is included in assets whose use is limited or restricted in the accompanying consolidated balance sheets.

Litigation

The System is involved in litigation and regulatory investigations 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 System's financial position, results of operations or cash flows.

Health Insurance

The System has a self-funded health insurance plan. The plan is administered by an insurance company which assists in determining the current funding requirements of participants under the terms of the plan and the liability for claims and assessments that would be payable at any given point in time. The System recognizes revenue for services provided to employees of the System during the year. The System is insured above a stop-loss amount of $440 on individual claims. Estimated unpaid claims, and those claims incurred but not reported at September 30, 2019 and 2018, have been recorded as a liability of $4,391 and $6,724, respectively, and are reflected in the accompanying consolidated balance sheets within accounts payable and accrued expenses.

(In thousands)

7. Commitments and Contingencies (Continued)

Operating Leases

The System has various operating leases relative to its office and offsite locations. Future annual minimum lease payments under noncancellable lease agreements as of September 30, 2019 are as follows:

Year Ending September 30:	
2020	$ 6,833
2021	6,278
2022	5,842
2023	5,673
2024	4,796
Thereafter	13,142
	$42,564

Rent expense was $7,392 and $6,616 for the years ended September 30, 2019 and 2018, respectively.

8. Net Assets With Donor Restrictions

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

	2019	2018
Purpose restriction:		
Health education and program services	$14,734	$15,481
Capital acquisitions	1,764	1,646
Indigent care	133	239
Pledges receivable with stipulated purpose and/or time restrictions	223	214
	16,854	17,580
Perpetual in nature:		
Health education and program services	18,319	17,759
Capital acquisitions	803	803
Indigent care	1,811	1,810
Annuities to be held in perpetuity	275	275
	21,208	20,647
Total net assets with donor restrictions	$38,062	$38,227

(In thousands)

9. Patient Service and Other Revenue

Net patient service revenue for the years ended September 30 is as follows:

	2019	2018
Gross patient service charges:		
Inpatient services	$ 570,029	$ 538,592
Outpatient services	687,370	641,817
Physician services	215,885	177,347
Less charitable services	(12,773)	(12,021)
	1,460,511	1,345,735
Less contractual allowances and discounts:		
Medicare	(543,569)	(487,941)
Medicaid	(130,615)	(98,632)
Other	(279,051)	(267,214)
	(953,235)	(853,787)
Total Hospital net patient service revenue (net of contractual allowances and discounts)	507,276	491,948
Other entities	2,822	699
	$ 510,098	$ 492,647

An estimated breakdown of patient service revenue, net of contractual allowances, discounts and provision for doubtful accounts recognized in 2019 and 2018 from these major payor sources, is as follows for the Hospital. The provision for doubtful accounts for subsidiaries of the Hospital was not significant in 2019 and 2018.

	Hospital			
	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2019				
Private payors (includes coinsurance and deductibles)	$ 563,410	$(261,239)	$(13,850)	$288,321
Medicaid	152,217	(130,615)	–	21,602
Medicare	714,262	(543,569)	(3,956)	166,737
Self-pay	30,622	(17,812)	(5,934)	6,876
	$1,460,511	$(953,235)	$(23,740)	$483,536

(In thousands)

9. Patient Service and Other Revenue (Continued)

	Hospital			
	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2018				
Private payors (includes coinsurance and deductibles)	$ 527,965	$(236,785)	$ (17,106)	$274,074
Medicaid	134,761	(112,341)	–	22,420
Medicare	654,270	(487,941)	(4,887)	161,442
Self-pay	28,739	(16,720)	(7,329)	4,690
	$1,345,735	$(853,787)	$ (29,322)	$462,626

10. Functional Expenses

The System provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows for the year ended September 30, 2019:

	Health Services	General and Administrative	Fund-raising	Total
Salaries and wages	$208,279	$41,607	$ 473	$250,359
Employee benefits	51,485	10,285	117	61,887
Supplies and other	91,029	14,912	154	106,095
Purchased services	24,362	8,369	134	32,865
Professional fees	7,675	6	–	7,681
Depreciation and amortization	17,459	8,415	276	26,150
Medicaid enhancement tax	22,442	–	–	22,442
Interest	3,173	1,506	50	4,729
	$425,904	$85,100	$ 1,204	$512,208

For the year ended September 30, 2018, excluding Medicaid enhancement tax, depreciation and amortization expense and interest expense, the System provided $356,348, $76,788 and $946 in health services expense, general and administrative expenses and fundraising expenses, respectively.

(In thousands)

10. Functional Expenses (Continued)

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

11. Charity Care and Community Benefits (Unaudited)

The Hospital maintains records to identify and monitor the level of charity care it provides. The Hospital provides traditional charity care, as well as other forms of community benefits. The estimated cost of all such benefits provided is as follows for the years ended September 30:

	2019	2018
Government sponsored healthcare	$29,683	$24,645
Community health services	2,190	2,131
Health professions education	2,874	3,596
Subsidized health services	42,431	40,595
Research	84	91
Financial contributions	552	605
Community building activities	40	8
Community benefit operations	70	58
Charity care costs (see Note 1)	4,696	4,528
	$82,620	$76,257

In addition, the Hospital incurred estimated costs for services to Medicare patients in excess of the payment from this program of $68,494 and $60,867 in 2019 and 2018, respectively.

(In thousands)

12. Concentration of Credit Risk

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

	2019	2018
Patients	12%	9%
Medicare	32	36
Anthem Blue Cross	14	16
Cigna	3	3
Medicaid	11	10
Commercial	25	23
Workers' compensation	3	3
	100%	100%

13. Volunteer Services (Unaudited)

Total volunteer service hours received by the Hospital were approximately 24,200 in 2019 and 13,300 in 2018. The volunteers provide various nonspecialized services to the Hospital, none of which has been recognized as revenue or expense in the accompanying consolidated statements of operations.

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 System uses various methods including market, income and cost approaches. Based on these approaches, the System often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The System utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the System is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

(In thousands)

14. 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 System performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2019 and 2018. In accordance with ASU 2015-07, certain investments that are measured using the net value per share practical expedient have not been classified in the fair value hierarchy.

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

	Level 1	Level 2	Level 3	Total
2019				
Cash and cash equivalents	$ 47,488	$ –	$ –	$ 47,488
Fixed income securities	41,310	–	–	41,310
Marketable equity and other securities	96,319	–	–	96,319
Inflation-protected securities and other	12,413	–	–	12,413
Trust funds administered by others	–	–	10,903	10,903
	$197,530	$ –	$10,903	208,433
Funds measured at net asset value:				
Marketable equity and other securities				175,251
				$383,684
2018				
Cash and cash equivalents	$ 53,575	$ –	$ –	$ 53,575
Fixed income securities	60,917	–	–	60,917
Marketable equity and other securities	104,670	–	–	104,670
Inflation-protected securities and other	21,166	–	–	21,166
Trust funds administered by others	–	–	11,051	11,051
	$240,328	$ –	$11,051	251,379
Funds measured at net asset value:				
Marketable equity and other securities				172,826
				$424,205

(In thousands)

14. Fair Value Measurements (Continued)

In addition, in 2019, there are certain investments totaling $2,009 which are appropriately being carried at cost.

The System's Level 3 investments consist of funds administered by others. The fair value measurement is based on significant unobservable inputs.

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 consolidated balance sheets and statements of operations.

A reconciliation of the fair value measurements using significant unobservable inputs (Level 3) is as follows for 2019 and 2018:

	Trust Funds Administered by Others
Balance at September 30, 2017	$11,002
Net realized and unrealized gains	49
Balance at September 30, 2018	11,051
Net realized and unrealized losses	(148)
Balance at September 30, 2019	$10,903

The table below sets forth additional disclosures for investment funds (other than mutual funds) valued based on net asset value to further understand the nature and risk of the investments by category:

	Fair Value	Unfunded Commit-ments	Redemption Frequency	Redemption Notice Period
September 30, 2019:				
Funds-of-funds	$15,855	$ –	Semi-monthly	5 days
Funds-of-funds	10,123	–	Monthly	15 days
Funds-of-funds	57,755	–	Quarterly	45 – 65 days
Funds-of-funds	14,807	–	Annual	60 - 90 days
Funds-of-funds	8,912	–	Semi-annual	60 days*
Funds-of-funds	4,979	15,283	Illiquid	N/A
Collective trust funds	14,569	–	Daily	10 days
Collective trust funds	48,251	–	Monthly	6 – 10 days

(In thousands)

14. Fair Value Measurements (Continued)

	Fair Value	Unfunded Commit-ments	Redemption Frequency	Redemption Notice Period
September 30, 2018:				
Funds-of-funds	$15,060	$ –	Semi-monthly	5 days
Funds-of-funds	10,300	–	Monthly	15 days
Funds-of-funds	52,984	–	Quarterly	45 – 65 days
Funds-of-funds	19,348	–	Annual	60 - 90 days
Funds-of-funds	8,342	–	Semi-annual	60 days*
Funds-of-funds	2,033	4,412	Illiquid	N/A
Collective trust funds	14,062	–	Daily	10 days
Collective trust funds	50,697	–	Monthly	6 – 10 days

* Limited to 25% of the investment balance at each redemption.

Investment Strategies

Fixed Income Securities

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 and Other Securities

The primary purpose of marketable 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 marketable equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics including style and capitalization. The System may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

The System invests in other securities that are considered alternative investments that consist of limited partnership interests in investment funds, which, in turn, invest in diversified portfolios predominantly comprised of equity and fixed income securities, as well as options, futures contracts, and some other less liquid investments. Management has approved procedures pursuant to the methods in which the System 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. Collective trust funds are generally valued based on the proportionate share of total fund net assets.

(In thousands)

14. Fair Value Measurements (Continued)

System management is responsible for the fair value measurements of investments reported in the consolidated financial statements. Such amounts are generally determined using audited financial statements of the funds and/or recently settled transactions and is estimated using the net asset value per share of the fund. 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.

The Hospital has committed to invest up to $19,683 with various investment managers, and had funded $4,400 of that commitment as of September 30, 2019. As these investments are made, the Hospital reallocates resources from its current investments resulting in an asset allocation shift within the investment pool.

Inflation-Protected Securities

The primary purpose of inflation-protected securities is to provide protection against the negative effects of inflation.

Fair Value of Other Financial Instruments

Other financial instruments consist of accounts and pledges receivable, accounts payable and accrued expenses, estimated third-party payor settlements, and long-term debt and notes payable. The fair value of all financial instruments other than long-term debt and notes payable approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value. The fair value of the System's long-term debt and notes payable is estimated using discounted cash flow analyses, based on the System's current incremental borrowing rates for similar types of borrowing arrangements. The carrying value and fair value of the System's long-term debt and notes payable amounted to $129,436 and $148,672, respectively, at September 30, 2019, and $138,949 and $155,435, respectively, at September 30, 2018.

15. Financial Assets and Liquidity Resources

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

Cash and cash equivalents	$ 6,404
Short-term investments	23,228
Accounts receivable	68,614
Funds held by trustee for workers' compensation reserves, self-insurance escrows and construction costs	38,141
	$136,387

15. **Financial Assets and Liquidity Resources (Continued)**

To manage liquidity, the System maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents and short-term investments include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the System. In addition, the System has board-designated assets without donor restrictions that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2019, the balance of liquid investments in board-designated assets was $276,690.

CONCORD HOSPITAL
BOARD OF TRUSTEES
2020

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David Stevenson, MD
Jeffrey Towle
Tanja Vanderlinde, MD (ex-officio, CH Medical Staff President)

Treasurer (not Member of the Board):
Scott W. Sloane

9/2020

LISA K. MADDEN, MSW, LICSW

PROFESSIONAL EXPERIENCE

Riverbend Community Mental Health Center, Inc., Concord, NH, 5/2020 – present
President and Chief Executive Officer
Concord Hospital, Concord, NH, 5/2020 – present
Vice President of Behavioral Health
Chief executive for a full service community mental health center serving the greater Concord community. This position is responsible for the oversight of all clinical, financial, human resource, community advocacy and fundraising operations. Riverbend is a member of the Capital Region Health Care system and the President & CEO sits on the Board of Directors. This Vice President of Behavioral Health at Concord Hospital is a member of the senior leadership team. This position works collaboratively with medical and administrative leadership to advance services for those dealing with mental illness and addiction issues. This position is responsible for the oversight of all professional psychiatric services in the facility. The VP works closely with the nursing leadership to manage the inpatient psychiatric treatment services as well.

Southern New Hampshire Health, Nashua, NH, 7/15 – 5/2020
Associate Vice President of Behavioral Health
Executive Director of Region 3 Integrated Delivery Network
Responsible for the oversight of all behavioral health services within Southern New Hampshire Health system, this includes services at Southern New Hampshire Medical Center (SNHMC) and Foundation Medical Partners (FMP). In addition, serve as the Executive Director of the 1115 DSRIP Integrated Delivery Network (ION) for the Greater Nashua region. Duties for both positions include:

- Member of the Executive Leadership Team for both SNHMC and FMP.
- Oversee the program development, implementation and clinical services in the following departments:
  - Emergency Department
  - Partial Hospital Program (PHP)
  - Intensive Outpatient Program for Substance Use Disorders (IOP)
  - 18 bed inpatient behavioral health unit (BHU)
  - Foundation Counseling and Wellness -outpatient clinical services
  - Foundation Collaborative Care - outpatient psychiatric evaluation and medication management
  - Center for Recovery Management - medication for addiction treatment (MAT)
  - Integrated Behavioral Health in Primary Care Practices
- Responsible for the fiscal management of the above.
- Work closely with medical providers, practice managers and staff to address the needs of people living with mental illness and addictions. Addressing issues related to stigma and supporting their efforts to treat everyone with dignity and respect.
- Represent SNHH in community forums including:
  - New Hampshire Hospital Association Behavioral Health Peer Group

  - New Hampshire Hospital Association Behavioral Health Learning Collaborative
  - Mayor's Suicide Prevention Task Force
- Seek funding for programs from various foundations and organizations.
- Participate in quality reviews and discussions with private insurance companies and state managed care organizations. Discussions include incentive options and program development opportunities for their members.
- Work closely with DHHS leadership to advance clinical treatment options in the community.
- Responsible for the implementation of the 1115 DSRIP waiver in Greater Nashua
  - SNHMC is the fiscal agent for the demonstration.
  - Work closely with 30 community partners to achieve the goals of the waiver.
  - Member of the Workforce Development Policy Subcommittee, focus on legislative opportunities that will assist with addressing the workforce shortage in NH.
  - Participate in extensive governance process that assures transparency in the distribution of funds to community partners.
  - Assure the special terms and conditions established by the state are implemented.

Center for Life Management, Derry, NH
Vice President and Chief Operating Officer, 6/05 - 6/15

Responsible for the oversight of efficient operations of outpatient clinical systems of care in accordance with all federal and state requirements.

- Oversee all clinical services for the Community Mental Health Center for Region 10 in New Hampshire. Services include various therapeutic interventions, targeted case management, supported housing, wellness services, integrated care and community support services.
- Increased revenue by over 100% and increased staff by 41%. Responsible for the management of approximately 200 employees under operations.
- Established and maintain clinical service goals and incentive pay for performance system within a financially self-sustaining model of care.
- Provide leadership for extensive program development. Responsible for the implementation and expansion of new or existing programs in response to community needs.
- Responsible for monitoring clinical and administrative costs and revenue generation as well as the submission of the annual program budgets to the President and CEO.
- Collaborate with the Vice President of Quality and Compliance to determine the training needs for clinical and administrativestaff.
- Assist the President and CEO in developing short and long range strategic plan including program expansions, business development, facilities and capital usage and/or improvements.
- Responsible for the establishment and maintenance of an integrated care model which allows for seamless access to services within the agency, coordination of services with area healthcare providers, as well as provision of behavioral healthcare consultation services at the physicians offices.
- Assisted in the process of consolidating three sites into one new facility in July 2007. Primary responsibility for the expansion of services in Salem in September 2014.
- Worked closely with the COO of a local hospital to develop and expand a long term contract to provide emergency evaluation services at the hospital and to assist

with disposition to appropriate level of care.

- Worked extensively with Senior Management to prepare for Medicaid Care Management in New Hampshire. Part of the team that established the first in the state per member per month contract with the MCO's inclusive of incentive metrics.

Lisa K Madden, LICSW, LLC
Consultant, 6/04 - 6105

Independent contractor providing consultation services to a community counseling center and a specialized foster care organization.

Interim Clinic Director, 8104 - 5105
Wayside Youth and Family Support, Framingham, MA

Responsible for the turnaround management of a large community counseling center in Framingham. Accomplishments include:

- Reorganized clinical team, supervisory structure and support staff functions
- Implemented necessary performance improvement plans
- Hired staff with significantly increased productivity expectations
- Assisted in the implementation of a new Performance Management and Billing System
- Worked diligently to foster a positive work environment through extensive verbal and written communication; staff involvement in decisions when appropriate; providing direct feedback when necessary; and by providing support. The goal was to foster a positive and cooperative "culture" in the clinic.
- Assisted senior management with budget development.

Clinical Supervisor, 7104 - 6105
The Mentor Network, Lawrence MA

- Provide clinical supervision to MSW's seeking independent licensure.
- Provide training and consultation to the staff on such topics as diagnostic evaluations, treatment plans and case presentations.
- Provide group support and trauma debriefing after a critical incident.

The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)
The Family Counseling Center
Northeast Regional Clinic Director, Lawrence, .MA 12/99 - 9/03

Responsible for turnaround management of the clinics in the Northeast Region of MSPCC, specifically the cities of Lawrence, Lynn and Lowell. The clinics had been struggling with staff recruitment and retention, reduced revenue, poor management of contracts, as well as significant problems in the medical records department. Responsibilities included budget development, implementation and accountability. Accomplishments include:

- Grew clinical team from 15 to 32 clinicians in three years.
- Developed Multi-Cultural Treatment Team.
- Increased annual third party revenue by 70%; increased annual contract revenue by 65%.
- Contracts with the Department of Social Services; the Department of Mental Health in conjunction with the Professional Parent Advocacy League; the Department of Education and the Community Partnerships for Children and HeadStart.
- Organized a successful site visit for re-licensure from the Department of Public Health (DPH) as well as the Council on Accreditation (COA).
- Reorganized Medical Records to meet DPH and COA standards; reorganize claims support resulting in increased revenue received for services rendered and significantly reduced write-offs.
- Participated on the HIPAA Task force-assisted in the development and implementation of the federally mandated Health Information Portability and Accountability Act policies and procedures for **MSPCC.**

Clinic Director, Hyannis, MA 9/95-12/99
Responsible for the turnaround management of a regional clinic serving children and families on Cape Cod. The clinic had experienced over 70% turnover, significant reduction in revenue, and a series of very negative stories in the local media because of the agency's response to the implementation of managed care. Responsible for marketing and public relations; redevelopment of a high quality clinical treatment team; as well as, increasing revenue and program development. Accomplishments include:

- Grew clinical team from 12 to 37 in three years.
- Streamlined intake procedures to increase access to services and reduce wait times.
- Increased annual third party revenue by 80%.
- Developed consultative relationships with two of Cape Cod's most well respected children's services providers.
- Developed first private/public partnership between MSPCC and a private practice to increase the availability of specialty clinical services.
- Developed internship program for Master's level clinician candidates.

North Essex Community Mental Health Center, (NECMHC, Inc.), Newburyport/Haverhill, MA
Employee Assistance Professional, Clinical Social Worker, 9/93-7/95

NECMHC, Inc., Newburyport/Haverhill, MA
Clinical Social Worker - Intern, 5193-9/93

Worcester Children's Friend Society, Worcester, MA
Clinical Social Worker - Intern, 9/92-4/93

The Jernberg Corporation, Worcester, MA
EAP Case Management Supervisor, 4190-4/93
EAP Case Manager, 2/89-4/90

The Carol Schmidt Diagnostic Center and Emergency Shelter, YOU, Inc., Worcester, MA, 10/85-2/89
Clinical Counselor I & II

EDUCATION

University of Connecticut, School of Social Work, West Hartford, CT
Masters in Social Work, Casework/Administration, August 1993

Clark University, Worcester, MA
Bachelor of Arts, Government/Human Services, May 1985

PROFESSIONAL LICENSE

Licensed Independent Clinical Social Worker, MA # 1026094

TEACHING and PUBLICATION

Mental Health Management, New England College, Graduate School
Summer2007

Madden, Lisa K., 2009. Targeted Case Management Implementation at the Center for Life Management, Compliance Watch, volume 2, issue 3, p. 8-10.

References available upon request

Monica L. Percy Edgar

Education/Professional Certificates

1994 – 1998

Masters in Psychiatric Nursing - Rivier College, Nashua, NH.
Focus of practicum sites:
Hospital Consultation – Dartmouth Hitchcock Medical Center, Lebanon NH
Assessment and Individual/Group therapy with co-occurring-
Substance Use Services (SUS), Concord Hospital, Concord, NH.
Psychiatric Assessment/Psychopharmacotherapy – Concord Psychiatric Associates, Concord, NH.

1985 – 1987

B. S. in Nursing, Castleton State College, Castleton, VT.

1981 – 1984

A. D. in Nursing, Castleton State College, Castleton, VT

Certified Adult Psychiatric and Mental Health Clinical Specialist, American Nurse Credentialing Ctr

Drug Enforcement Administration (DEA) License with X waiver

Licensed Advanced Practice Registered Nurse, New Hampshire

Licensed Registered Nurse, New Hampshire

Master Licensed Alcohol and Drug Counselor

Professional Experience

2010 to Present

Director, Concord Hospital Substance Use Services; Provide both Administrative and Clinical responsibilities.

2017 to Present

Medication Assisted Therapy (MAT) Provider, Riverbend Community Mental Health Ctr. Choices, Provide assessment and MAT for substance use disorders.

1998 to 2017

Psychiatric Nurse Practitioner, Riverbend Counseling Associates, Concord, NH.
Psychiatric evaluation and psychopharmacotherapy.

1998 to 2010

Psychiatric Nurse Practitioner, Substance Use Services, Concord Hospital, Concord, NH.
Co-occurring diagnosis evaluations, psychopharmacotherapy, facilitator of individual and group therapy, provide insurance utilization review, implementation of evidence based practices, consultation for colleagues, and patient advocate.

1996 to 1998

Case Manager for Psychiatric Partial Hospitalization Program and Outpatient Electro-convulsive Therapy (ECT) program, Concord Hospital, Concord, NH.
Developed and implemented outpatient ECT program, and provided case management services.

1995-1998

Staff Nurse for Fresh Start, Concord Hospital, Concord, NH.
Substance use disorders assessment, case management, and facilitator of psycho-educational groups in the intensive outpatient program (IOP).

1991-1996

Staff Nurse, Acute Adult Psychiatric Unit, Concord Hospital, Concord, NH.
Psychiatric nursing assessment and treatment, planned and implemented therapeutic groups, Clinical II RN, Evening Senior Resource Person (RP), and coordinated unit staffing schedule.

1990 to 1991

Medical-Surgical Staff Nurse, Medical-Surgical Unit, Copley Hospital, Morrisville, VT.
Provided medical-surgical nursing care to all ages.

1989 to 1990

Charge Nurse, Long-term Geriatric Facility, McKerley Health Care Center, Laconia, NH.
Supervised and provided geriatric nursing care.

1985 to 1989

Charge Nurse, Chemical Dependency Rehabilitation, Seminole Point Hospital, Sunapee, NH.
Assessment and treatment of adult substance use disorder withdrawal management.

Honors and Professional Memberships

Member of NH Governor's Commission, Treatment and Recovery Task Force

2009 Addiction Health Services Research Award, Center Substance Abuse Treatment (CSAT)

2008 New England Addiction Leadership Institute, New Hampshire Representative

Member of American Society of Addiction Medicine

Member, New Hampshire Nurse Practitioner Association

Member, New Hampshire Alcohol and Drug Association

Member, Sigma Theta Tau, National Honor Society, Graduate Level

Seminars and in-service trainings throughout career

RESUME

ROBERT P. STEIGMEYER

Career History:

1/2014 – Present	Capital Region Health Care and Concord Hospital Concord, NH	President and CEO
2012 – 12/2013	Geisinger Community Medical Center Scranton, PA	CEO
2010 – 2012	Community Medical Center Healthcare System Scranton, PA	President and CEO
2005 – 2010	Northwest Hospital & Medical Center Seattle, WA	Senior Vice President-Operations & Finance
1993 – 2005	ECG Management Consultants Seattle, WA	Principal/Shareholder Senior Manager Manager
1989 – 1993	Ernst & Young St. Louis, MO	Manager Senior Consultant Consultant

Educational Background:

1989	Master of Health Administration Master of Business Administration St. Louis University
1985	Bachelor of Arts Wabash College

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Lisa K. Madden	VP, Behavioral Health		0%	
Monica Edgar	Director, Substance Use Services		0%	
Robert Steigmeyer	President & CEO		0%	

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 3rd Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #3") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Littleton Hospital Association d.b.a. Littleton Regional Healthcare, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 600 Saint Johnsbury Road, Littleton, NH 03561.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 31, 2018 (Item #17A), as amended on September 18, 2019, (Item #20), and on June 24, 2020, (Item #31) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Paragraph 3. Renewal, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement and increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $2,160,689.

3. Modify Exhibit A Amendment #1, Scope of Services, by replacing in its entirety with Exhibit A Amendment #3, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.

4. Modify Exhibit B Amendment #1, Methods and Conditions Precedent to Payment, by replacing in its entirety with Exhibit B Amendment #3, Methods and Conditions Precedent to Payment, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein.

5. Modify Exhibit B-1 Budget by reducing the total budget amount by $388,115, which is identified as unspent funding of which $175,000 is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020), as specified in Exhibit B-4 Amendment #3 NCE; and of which $213,115 is being carried forward to fund the activities in this Agreement for SFY 21 (January 1, 2021 through June 30, 2021) as specified, in part, in Exhibit B-6 Amendment #3.

6. Add Exhibit B-4 Amendment #3 NCE, which is attached hereto and incorporated by reference herein.

7. Add Exhibit B-5 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.

8. Add Exhibit B-6 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

9. Add Exhibit B-7 Amendment #3 GovComm, which is attached hereto and incorporated by

reference herein.

10. Add Exhibit B-8 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective September 29, 2020, upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/17/2020
Date

DocuSigned by:
Katja Fox
ED8D05B04CB3442...
Name: Katja Fox
Title: Director

Littleton Hospital Association d.b.a. Littleton Regional Healthcare

12/16/2020
Date

DocuSigned by:
Robert Nutter
A165528D0D154D2...
Name: Robert Nutter
Title: President & CEO

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/17/2020
Date

DocuSigned by:
D5CA9202E32C4AE...
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. All Exhibits B Amendment #3 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Littleton Region with access to referrals to SUD treatment and recovery support services and other health and social services.

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

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

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

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

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

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

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

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

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

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

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

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

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

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

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

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

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

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

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

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

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff, capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

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

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

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

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

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

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

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

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

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

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

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

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

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

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

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

3.1.10.5.4.1.1. A Doorway client;

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

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

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

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

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

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

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service

provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

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

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

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

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

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

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

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

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

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

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

3.1.11.8.3. Upon discharge from the initially referred service.

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

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

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare,

and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

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

3.3. The Contractor shall provide services in accordance with:

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

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

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

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

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

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

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

4. Subcontracting for the Doorways

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

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

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

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

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

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

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

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

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

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

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

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

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

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

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

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

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

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

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

5.7.4.1. The contract requirements.

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

5.8. The Contractor shall provide staff, subcontractors, or end users as defined in Exhibit K with periodic training in practices and procedures to ensure compliance with information

security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (14) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

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

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

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

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

7. Health Insurance Portability and Accountability Act and Confidentiality:

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

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

8. Reporting Requirements.

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

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

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

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

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

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

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s)

must collect and share data with the Department in a format specified by the Department.

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

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

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

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

11.4. The Contractor and referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal

management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

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

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

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

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

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

13. Termination Report/Transition Plan

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

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

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

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

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

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

14. Credits and Copyright Ownership

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

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

15. Operation of Facilities: Compliance with Laws and Regulations

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

16. Equal Employment Opportunity Plan (EEOP)

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

17. Equipment Purchases

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

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

18. Compliance with Federal and State Laws

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

18.2. Time and Manner of Determination.

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

18.3. Documentation

18.3.1. In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The

Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

18.4. Fair Hearings

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

EXHIBIT B Amendment #3

Methods and Conditions Precedent to Payment

1. This Agreement is funded by:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI083326.
   1.2. 2.72% Other Funds from Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment Funds.
2. Governor Commission Funds.
   2.1. The Contractor shall utilze funds in Exhibit B-5 Amendment #3 GovComm and Exhibit B-7 Amendment #3 GovComm for the purpose of providing services and supports to clients whose needs to not make them eliglbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit B-1, Budget through Exhibit B-8 Amendment #3 SOR II.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or other payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

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

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

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

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

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

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

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported:

6.1.3.1. Unallowable expenses include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

6.1.3.1.7. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference

grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

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

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

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

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

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

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

11. 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.

12. The Contractor must provide the services in Exhibit A, Amendment #3 Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A Amendment #3, Scope of Services, including failure to submit required monthly and/or quartery reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

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

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

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

Contractor Name: Littleton Hospital Association d.b.a Littleton Regional Healthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-07
Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 75,000.00	$ -	$ 75,000.00		$ -	$ -	$ 75,000.00	$ -	$ 75,000.00
2. Employee Benefits	$ 15,000.00	$ -	$ 15,000.00		$ -	$ -	$ 15,000.00	$ -	$ 15,000.00
3. Consultants	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
Lab	$ 4,000.00	$ -	$ 4,000.00		$ -	$ -	$ 4,000.00	$ -	$ 4,000.00
Pharmacy	$ 30,000.00	$ -	$ 30,000.00		$ -	$ -	$ 30,000.00	$ -	$ 30,000.00
Medical	$ 3,000.00	$ -	$ 3,000.00		$ -	$ -	$ 3,000.00	$ -	$ 3,000.00
Office	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ 18,000.00	$ -	$ 18,000.00		$ -	$ -	$ 18,000.00	$ -	$ 18,000.00
8. Current Expenses	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
Flex Funding	$ 30,000.00	$ -	$ 30,000.00		$ -	$ -	$ 30,000.00	$ -	$ 30,000.00
	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -
TOTAL	$ 175,000.00	$ -	$ 175,000.00	$ -	$ -	$ -	$ 175,000.00	$ -	$ 175,000.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS RN

Date 12/16/2020

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

Contractor Name: Littleton Hospital Association d.b.a Littleton Regional Healthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-07

Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 3,000.00	$ -	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00	$ -	$ 3,000.00
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex Funding	$ 15,750.00	$ -	$ 15,750.00	$ -	$ -	$ -	$ 15,750.00	$ -	$ 15,750.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 18,750.00	$ -	$ 18,750.00	$ -	$ -	$ -	$ 18,750.00	$ -	$ 18,750.00
Indirect As A Percent of Direct		0.0%							

DS
RN
Contractor Initials

Date 12/16/2020

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

Contractor Name: Littleton Hospital Association d.b.a Littleton Regional Healthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-07
Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 154,500.00	$ -	$ 154,500.00				$ 154,500.00	$ -	$ 154,500.00
2. Employee Benefits	$ 30,900.00	$ -	$ 30,900.00				$ 30,900.00	$ -	$ 30,900.00
3. Consultants	$ -	$ -	$ -				$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -				$ -	$ -	$ -
Rental	$ -	$ -	$ -				$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -				$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -				$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -				$ -	$ -	$ -
Educational	$ -	$ -	$ -				$ -	$ -	$ -
Lab	$ 4,000.00	$ -	$ 4,000.00				$ 4,000.00	$ -	$ 4,000.00
Pharmacy	$ 40,000.00	$ -	$ 40,000.00				$ 40,000.00	$ -	$ 40,000.00
Medical	$ 3,000.00	$ -	$ 3,000.00				$ 3,000.00	$ -	$ 3,000.00
Office	$ -	$ -	$ -				$ -	$ -	$ -
6. Travel	$ 1,000.00	$ -	$ 1,000.00				$ 1,000.00	$ -	$ 1,000.00
7. Occupancy	$ 37,080.00	$ -	$ 37,080.00				$ 37,080.00	$ -	$ 37,080.00
8. Current Expenses	$ -	$ -	$ -				$ -	$ -	$ -
9. Software	$ -	$ -	$ -				$ -	$ -	$ -
10. Marketing/Communications	$ 10,000.00	$ -	$ 10,000.00				$ 10,000.00	$ -	$ 10,000.00
11. Staff Education and Training	$ 10,000.00	$ -	$ 10,000.00				$ 10,000.00	$ -	$ 10,000.00
12. Subcontracts/Agreements	$ -	$ -	$ -				$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -				$ -	$ -	$ -
Flex funding	$ 132,853.00	$ -	$ 132,853.00				$ 132,853.00	$ -	$ 132,853.00
	$ -	$ -	$ -				$ -	$ -	$ -
	$ -	$ -	$ -				$ -	$ -	$ -
TOTAL	$ 423,333.00	$ -	$ 423,333.00	$ -	$ -	$ -	$ 423,333.00	$ -	$ 423,333.00
Indirect As A Percent of Direct		0.0%							

DS
RN
Contractor Initials

Date 12/16/2020

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

Contractor Name: Littleton Hospital Association d.b.a Littleton Regional Healthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-07

Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -				$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -				$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -				$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -				$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -				$ -	$ -	$ -
6. Travel	$ -	$ -	$ -				$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -				$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -				$ -	$ -	$ -
9. Software	$ -	$ -	$ -				$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -				$ -	$ -	$ -
11. Staff Education and Training	$ 1,000.00	$ -	$ 1,000.00				$ 1,000.00	$ -	$ 1,000.00
12. Subcontracts/Agreements	$ -	$ -	$ -				$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -				$ -	$ -	$ -
Flex funding	$ 5,250.00	$ -	$ 5,250.00				$ 5,250.00	$ -	$ 5,250.00
	$ -	$ -	$ -				$ -	$ -	$ -
	$ -	$ -	$ -				$ -	$ -	$ -
TOTAL	$ 6,250.00	$ -	$ 6,250.00	$ -	$ -	$ -	$ 6,250.00	$ -	$ 6,250.00

Indirect As A Percent of Direct 0.0%

Contractor Initials DS RN

Date 12/16/2020

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

Contractor Name: Littleton Hospital Association d.b.a Littleton Regional Healthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-07
Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 77,250.00	$ -	$ 77,250.00				$ 77,250.00	$ -	$ 77,250.00
2. Employee Benefits	$ 15,450.00	$ -	$ 15,450.00				$ 15,450.00	$ -	$ 15,450.00
3. Consultants	$ -	$ -	$ -				$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -				$ -	$ -	$ -
Rental	$ -	$ -	$ -				$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -				$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -				$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -				$ -	$ -	$ -
Educational	$ -	$ -	$ -				$ -	$ -	$ -
Lab	$ 4,000.00	$ -	$ 4,000.00				$ 4,000.00	$ -	$ 4,000.00
Pharmacy	$ 30,900.00	$ -	$ 30,900.00				$ 30,900.00	$ -	$ 30,900.00
Medical	$ 3,000.00	$ -	$ 3,000.00				$ 3,000.00	$ -	$ 3,000.00
Office	$ -	$ -	$ -				$ -	$ -	$ -
6. Travel	$ -	$ -	$ -				$ -	$ -	$ -
7. Occupancy	$ 18,540.00	$ -	$ 18,540.00				$ 18,540.00	$ -	$ 18,540.00
8. Current Expenses	$ -	$ -	$ -				$ -	$ -	$ -
9. Software	$ -	$ -	$ -				$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -				$ -	$ -	$ -
11. Staff Education and Training	$ 3,000.00	$ -	$ 3,000.00				$ 3,000.00	$ -	$ 3,000.00
12. Subcontracts/Agreements	$ -	$ -	$ -				$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -				$ -	$ -	$ -
	$ 59,526.00	$ -	$ 59,526.00				$ 59,526.00	$ -	$ 59,526.00
	$ -	$ -	$ -				$ -	$ -	$ -
	$ -	$ -	$ -				$ -	$ -	$ -
TOTAL	$ 211,666.00	$ -	$ 211,666.00	$ -	$ -	$ -	$ 211,666.00	$ -	$ 211,666.00
Indirect As A Percent of Direct		0.0%							

DS
RN
Contractor Initials

Date 12/16/2020

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 LITTLETON HOSPITAL ASSOCIATION is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on April 04, 1906. 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: **60919**

Certificate Number: **0004924162**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 2nd day of June A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, ROGER GINGUE, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of Littleton Hospital Association dba Littleton Regional Healthcare.
(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 December 12, 2016, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That ROBERT F. NUTTER, President & CEO

is duly authorized on behalf of Littleton Hospital Association dba Littleton Regional Healthcare to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated:_____, 2020

Roger Gingue
Roger Gingue (Dec 3, 2020 11:29 EST)

Signature of Elected Officer
Name: ROGER GINGUE
Title: Chairman, Board of Trustees

DocuSign Envelope ID: 6695C8BC-F1F7-406C-B156-9BBBA550E6E8

CERTIFICATE OF LIABILITY INSURANCE

Date: 09/28/20

Administrator:
New England Special Risks, Inc.
19 Oyster Way
Mashpee, Ma. 02649
Phone: (508) 561-6111

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

INSURERS AFFORDING COVERAGE

Insurer A:	Coverys Insurance Co.
Insurer B:	AIM Mutual Insurance Co.
Insurer C:	
Insurer D:	
Insurer E:	

Insured:
Littleton Hospital Association DBA Littleton Regional Healthcare
600 St. Johnsbury Rd.
Littleton, NH. 03561

Coverages

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 the 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, aggregate limits shown may have been reduced by paid claims.

INS. LTR.	TYPE OF INSURANCE	POLICY NUMBER	Policy Effective Date	Policy Expiration Date	LIMITS		
A	**General Liability** ☑ Commercial General Liability ☐ Claims Made ☑ Occurrence ☐ ☐ General Aggregate Limit Applies Per: ☑ Policy ☐ Project ☐ Loc	005NH-000032874	10/1/2020	10/1/2021	Each Occurrence	$	1,000,000
					Fire Damage (Any one fire	$	50,000
					Med Exp (Any one person)	$	5,000
					Personal & Adv Injury	$	1,000,000
					General Aggregate	$	3,000,000
					Products - Comp/Op Agg	$	1,000,000
	Automobile Liability ☐ Any Auto ☐ All Owned Autos ☐ Scheduled Autos ☐ Hired Autos ☐ _____				Combined Single Limit (Each accident)	$	
					Bodily Injury (Per person)	$	
					Bodily Injury (Per accident)	$	
					Property Damage (Per accident)	$	
	Garage Liability ☐ Any Auto ☐				Auto Only - Ea. Accident	$	
					Other Than Auto Only: Ea. Acc	$	
					Other Than Auto Only: Agg	$	
A	**Excess Liability** ☑ Occurrence ☑ Claims Made ☐ Deductible ☐ Retention $	005NH-000032874	10/1/2020	10/1/2021	Each Occurrence	$	10,000,000
					Aggregate	$	10,000,000
						$	
						$	
						$	
B	**Workers Compensation and Employers' Liability**	ECC-600-4000599	10/1/2020	10/1/2021	☑ Statutory Limits ☐ Other		
					E.L. Each Accident	$	500,000
					E.L. Disease-Ea. Employe	$	500,000
					E.L. Disease - Policy Limit	$	500,000
A	**Healthcare Medical Professional Liability-Claims Made**	005NH-000032874	10/1/2020	10/1/2021	Per Incident		$1,000,000
					Aggregate		$3,000,000

Description of operations/vehicles/exclusions added by endorsement/special provision

Evidence of Current General Liability, Healthcare Professional Liability, Excess Liability and Workers Compesation Insurance Coverage for the Insured.

Certificate Holder

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

Should any of the above policies be canceled before the expiration date thereof, the issuing insurer will endeavor to mail 10 days written notice to the certificate holder named to the left, but failure to do so shall impose no obligation or liability of any kind upon the insurer, its agents or representatives.

Authorized Representative

Emanuel Palabrica

NCH north country healthcare | Littleton Regional Healthcare

About LRH

Our Mission

To provide quality, compassionate and accessible healthcare in a manner that brings value to all.

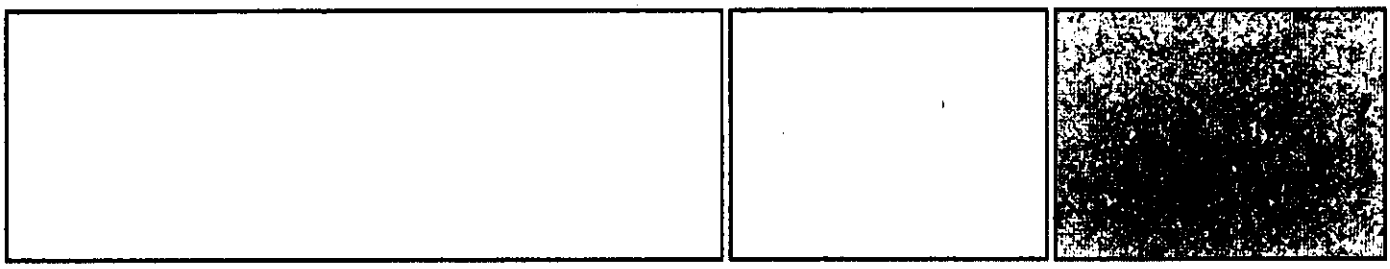
Our Vision

LRH will be the leading provider of health care, and the best organization in which to work.

Our Values

- ICARE: Integrity, Compassion, Accountability, Respect, Excellence

BerryDunn



LITTLETON REGIONAL HEALTHCARE

LITTLETON HOSPITAL ASSOCIATION, INC. (d/b/a LITTLETON REGIONAL HEALTHCARE)

FINANCIAL STATEMENTS

September 30, 2019 and 2018

With Independent Auditor's Report

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

September 30, 2019 and 2018

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BerryDunn

INDEPENDENT AUDITOR'S REPORT

The Board of Trustees
Littleton Hospital Association, Inc.
(d/b/a Littleton Regional Healthcare)

We have audited the accompanying financial statements of Littleton Hospital Association, Inc. (d/b/a Littleton Regional Healthcare), which comprise the balance sheets as of September 30, 2019 and 2018, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. 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 auditor's 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 Littleton Regional Healthcare as of September 30, 2019 and 2018, and the results of its operations, changes in its net assets, and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Other Matter

Change in Accounting Principle

As discussed in Note 1 to the financial statements, in 2019 Littleton Regional Healthcare adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities (Topic 958)*. Our opinion is not modified with respect to this matter.

Berry Dunn McNeil & Parker, LLC

Manchester, New Hampshire
February 24, 2020

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Balance Sheets

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets		
Cash and cash equivalents	$ 291,187	$ 3,958,019
Patient accounts receivable, net	11,060,454	9,123,489
Supplies	2,195,332	1,938,794
Due from related parties	254,633	402,081
Prepaid expenses and other current assets	4,520,285	4,425,652
Total current assets	18,321,891	19,848,035
Assets limited as to use	44,765,838	49,022,077
Property and equipment, net	38,050,941	37,741,010
Total assets	$101,138,670	$106,611,122

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

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities		
Current portion of long-term debt	**$ 1,263,501**	$ 1,176,795
Accounts payable and other accrued expenses	**5,149,630**	2,631,216
Accrued salaries, wages and related accounts	**4,050,563**	3,230,895
Other current liabilities	**608,811**	520,715
Current portion of estimated third-party payor settlements	**1,831,892**	3,368,403
Due to related parties	**220,743**	530,458
Total current liabilities	**13,125,140**	11,458,482
Deferred compensation	**3,039,019**	2,970,751
Long-term debt, less current portion	**23,283,793**	24,463,800
Estimated third-party payor settlements, less current portion	**7,000,377**	5,598,948
Interest rate swap	**2,319,861**	1,507,465
Total liabilities	**48,768,190**	45,999,446
Net assets		
Without donor restrictions	**49,733,881**	58,054,504
With donor restrictions	**2,636,599**	2,557,172
Total net assets	**52,370,480**	60,611,676
Total liabilities and net assets	**$101,138,670**	$106,611,122

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Statements of Operations

Years Ended September 30, 2019 and 2018

	2019	2018
Revenues, gains and other support without donor restrictions		
Patient service revenue (net of contractual allowances and discounts)	$ 95,403,886	$ 90,193,850
Less provision for bad debts	5,343,535	5,295,151
Net patient service revenue	90,060,351	84,898,699
Other revenues	5,228,745	5,373,017
Net assets released from restriction for operations	71,826	306,293
Total revenues, gains and other support without donor restrictions	95,360,922	90,578,009
Expenses		
Salaries, wages and fringe	52,914,768	46,613,305
Contract labor	6,472,460	5,347,358
Supplies and other	30,560,522	27,716,375
Medicaid enhancement tax	3,736,209	3,530,402
Depreciation	4,559,575	4,551,192
Interest	927,208	905,076
Total expenses	99,170,742	88,663,708
Operating (loss) income	(3,809,820)	1,914,301
Nonoperating gains (losses)		
Income from investments, net	936,224	2,687,417
Gifts without donor restrictions, net of expenses	39,326	38,840
Community benefit and contribution expense	(344,653)	(350,805)
Unrealized (loss) gain on interest rate swap	(812,396)	874,697
Other (loss) income	(4,329,304)	549,767
Nonoperating (losses) gains, net	(4,510,803)	3,799,916
(Deficiency) excess of revenues, gains and other support over expenses and losses and (decrease) increase in net assets without donor restrictions	$ (8,320,623)	$ 5,714,217

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

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Statements of Changes in Net Assets

Years Ended September 30, 2019 and 2018

	Without Donor Restrictions	With Donor Restrictions	Total
Balances, October 1, 2017	$ 52,340,287	$ 2,609,422	$ 54,949,709
Excess of revenues, gains and other support over expenses and increase in net assets without donor restrictions	5,714,217	-	5,714,217
Contributions	-	151,808	151,808
Investment income, net	-	102,235	102,235
Net assets released from restriction for operations	-	(306,293)	(306,293)
Increase (decrease) in net assets	5,714,217	(52,250)	5,661,967
Balances, September 30, 2018	58,054,504	2,557,172	60,611,676
Deficiency of revenues, gains and other support over expenses and losses and decrease in net assets without donor restrictions	(8,320,623)	-	(8,320,623)
Contributions	-	114,781	114,781
Investment income, net	-	36,472	36,472
Net assets released from restriction for operations	-	(71,826)	(71,826)
(Decrease) increase in net assets	(8,320,623)	79,427	(8,241,196)
Balances, September 30, 2019	$ 49,733,881	$ 2,636,599	$ 52,370,480

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

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Statements of Cash Flows

Years Ended September 30, 2019 and 2018

	2019	2018
Cash flows from operating activities		
(Decrease) increase in net assets	$ (8,241,196)	$ 5,661,967
Adjustments to reconcile (decrease) increase in net assets to net cash (used) provided by operating activities		
Provision for bad debts	5,343,535	5,295,151
Depreciation	4,559,575	4,551,192
Loss (gain) on sale of property and equipment	31,197	(117,983)
Net realized and unrealized gains on investments	(468,135)	(2,231,243)
Unrealized loss (gain) on interest rate swap	812,396	(874,697)
(Increase) decrease in assets		
Patients accounts receivable	(7,280,500)	(5,811,894)
Supplies	(256,538)	(117,193)
Prepaid expenses and other current assets	(94,633)	(2,543,744)
Due from related party	147,448	(254,243)
Increase (decrease) in liabilities		
Accounts payable and other accrued expenses	2,889,643	25,188
Accrued salaries, wages and related accounts	819,668	285,927
Other current liabilities	88,096	(343,272)
Due to third-party payors	(135,082)	568,582
Reserve for self-funded health insurance	-	(395,941)
Due to related party	(309,715)	486,744
Deferred compensation	68,268	344,117
Net cash (used) provided by operating activities	(2,025,973)	4,528,658
Cash flows from investing activities		
Purchases of investments	(16,256,825)	(18,316,948)
Proceeds from sale of investments	20,981,199	14,613,020
Purchases of property and equipment	(5,171,933)	(3,271,241)
Proceeds from sale of property and equipment	12,000	426,000
Net cash used by investing activities	(435,559)	(6,549,169)
Cash flows from financing activities		
Payments on long-term debt	(1,205,300)	(1,150,841)
Net cash used by financing activities	(1,205,300)	(1,150,841)
Net decrease in cash and cash equivalents	(3,666,832)	(3,171,352)
Cash and cash equivalents, beginning of year	3,958,019	7,129,371
Cash and cash equivalents, end of year	$ 291,187	$ 3,958,019
Supplemental disclosures of cash flow information		
Interest paid	$ 926,658	$ 901,835
Noncash investing and financing transactions		
Acquisition of property and equipment financed through capital lease	$ 111,999	$ 390,192
Acquisition of equipment included in accounts payable	$ -	$ 371,229

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

Organization

Littleton Hospital Association, Inc. (d/b/a Littleton Regional Healthcare) (Hospital) is a New Hampshire not-for-profit corporation which operates a community-oriented general hospital. Effective April 1, 2016, North Country Healthcare, Inc. (NCHI) became the sole corporate member of the Hospital. NCHI is also the parent company of Androscoggin Valley Hospital (AVH), Upper Connecticut Valley Hospital (UCVH), Weeks Medical Center (Weeks), and North Country Home Health & Hospice Agency, Inc. (Home Health) Any and all activity with these entities is disclosed as activity with related parties. Effective September 30, 2019, the Hospital formally disaffiliated with NCHI and is now a stand-alone hospital. The Hospital has indemnified certain employees and board members against claims made by NCHI and its affiliates. Any obligation the Hospital may incur under this arrangement is not reasonably estimable.

1. Summary of Significant Accounting Policies

Basis of Presentation

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification Topic (ASC) 958, *Not-For-Profit Entities*.

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Hospital. These net assets may be used at the discretion of the Hospital's management and the Board of Trustees.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Hospital or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Under FASB ASC 958 and FASB ASC 954, *Health Care Entities*, all not-for-profit healthcare organizations are required to provide a balance sheet, a statement of operations, a statement of changes in net assets, and a statement of cash flows. FASB ASC 954 requires reporting amounts for an organization's total assets, liabilities, and net assets in a balance sheet; reporting the change in an organization's net assets in the statements of operations and changes in net assets; and reporting the change in its cash and cash equivalents in a statement of cash flows.

Donor restricted contributions are reported as increases in net assets with donor restrictions. When a restriction expires, net assets are reclassified from net assets with donor restrictions to net assets without donor restrictions in the statements of operations and changes in net assets.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reported period. Actual results could differ from those estimates.

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income.

Cash and Cash Equivalents

Cash and cash equivalents include money market funds with a maturity of three months or less when purchased. Cash and cash equivalents exclude assets whose use is limited by the Board of Trustees. The Hospital maintains its cash in deposit accounts which, at times, may exceed federal depository insurance limits. Management believes credit risk related to these investments is minimal. The Hospital has not experienced any losses in such accounts.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to operations and a credit to a valuation allowance based on its assessment of individual accounts and historical adjustments. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to patient accounts receivable.

In evaluating the collectibility of accounts receivable, the Hospital analyzes past results and identifies trends for each major payor source of revenue for the purpose of estimating the appropriate amounts of the allowance for doubtful accounts and the provision for bad debts. The adequacy of the allowance for doubtful accounts is regularly reviewed. For receivables associated with services provided to patients who have third-party coverage, an allowance for doubtful accounts and a provision for bad debts are established at varying levels based on the age and payor source of the receivable. For receivables associated with self-pay patients, the Hospital records a provision for bad debts in the period of service based on past experience indicating the inability or unwillingness to pay amounts for which they are financially responsible.

Supplies

Supplies are carried at the lower of cost (determined by the first-in, first-out method) or market.

Investments and Investment Income

Investments in equity securities with readily-determinable fair values and all investments in debt

securities are measured at fair value in the balance sheets. Values of investments in limited partnerships or companies are based on the net asset values (NAV) per share of the respective funds as reported in the financial statements of the related interest and provided by the investment manager. Management reviews and evaluates the valuations provided by the investment managers and believes these valuations are a reasonable estimate of fair value at September 30, 2019 and 2018, but are subject to uncertainty and, therefore may differ from the value that would have been used had a ready market for the investments existed.

Management has adopted FASB ASC 825-10-35-4, *Financial Instruments - Overall - Subsequent Measurement - Fair Value Option*, and has elected the fair value option relative to its investments, which consolidates all investment performance activity within the nonoperating gains (losses) section of the statements of operations to simplify the presentation of investment return in the statement of operations.

Donor-restricted investment income and gains (losses) on investments on donor-restricted investments are recorded within net assets with donor restrictions until expended in accordance with the donor's restrictions.

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

Property and Equipment

Property and equipment acquisitions are recorded at cost or, if contributed, at fair market value determined at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings or equipment, are reported as support without donor restrictions unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Employee Fringe Benefits

The Hospital has an "earned time" plan to provide certain fringe benefits for its employees. Under

this plan, each employee "earns" paid leave each payroll period. Accumulated hours may be used for vacations, holidays or illnesses. Hours earned, but not used, vest with the employees up to established limits. The Hospital accrues the cost of these benefits as they are earned.

Interest Rate Swap

The Hospital uses an interest rate swap contract to eliminate the cash flow exposure of interest rate movements on variable-rate debt. The Hospital has adopted FASB ASC 815, *Derivatives and Hedging*, to account for its interest rate swap contract. The interest rate swap is not considered a cash flow hedge and, therefore, is included within nonoperating gains (losses).

Nonoperating Gains (Losses)

Activities other than those in connection with providing healthcare services are considered to be nonoperating. Nonoperating gains and losses consist primarily of income and gains and losses on invested funds, unrestricted gifts, community benefit expense, unrealized gain (loss) on interest rate swap, and expenses incurred related to the disaffiliation with NCHI.

(Deficiency) Excess of Revenues, Gains and Other Support Over Expenses and Losses

The statements of operations include (deficiency) excess of revenues, gains and other support over expenses and losses. Changes in net assets without donor restrictions, if any, which are excluded from (deficiency) excess of revenues, gains and other support over expenses and losses, consistent with industry practice, include net assets released from restriction for capital acquisition and net asset transfers.

Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively-determined rates per discharge, reimbursed costs, discounted charges and per diem rates. 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.

Donor Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. Contributions received with donor restrictions that limit the use of the donated assets are reported as net assets with donor restrictions. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net

assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restriction. Donor restricted contributions whose restrictions are met within the same year as received are reported as contributions without donor restrictions in the accompanying financial statements.

Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenue.

Transactions with Infrequency of Occurrence

A transaction not reasonably expected to recur in the foreseeable future is considered to occur infrequently. The past occurrence of an event or transaction for a particular entity provides evidence to assess the probability of recurrence of that type of event or transaction in the foreseeable future. During 2018, the Hospital entered into a class-action lawsuit with an investment bank related to misleading interest rates. The class-action lawsuit resulted in a favorable settlement to the Hospital in the amount of $549,767, which is included in other nonoperating income on the statement of operations.

Newly Adopted Accounting Pronouncement

In 2019, the Hospital adopted FASB Accounting Standards Update (ASU) No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities (Topic 958)*, which makes targeted changes to the not-for-profit financial reporting model. Under the ASU, net asset reporting is streamlined and clarified. The existing three category classification of net assets is replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property, plant, and equipment has also been simplified and clarified. New disclosures highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. The ASU also imposes several new requirements related to reporting expenses. The adoption of the ASU had no impact on previously reported total net assets and has been applied retrospectively to all periods presented.

Subsequent Events

For purposes of the preparation of these financial statements in conformity with U.S. GAAP, the Hospital has considered transactions or events occurring through February 24, 2020, which was the date the financial statements were available to be issued.

On October 7, 2019, the Hospital and NCHI executed an agreement providing that, effective September 30, 2019, the Hospital formally disaffiliated with NCHI, and is now a stand-alone hospital. The agreement was reached after several months of negotiations and a review by the New Hampshire Director of Charitable Trusts.

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Notes to Financial Statements

September 30, 2019 and 2018

2. Net Patient Service Revenue and Patient Accounts Receivable

Net Patient Service Revenue

Net patient service revenue is reported net of contractual allowances and other discounts as follows for the years ended September 30:

	2019	2018
Gross patient service revenue		
Routine services	$ 6,700,826	$ 6,784,417
Ancillary services	175,207,114	161,167,308
	181,907,940	167,951,725
Less contractuals and discounts	86,504,054	77,757,875
Patient service revenue (net of contractual allowances and discounts)	95,403,886	90,193,850
Less provision for bad debts	5,343,535	5,295,151
Net patient service revenue	$ 90,060,351	$ 84,898,699

Patient Accounts Receivable

Patient accounts receivable are stated net of estimated contractual allowances and allowance for bad debts as follows as of September 30:

	2019	2018
Patient accounts receivable	$ 27,597,943	$ 21,746,489
Less estimated contractual allowances	11,569,832	8,612,000
Less estimated allowance for bad debts	4,967,657	4,011,000
Patient accounts receivable, net	$ 11,060,454	$ 9,123,489

During 2019, the Hospital increased its estimates from approximately $2,115,000 to approximately $2,446,000 and from approximately $1,293,000 to approximately $1,804,000 in the allowance for doubtful accounts relating to self-pay and commercial insurance patients, respectively. During 2019, self-pay write-offs increased from approximately $6,119,000 to approximately $6,253,000. Such increases are the result of higher-deductible health insurance plans and staffing related issues which affected the revenue cycle process.

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

Medicare

The Hospital is a Critical Access Hospital (CAH). Under the CAH program, the Hospital is reimbursed at 101% of allowable costs for its inpatient and most outpatient services provided to Medicare patients. The Hospital is reimbursed at tentative rates with final determination after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's cost reports have been audited by the fiscal intermediary through September 30, 2015.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are reimbursed under prospectively-determined per-discharge rates. The prospectively-determined per-discharge rates are not subject to retroactive adjustment. Outpatient services rendered to Medicaid beneficiaries are reimbursed on a combination of prospectively-determined fee schedules and a cost reimbursement methodology. The Hospital is reimbursed for outpatient services at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid fiscal intermediary. The Hospital's cost reports have been audited by the fiscal intermediary through September 30, 2013.

Anthem

Inpatient and outpatient services rendered to Anthem subscribers are reimbursed based on standard charges, less a negotiated discount, except for lab and radiology services which are reimbursed on fee schedules.

Revenue from the Medicare and Medicaid programs accounted for approximately 33% and 10%, respectively, of the Hospital's patient service revenue (net of contractual allowances and discounts) for the year ended September 30, 2019, and 35% and 12%, respectively, of the Hospital's patient service revenue (net of contractual allowances and discounts) for the year ended September 30, 2018. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue decreased by approximately $50,000 and $262,000 in 2019 and 2018, respectively, due to changes in estimates and differences in retroactive adjustments compared to amounts previously estimated.

The Hospital has also entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Hospital under these agreements includes prospectively-determined rates, discount from charges and prospectively-determined daily rates.

The Hospital recognizes patient service revenue associated with services rendered to patients who have third-party payor coverage on the basis of contractual rates for such services. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates (or on the basis of discounted rates, if negotiated or provided by policy). Based on historical trends, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services rendered. Thus, the Hospital records a provision for bad debts related to uninsured patients in the period the services are rendered. Patient service revenue, net of contractual allowances and discounts but before the provision for bad debts, recognized in the period from these major payor sources are as follows:

	2019	2018
Total all payors		
Third-party payors	$ 90,251,626	$ 85,422,571
Self-pay	5,152,260	4,771,279
Patient service revenue (net of contractual allowances and discounts)	$ 95,403,886	$ 90,193,850

Disproportionate Share Hospital Payments

Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients. The federal government distributes federal DSH funds to each state based on a statutory formula. The states, in turn, distribute their portion of the DSH funding among qualifying hospitals. The states are to use their federal DSH allotments to help cover the costs of hospitals that provide care to low-income patients when those costs are not covered by other payors. The State of New Hampshire's plan for the distribution of DSH monies to its hospitals has not yet been approved by the Centers for Medicare and Medicaid Services (CMS). Therefore, amounts recorded by the Hospital are subject to change. Included within contractual allowances in patient service revenue (net of contractual allowances and discounts) in the statements of operations is approximately $4,500,000 and $3,542,000, respectively, for the years ended September 30, 2019 and 2018 related to DSH payments.

Long-term estimated third-party payor settlements consist of estimates related to Medicare's potential disallowance of Medicaid enhancement tax as an allowable cost and state disproportionate share pending settlements. Due to unresolved issues at the federal level for both matters, the Hospital has classified the balances as long-term.

3. Community Benefit

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Patients deemed as not meeting criteria for the New Hampshire Health Access Network are then considered for the Hospital's Charity Care program. The individual must be deemed ineligible for Medicaid and the Buffington Fund (Lisbon residents only) to be considered for the program.

Charity care is granted on a sliding scale based on gross income and family size as compared to the federal poverty guidelines as follows:

- Up to 200% of federal poverty guidelines receive 100% charity care;
- 201%-225% of federal poverty guidelines receive 75% charity care;
- 226%-275% of federal poverty guidelines receive 50% charity care; and
- 276%-300% of federal poverty guidelines receive 25% charity care.

The net cost of charity care provided was approximately $592,000 in 2019 and $569,000 in 2018. The total cost estimate is based on an overall financial statement cost to charge ratio applied against gross charity care charges. In 2019 and 2018, 0.60% and 0.64%, respectively, of all services as defined by percentage of gross revenue was provided on a charity basis.

In 2019, of a total of 1,609 inpatients, 43 received their entire episode of service on a charity basis and 18 received partial subsidy. In 2018, of a total of 1,641 inpatients, 42 received full charity and 29 received partial subsidy.

4. Availability and Liquidity of Financial Assets

The Hospital had working capital of $5,196,751 and $8,389,553 at September 30, 2019 and 2018, respectively. The Hospital had average days (based on normal expenditures) cash and cash equivalents on hand of 1 and 17 at September 30, 2019 and 2018, respectively.

The Hospital's goal is to maintain financial assets to meet 40 days of operating expenses ($10,368,347 and $9,217,810 at September 30, 2019 and 2018, respectively). The annual operating budget is determined with the goal of generating sufficient net patient service revenue and cash flows to allow the Hospital to be sustainable to support its mission and vision.

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, were as follows as of September 30:

	2019	2018
Cash and cash equivalents	$ 291,187	$ 3,958,019
Patient accounts receivable, net	11,060,454	9,123,489
Other receivables, net (included in other current assets)	2,202,922	2,218,078
Financial assets available to meet general expenditures within one year	$ 13,554,563	$ 15,299,586

The Hospital has assets limited as to use of $39,102,700 and $43,514,141 at September 30, 2019 and 2018, respectively, that are designated assets set aside by the Board of Trustees for future capital improvements and other purposes. These assets limited as to use are not available for general expenditure within the next year, however, the internally designated amounts could be made available, if necessary.

LITTLETON HOSPITAL ASSOCIATION, INC.
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Notes to Financial Statements

September 30, 2019 and 2018

5. Property and Equipment

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

	2019	2018
Land	$ 764,443	$ 764,443
Land improvements	3,806,523	3,792,448
Buildings	42,428,399	41,202,168
Fixed equipment	14,809,598	14,664,397
Major moveable equipment	37,439,514	33,871,778
Assets under capital leases	1,239,569	717,383
	100,488,046	95,012,617
Less accumulated depreciation and amortization	62,879,640	58,628,917
	37,608,406	36,383,700
Construction-in-progress	442,535	1,357,310
	$ 38,050,941	$ 37,741,010

6. Assets Limited as to Use

Assets limited as to use consisted of the following as of September 30:

	2019	2018
Board-designated for capital acquisition and operations	$ 39,102,700	$ 43,514,141
Deferred compensation	3,039,019	2,970,751
With donor restrictions - temporary in nature	624,028	538,633
With donor restrictions - held in perpetuity	2,000,091	1,998,552
Total	$ 44,765,838	$ 49,022,077

The composition of assets limited as to use consisted of the following at September 30:

	2019	2018
Cash and cash equivalents	$ 1,045,912	$ 3,012,897
Fixed income	4,753,008	4,579,679
Mutual funds	26,970,818	29,345,376
Other investments	11,996,100	12,084,125
Total	$ 44,765,838	$ 49,022,077

LITTLETON HOSPITAL ASSOCIATION, INC.
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Notes to Financial Statements

September 30, 2019 and 2018

Investment income and gains (losses) consisted of the following:

	2019	2018
Net assets without donor restrictions:		
Interest and dividends, net of fees	$ 490,161	$ 554,473
Realized gains	420,760	106,958
Unrealized gains	25,303	2,025,986
	936,224	2,687,417
Net assets with donor restrictions:		
Interest and dividends, net of fees	14,400	3,936
Realized losses	(12,046)	(10,999)
Unrealized gains	34,118	109,298
	36,472	102,235
	$ 972,696	$ 2,789,652

Changes in endowment (with donor restrictions) net assets are as follows:

	2019	2018
Endowment net assets, beginning of year	$ 2,365,387	$ 2,286,360
Investment return		
Investment income, net of fees	57,109	113,543
Realized gains (losses) on investments	1,580	(286)
Unrealized (losses) gains on investments	(2,456)	15,047
Total investment return, net	56,233	128,304
Contributions	1,539	3,245
Appropriation of endowment assets for expenditure	(48,499)	(52,522)
Endowment net assets, end of year	$ 2,374,660	$ 2,365,387

Interpretation of Relevant Law

The Hospital has interpreted the State of New Hampshire Uniform Prudent Management of Institutional Funds Act (UPMIFA) such that the Board of Trustees is allowed to appropriate for expenditure for the uses and purposes for which the endowment fund is established, unless otherwise specified by the donor, so much of the net appreciation, realized and unrealized, in the fair value of the assets of the endowment fund over the historic dollar value of the fund, as is prudent. In so doing, the Board must consider the long-term and short-term needs of the Hospital in carrying out its purpose, its present and anticipated financial requirements, expected total return on its investments, price-level trends, and general economic conditions. As a result of this interpretation, the Hospital classifies as net assets with perpetual donor restriction (a) the original value of the gifts donated to the perpetual endowment when explicit donor stipulations requiring perpetual maintenance of the historical fair value are present, and (b) the original value of the subsequent gifts to be maintained in perpetuity when explicit donor stipulations requiring perpetual maintenance of the historical fair value are present. The remaining portion of the donor restricted endowment fund composed of accumulated gains not required to be maintained in perpetuity is classified as net assets with donor restrictions temporary in nature until those amounts are appropriated for expenditure in a manner consistent with the donor's stipulations. The Board approves amounts to be appropriated from time to time, based on the Hospital's needs and the provisions of UPMIFA.

Investment Policy and Strategies Employed for Achieving Objectives

In managing its diversified portfolio, the Hospital measures the performance of its investment portfolio's components against the appropriate market benchmark. The investment objective for the portfolio is to achieve the highest long-term total return on assets that is consistent with prudent investment practices. Over the long term, the policy provides that good investment performance should maintain or enhance the purchasing power of the portfolio's assets. A secondary objective is to achieve an annualized return that meets or exceeds a Policy Index that is comprised of reasonable market benchmarks in a weighting that is consistent with the target asset allocation as approved by the Hospital.

The portfolio assets have a long-term, indefinite time horizon with relatively low liquidity needs. As such, the Fund may take advantage of less liquid investments and assume a time horizon that extends well beyond a normal market cycle. It is expected, however, that sufficient portfolio diversification will smooth volatility and help to assure a reasonable consistency of return. The portfolio is managed on a total return basis.

Funds with Deficiencies

From time to time, the fair value of assets associated with donor-restricted endowment funds may fall below the level of the donors' original gift(s) or what UPMIFA may require the Hospital to retain as a fund of perpetual duration ("underwater"). The Hospital's policy prohibits appropriating amounts from underwater endowment funds and there were no deficiencies of this nature that are reported in net assets with donor restrictions as of September 30, 2019 and 2018.

7. Borrowings

Long-term debt consisted of the following as of September 30:

	2019	2018
Series 2015A fixed-rate bonds held by T.D. Bank N.A., payable in variable monthly principal and interest installments through September 2038; interest rate of 2.39%; collateralized by substantially all Hospital assets and gross receipts.	$ 4,609,736	$ 4,799,418
Series 2015B variable-rate bonds held by T.D. Bank N.A., payable in variable monthly principal and interest installments through September 2038; interest rate of 69.75% of one-month London Interbank Offering Rate (LIBOR) plus 0.73% (2.22% at September 30, 2019); collateralized by substantially all Hospital assets and gross receipts (see interest rate swap agreement disclosure).	18,331,555	18,976,322
2.97% note payable to a bank, due in variable monthly installments including interest, through April 2023; collateralized by substantially all Hospital assets.	1,113,744	1,404,004
Various capital leases, payable in 60 to 120 monthly principal payments ranging from $1,858 to $5,272 including interest rates varying from 2.84% to 8.49%; and maturing between July 2023 and July 2028; collateralized by specific assets acquired under capital leases.	661,029	638,503
Total long-term debt, before unamortized and deferred issuance costs	24,716,064	25,818,247
Unamortized deferred issuance costs	(168,770)	(177,652)
Total long-term debt	24,547,294	25,640,595
Less current portion	1,263,501	1,176,795
Long-term debt, excluding current portion	$ 23,283,793	$ 24,463,800

The Series 2015 bonds require the Hospital to meet certain covenants. As of September 30, 2019 the Hospital was not in compliance with certain of these covenant requirements, however, a waiver was subsequently granted for the violation by the lending institution.

Annual principal maturities on long-term debt, including capital leases, for fiscal years subsequent to September 30, 2019 are as follows:

	Bonds and Notes Payable	Capital Lease Obligations
2020	$ 1,160,706	$ 102,795
2021	1,202,509	109,538
2022	1,243,578	116,772
2023	1,148,782	121,007
2024	991,686	41,542
Thereafter	18,307,774	169,375
	$ 24,055,035	$ 661,029

Interest on long-term debt, excluding letter-of-credit fees, was $927,208 and $905,076 for the years ended September 30, 2019 and 2018, respectively.

Interest Rate Swap

In connection with the issuance of the Series 2015B bonds, the Hospital entered into an interest rate swap agreement to hedge the associated interest rate risk. The swap notional amount was $14,139,000 at September 30, 2019. The swap terminates on October 11, 2027. The interest rate swap agreement requires the Hospital to pay a fixed rate of 3.5625% in exchange for a variable rate of 69.75% of one-month LIBOR plus 0.73% which matches the rate under the bonds.

The Hospital is required to include the fair value of the swap in the balance sheets, and annual changes, if any, in the fair value of the swap in the statements of operations. For example, during the holding period, the annually-calculated value of the swap will be reported as an asset if interest rates increase above those in effect on the date the swap was entered into and as an unrealized gain in the statements of operations, which will generally be indicative that the net fixed rate the Hospital is paying is below market expectations of rates during the remaining term of the swap. The swap will be reported as a liability (and as an unrealized loss in the statements of operations) if interest rates decrease below those in effect on the date the swap was entered into, which will generally be indicative that the net fixed rate the Hospital is paying on the swap is above market expectations of rates during the remaining term of the swap. These annual accounting adjustments of value changes in the swap transaction are non-cash recognition requirements, the net effect of which is intended to be zero at the maturity date of the swap agreement. The Hospital retains the sole right to terminate the swap agreement should the need arise. The Hospital recorded the swap at its liability position of $2,319,861 and $1,507,465 at September 30, 2019 and 2018, respectively.

8. Retirement Plans

The Hospital sponsors a 403(b) retirement plan for its employees. Contributions are computed as a percentage of earnings and are funded as accrued. Effective November 1, 2017, the Hospital merged its plan with that of the other members of NCHI in the North Country Healthcare Retirement Plan (Plan). The Hospital intends to exit the Plan as part of the disaffiliation with NCHI.

The amount charged to expense for the 403(b) plan totaled $714,674 and $623,782 for 2019 and 2018, respectively.

In addition, the Hospital maintains a 457(b) deferred compensation plan for certain employees. An asset and a liability of $3,039,019 and $2,970,751, respectively, have been recorded related to this plan for 2019 and 2018.

9. Commitments and Contingencies

Professional Liability Insurance

The Hospital maintains medical malpractice insurance coverage on a claims-made basis. The Hospital is subject to complaints, claims, and litigation due to potential claims which arise in the normal course of business. U.S. GAAP requires the Hospital to accrue the ultimate cost of malpractice claims when the incident that gives rise to the claim occurs, without consideration of insurance recoveries. Expected recoveries are presented as a separate asset. The Hospital has evaluated its exposure to losses arising from identifiable potential claims and has properly accounted for them in the balance sheets for the years ended September 30, 2019 and 2018. The Hospital intends to renew coverage on a claims-made basis and anticipates that such coverage will be available in future periods.

Health Insurance

During 2018, the Hospital terminated its self-funded health insurance plan for its employees. At September 30, 2018, there were no accrued estimated costs on incurred but not reported claims. The Hospital established a traditional health insurance plan that provides the employees the option of choosing one of six plan options that best suits the needs of the employee.

Operating Leases

The Hospital as lessee has various non-cancelable leases for office space, including space sub-leased, all of which are classified as operating leases. Lease expense was $415,481 and $550,430 for the years ended September 30, 2019 and 2018, respectively. Future minimum lease payments are as follows for years ending September 30:

2020	$ 543,189
2021	553,922
2022	529,652
2023	545,541
2024	561,907
Total future minimum lease payments	$ 2,734,211

Professional Services Agreement

The Hospital entered into a professional services, medical direction and management agreement (Agreement) with The Alpine Clinic, LLC (Alpine) in March 2012. Alpine is a private physician practice group with clinical sites in five towns in northern New Hampshire providing orthopedic care, clinical services and related physical therapy, radiology and magnetic resonance imaging services to patients in this region. The initial term of the Agreement was in effect for a period of three years. There are provisions under the Agreement for early termination, subject to agreement between the two parties. Subsequent to the expiration of the initial term, the arrangement has continued on a monthly basis.

Under the terms of the Agreement, the Hospital has agreed to sub-lease Alpine's offices, furniture and equipment. The Hospital has agreed to engage Alpine to provide the professional orthopedic and physical therapy services through the physicians, nurse practitioners, physician assistants, and licensed physical therapists employed by Alpine. Alpine has agreed to engage the radiology and magnetic resonance imaging technicians employed by the Hospital to provide the technical services in connection with imaging services to Hospital patients at the Alpine offices. The Hospital has also agreed to engage Alpine to provide the services of all administrative and support staff as is necessary and desirable for the effective and efficient delivery of the orthopedic, physical therapy and imaging services.

Alpine has agreed that its sole compensation under this Agreement will be the fees set forth in the Agreement and that all payments from patients, third-party payors or otherwise for Alpine professional services furnished by the providers to Hospital patients will belong to the Hospital. The fees under the Agreement include an annual base fee, to be paid monthly, and a productivity fee which is to be paid within 30 days following the end of each year of the Agreement. The methodology used to calculate the base fee and productivity fee is specifically defined in the Agreement.

The fees paid to Alpine during the years ended September 30, 2019 and 2018 were $3,037,606 and $2,970,704, respectively, of which $177,497 is included in prepaid expenses and other current assets at September 30, 2019 and 2018.

Equipment Maintenance Agreement

During 2012, the Hospital entered into a capital lease to finance the purchase of a new Magnetic Resonance Imaging scanner. During 2018, the capital lease was paid in full and a new maintenance agreement was entered into for $9,856 per month. Total maintenance expense related to the capital lease in 2019 and 2018 was $113,208 and $137,557, respectively. The maintenance fee commitment expires in June 2022.

Payments in Lieu of Taxes

The Hospital entered into an agreement with the Town of Littleton that calls for annual payments in lieu of taxes through 2026 of $75,000 per year adjusted annually by the Consumer Price Index. For the years ended September 30, 2019 and 2018 the payments were $76,640 and $76,458, respectively.

Information Technology (IT) Purchased Services Agreement

In July 2019, the Hospital entered into a service agreement for contracted IT services. The initial agreement is for a five-year term ending July 2024. The agreement requires a monthly fee of $105,000 and total expense incurred by the Hospital for the year ended September 30, 2019 was $316,381.

10. Physician Practices

During 2019 and 2018, the Hospital operated several physician practices. For the years ended September 30, 2019 and 2018, the Hospital recognized net practice operations activity as follows:

	2019	2018
Net practice revenue	$ 16,671,957	$ 15,720,744
Direct expenses	26,781,048	21,520,710
Net loss (before indirect expenses)	$ (10,109,091)	$ (5,799,966)

11. Net Assets

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

	2019	2018
Funds maintained with donor restrictions temporary in nature:		
Construction fund	$ 19,476	$ 3,496
Indigent care	160,121	150,291
Health education	8,878	9,123
Pastoral care	9,234	9,475
Veterans transportation	1,953	1,872
Volunteer services	65,784	69,459
Other health-related services	370,935	314,904
Total funds maintained with donor restrictions temporary in nature	636,381	558,620

	2019	2018
Funds maintained in perpetuity:		
Investments to be held in perpetuity, the income from which is expendable to support healthcare services	2,000,218	1,998,552
Total net assets with donor restrictions	$ 2,636,599	$ 2,557,172
Net assets released from restrictions consisted of:		
Satisfaction of purpose restrictions - operations	$ 71,826	$ 306,293

12. Functional Expenses

The Hospital provides general healthcare services to residents within its geographic location. The statements of operations report certain categories of expenses that are attributable to both healthcare services and support functions. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Occupancy costs are allocated by square footage, employee benefits are allocated based on salaries and professional liability insurance is allocated based on expense for the physician. Expenses related to healthcare and support services for the year ended September 30 are as follows:

2019	Healthcare Services	General and Administrative	Total
Salaries, wages and fringe	$ 45,215,441	$ 7,699,327	$ 52,914,768
Contract labor	6,037,791	434,669	6,472,460
Supplies and other	20,111,129	10,449,393	30,560,522
Medicaid enhancement tax	-	3,736,209	3,736,209
Depreciation	3,753,651	805,924	4,559,575
Interest	927,208	-	927,208
	$ 76,045,220	$ 23,125,522	$ 99,170,742

2018	Healthcare Services	General and Administrative	Total
Salaries, wages and fringe	$ 39,866,789	$ 6,746,516	$ 46,613,305
Contract labor	5,112,321	235,037	5,347,358
Supplies and other	17,779,795	9,936,580	27,716,375
Medicaid enhancement tax	-	3,530,402	3,530,402
Depreciation	3,657,357	893,835	4,551,192
Interest	905,076	-	905,076
	$ 67,321,338	$ 21,342,370	$ 88,663,708

13. Concentration of Credit Risk

Patient Accounts Receivable

The Hospital grants credit without collateral to its patients, most of whom are local residents and insured under third-party payor agreements. The mix of receivables for patients and third-party payors at September 30, 2019 and 2018 was as follows:

	2019	2018
Medicare	27 %	26 %
Medicaid	10	12
Anthem	12	10
Other third-party payors	33	30
Patient	18	22
	100 %	100 %

14. Fair Value Measurement

FASB ASC Topic 820, *Fair Value Measurement*, defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. FASB ASC 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Notes to Financial Statements

September 30, 2019 and 2018

Assets and liabilities measured at fair value and net asset value on a recurring basis are summarized below:

	Fair Value Measurements at September 30, 2019		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)
Assets			
Cash and cash equivalents	$ 1,045,912	$ 1,045,912	$ -
Fixed income	1,713,989	-	1,713,989
Mutual funds			
Index funds	21,769,215	21,769,215	-
Bond funds	5,201,603	5,201,603	-
Total mutual funds	26,970,818	26,970,818	-
Assets to fund deferred compensation			
Fixed income	3,039,019	3,039,019	-
Total assets at fair value	32,769,738	$ 31,055,749	$ 1,713,989
Investments measured at NAV	11,996,100		
Total assets	$ 44,765,838		
Liabilities			
Interest rate swap	$ 2,319,861	$ -	$ 2,319,861
Total liabilities	$ 2,319,861	$ -	$ 2,319,861

LITTLETON HOSPITAL ASSOCIATION, INC.
(d/b/a LITTLETON REGIONAL HEALTHCARE)

Notes to Financial Statements

September 30, 2019 and 2018

	Fair Value Measurements at September 30, 2018		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)
Assets			
Cash and cash equivalents	$ 3,012,897	$ 3,012,897	$ -
Fixed income	1,608,928	-	1,608,928
Marketable equity securities			
Index funds	23,298,688	23,298,688	-
Bond funds	6,046,688	6,046,688	-
Total mutual funds	29,345,376	29,345,376	-
Assets to fund deferred compensation			
Fixed income	2,970,751	2,970,751	-
Total assets at fair value	36,937,952	$ 35,329,024	$ 1,608,928
Investments measured at NAV	12,084,125		
Total assets	$ 49,022,077		
Liabilities			
Interest rate swap	$ 1,507,465	$ -	$ 1,507,465
Total liabilities	$ 1,507,465	$ -	$ 1,507,465

Inputs other than quoted prices that are observable are used to value the interest rate swap. The Hospital considers these inputs to be Level 2.

The fair value of Level 2 assets has been measured using quoted market prices of similar assets and the fair value market approach, as determined by comparable sales data.

The fair value of the interest rate swap is measured using other than quoted prices that are observable to value the interest rate swap. These values represent the estimated amounts the Hospital would receive or pay to terminate the swap agreement, taking into consideration current interest rates and the current creditworthiness of the counterparty.

The following table sets forth a summary of the Hospital's investments valued using a reported NAV at September 30, 2019:

	Fair Value Estimated Using NAV Per Share at September 30				
Investment	2019	2018	Redemption Frequency	Other Redemption Restrictions	Redemption Notice Period
Nyes Ledge Capital Offshore Fund, LTD	**$ 5,490,763**	$ 5,469,384	Annually	Annually on December 31	90 days
Drake Capital Offshore Partners, LP	**4,473,553**	5,228,368	Semi-Annually	100% Annually (December 31) 25% Annually (June 30)	90 days
Seaport Global Property Securities, LP	**1,963,266**	1,304,659	Monthly	N/A	15 days
Hatteras Core Alternatives TEI Fund, LP (Hatteras Fund)	**68,518**	81,714	Quarterly	Each quarter Hatteras Fund allows up to 5% of the fund to be redeemed; if clients redemption requests are greater than 5% of the fund, each investor will be paid out a pro-rata portion of their redemption request	75 days
	$11,996,100	$ 12,084,125			

15. Medicaid Enhancement Tax and Disproportionate Share Payments

In New Hampshire, hospitals are subject to a 5.4% tax, the Medicaid Enhancement Tax, on net taxable revenues. The State of New Hampshire's distribution of DSH monies to the hospitals is subject to audit by CMS. A number of hospitals in New Hampshire filed a lawsuit relative to the results of the 2011 audit of these DSH payments and the court ruled in favor of the hospitals in March 2016. CMS has appealed the ruling and, until such time as the final ruling is made on the appeal, the Hospital has not changed its position with respect to the amounts recorded in its financial statements. Should the court's ruling stand, the Hospital expects to adjust the amounts held in contingency in the year the ruling is upheld.

16. Meaningful Use Revenues

The Medicare and Medicaid electronic health record (EHR) incentive programs provide a financial incentive for achieving "meaningful use" of certified EHR technology. The criteria for meaningful use was staged in three steps from fiscal year 2012 through 2016.

The meaningful-use attestation is subject to audit by CMS in future years. As part of this process, a final settlement amount for the incentive payments could be established that differs from the initial calculation, and could result in return of a portion or all of the incentive payments received by the Hospital. The Hospital has settled with CMS.

In 2019 and 2018, the Hospital recognized $976 and $8,500, respectively, of Medicare EHR program revenues for its eligible physicians.

In 2019 and 2018, the Hospital attested to Stage 2 meaningful-use certification from CMS and recorded meaningful-use revenues of $30,753 and $79,952, respectively.

17. Related Party Transactions

As a member of NCHI, the Hospital shared in various services with the other member Hospitals and the parent. For the years ended September 30, 2019 and 2018, the Hospital billed other member hospitals $1,722,925 and $2,198,490 and was billed $1,724,011 and $2,123,495, respectively for shared services. At September 30, 2019 and 2018, $254,633 and $402,081, respectively, was due from, and $220,743 and $530,458, respectively, was due to, the member Hospitals and the parent.

Total expenses incurred for services provided by other members are as follows:

	2019	2018
UCVH	$ 6,598	$ 1,839
Weeks	438,521	241,967
AVH	238,925	238,819
Home Health	1,631	-
NCHI	1,038,336	1,640,870
Total	$ 1,724,011	$ 2,123,495

LRH Board of Trustees (2020)

as of June 2020

	LAST NAME	FIRST NAME	Position
1	Chisolm	Fred	Member
2	Fitzpatrick	Dr. Patrick	Secretary
3	Fleury	Kathryn	Member
4	Garrison	Ashley	Member
5	Gingue	Roger	Chair
6	Goldberg	Dr. Stephen	Member
7	Hennessey	Erin	Treasurer
8	Jesseman	Richard	Member
9	Kunz	Elizabeth	Member
10	MacArthur	Dr. Dougald	Member
11	Morgan	Laurie	Member & LRH Auxiliary
12	Nutter	Bob	LRH President & CEO
13	Rankin	Dr. Deane	Member
14	Rocke	Alice	Medical Staff President
15	Shanshala II	Ed	Member
16	Smith	Paul	Member
17	Tremblay	Thomas	Member
18	Woodward	Jeff	Vice Chair

LAURYN ST. CYR

To continue to obtain knowledge and experience in a hospital setting.

EXPERIENCE

APRIL 2019 - PRESENT

REGISTRAR, LITTLETON REGIONAL HEALTHCARE

Responsible for patient registration in the Emergency Department, Radiology, and the Laboratory. I was also responsible for answering the phones and assisted the patient with their needs.

MAY 2019 – PRESENT

MEDICAL SECRETARY, LITTLETON REGIONAL HEALTHCARE

Responsible for patient check in/out in Urgent Care and provided excellent customer service throughout the process.

JUNE 2018 – AUGUST 2018

NANNY, JEFFERSON NH

Cared for three young girls for the summer. Tasks included meal preparation, activities, and took them on many field trips. I created calendars for each month that kept the parents involved in the upcoming activities.

JUNE 2017 – AUGUST 2018

LIFEGUARD, GROVETON NH

Responsible for supervision over the pool while on duty as well as taught swimming lessons in the morning.

EDUCATION

ANTICIPATED MAY 2020

BACHELORS DEGREE, PLYMOUTH STATE UNIVERSITY

My current GPA 3.71 and I was awarded with the Dean's scholarship and STEM scholarship.

JUNE 2019

HIGH SCHOOL DIPLOMA, GROVETON HIGH SCHOOL

My GPA was 3.5 and I was the President of the National Honor Society. I was also on the honor roll, student council and played two sports throughout high school.

APRIL 2019

INTERNSHIP, MOUNTAIN VIEW DENTAL

I interned at Mountain View Dental in Whitefield, NH during my senior year. During this time, I shadowed every position at the dental office, went to several classroom settings and taught about the importance and kept a journal of what I saw and what I learned each time I went.

SKILLS

- Attention to detail
- Excellent customer service
- Ability to multitask
- Reliable
- Flexible

ACTIVITIES

I was awarded the Rotary Youth Leadership Award in 2017. I volunteered at various events to help others in need. I volunteered at Weeks Medical Center in the volunteer office. I was also a two-sport athlete and the captain for both teams during my junior and senior year of high school.

ANDREW W. BORGHESE

Objective

To use the knowledge and skills that I have learned to provide comprehensive care in a Family Practice setting, while continuing to learn from the situations and the people around me no matter what the situation.

Work Experience

Littleton Regional Healthcare
Littleton, NH

October 2015 – Present
Physician Assistant – Certified
Emergency, Urgent Care, Primary Care
Member of Credentialing Committee June 2020-present
ACLS & PALS Certified

Islesboro Health Center - Rural Health Clinic

Islesboro, Me
May 2015 – Sept 2015
Physician Assistant
Treated patients with a wide range of Medical complaints

University of New England – Physician Assistant
Clinical Year Rotations

(Six Weeks each)

Family Medicine – Islesboro, Me
General Surgery – The Aroostook Medical Center, Presque Isle ME
Emergency Medicine – St. Mary's Hospital, Lewiston ME
Internal Medicine Inpatient – Portsmouth Regional Hospital, Portsmouth NH
Cardiology – St. Mary's Hospital, Lewiston ME
Family Medicine – Belgrade Health Center, Belgrade ME
Family Medicine – The Pines Health Center, Caribou ME
Geriatric Medicine – Maine Medical Center Geriatrics, Portland ME

Experience in:

History and Physicals, acute care visits, wound care, diabetes management, HTN management, Well Child Checks, medication management, dementia management, home visits, Suturing, large joint injections, lesion removal, EKG interpretation, and venipuncture

Littleton Regional Hospital

Littleton, NH

February 2, 2009 – April 2013

Certified Medical Assistant for the Physician Practices

- Scheduling appointment and surgery
- working in a variety of practices (Ortho, Neuro, Gen Surg, ENT, Occ Health, Uro, IM)
- Rooming patient's and assisting provider w/minor procedures

Loon Mountain Recreation Corp

Lincoln, NH

December 2002 – Present

2004-2007 - Ski Patrol Director/Full-time Ski Patroller

- Scheduling on mountain first aid personnel
- Overseeing all daily Ski Patrol operations
- Overseeing and participating in training of all patrollers
- Providing First Aid to customers in need
- Overseeing First Aid Room operations

2009 – present - part-time patroller

Education

University of New England

Portland, Me

Westbrook College of Health Professions

Masters of Physician Assistant

Graduated May 2015

Concorde Career Institute (AAMA Accredited)

Portland, OR

January 2008 – November 2008

Certificate of Medical Assisting with Limited X-Ray

Plymouth State University

Plymouth, NH

Bachelors of Science in Outdoor Recreation
Graduated May 2003

Organization & Activities

Member and Class of 2015 Representative - Maine Association of Physician Assistants (2013)
Member AAPA (2013-present)
CPR Certified American Heart Assoc. BLS (2002 – Present)
ACLS Certified (2014 – Present)
Outdoor Emergency Care Technician (2002 – Present)
Certified Member – American Association of Medical Assistants (2008 – 2014)
Member – American Society of Orthopedic Professionals (2011)
Certified Member and Examiner – Professional Ski Patrol Association (2005 - Present)
Member – Nation Ski Patrol (2002 – Present)
Board Member – Pemi Valley Search and Rescue Team (2009 – Present)
Appalachian Trail Thru-Hiker (2004)

References available upon request

Alyssa Presby

OBJECTIVE: To further my knowledge and skills as a Registered Nurse.

EDUCATION: Associates Degree of Nursing: May 2013
White Mountains Community College: Berlin, New Hampshire
Southern New Hampshire University: Currently enrolled in BSN program, expected graduation date October 2016

LICENSURE: Registered Nurse, State of New Hampshire, No. 067768-21

PROFESSIONAL EXPERIENCE:

November 2014-Present: RN Clinical Supervisor, Northwoods Home Health & Hospice, Lancaster NH

- The Clinical Supervisor supervises the PT, PTA OT, OTA, RN, LPN and LNA's. The Clinical supervisor reports to the Clinical Director. The Clinical Supervisor reviews staffing education needs, creates orientation plans. Assists new staff with patient visits that need support. Project managed new technology integration. Responsible for annual evaluations of staff members. Educates staff on case management and reviews admissions to ensure meeting medicare requirements. Networks with outside agencies as well as attends CQI meetings in Concord NH. Works with outside referral sources to develop processes to improve patient outcomes working as a team.

October 2013-November 2014: RN Weekend Manager, Morrison Nursing Home, Whitefield NH

- The RN Weekend Manager supervises the nursing department in the DON's absence. The Weekend Manager reviews staffing at the change of a shift, and assigns and replaces staff to meet patient care needs. Completes patient care rounds. Assists in orientation of weekend employees. Supervises and evaluates weekend employees.

May 2012 – August 2013: LPN to Registered Nurse, Country Village Center, Lancaster NH.

- Utilizing nursing principles and assessment skills, evaluates assigned group of patients and provides and documents nursing care. Promote patients' independence through individualized goals and family involvement. Assumes leadership responsibilities through direction and supervision of the unit's licensed nursing assistants. Attend to the daily operations of the unit on a per-shift unit level. Reports directly to shift nursing supervisor.

December 2012 - present: Per diem School Nurse, SAU 36, Lancaster N.H

- Provide timely assessment and care to ill and/or injured students during school hours. Insure preventive health services to facilitate the student's optimal physical, mental, emotional and social growth and development.

CERTIFICATIONS: Basic Life Support
Advanced Cardiac Life Support
Pediatric Advance Life Support
Completed NHHCA Nurse Leadership Series 2014
IV Certified

ADDITIONAL SKILLS/GOALS:

Promotes team work in a positive and respective manner in order to promote a culture of nurturing for our community; demonstrate understanding of time- management skills with multiple patients. Possess effective verbal and written communication skills. Demonstrate sound judgment, decision making and problem-solving skills. Build rapport within discipline levels with ease; encourage and promote a sense of team work to accomplish patient goals.

Amy Lucas PA-C

EDUCATION

University of New England, Biddeford and Portland, ME
Graduate Field of Study: Physician Assistant
Degree Awarded: Masters of Physician Assistant — May 2013

Undergraduate Field of Study: Medical Biology - 3/2 Pre-PA — Sept. 2008-May 2011
Degree Awarded: Bachelors of Science-Medical Biology — May 2012
Undergraduate GPA: 3.87

Honors:
Summa cum laude — May 2012
Alpha Chi Honors Society — Spring 2011-May 2013

HEALTH CARE EXPERIENCE

Coos County Family Health Services: Berlin, NH — Aug 2013-Present
Primary Care Physician Assistant
Responsibilities: Provide primary care services to Berlin, NH community. Provide preventive care, chronic condition management and acute care to patients ranging newborn to geriatrics. In office procedures: skin biopsies, joint injections, suturing and lesion excision.
Supervising Physicians: Dr. Elaine Chappell and Dr. Josee Bourbeau
Committees:
- Controlled Substances Task Force — Aug 2013- Dec 2015
- Extended Hours Work Group — March 2015-Present

Androscoggin Valley Hospital: Berlin, NH — Dec 2015-Present
Hospitalist Physician Assistant- per diem
Responsibilities: Provide inpatient care to Medical Surgical and ICU patients, help in Emergency Department as needed.
Supervising Physicians: Dr. Javier Cardenas and Dr. Mahala Patrick

LICENSE/CERTIFICATIONS

New Hampshire Physician Assistant License #0968	Expires: 12/2017
NCCPA Board Certification	Expires: 6/2019
American Heart Association ACLS	Expires: 2/2018
DEA License	Expires: 3/2019

References available upon request

curriculum vitae

BENJAMIN TIPTON, MPA-C

CLINICAL EXPERIENCE

June 2013 to Present
Physician Assistant Family Medicine
Northern Counties Health Care
Island Pond, VT

June 2013 to June 2017
Physician Assistant Urgent Care
Mid Coast Medical Group
Brunswick, Maine

June 2013 to June 2017
Physician Assistant Internal Medicine
Mid Coast Medical Group
Bath, ME

June 2010 to June 2013
Physician Assistant Family Practice
Full Circle Family Medicine
Damariscotta, ME

January 2008 to July 2010
Physician Assistant Orthopedics
Damariscotta, ME

July 2003 to January 2008
Physician Assistant Emergency Medicine
Solo Coverage of Rural Emergency Department
Mount Ascutney Hospital
Windsor, VT

September 1997 to July 2003
Physician Assistant Emergency Medicine
Southwestern Vermont Medical Center
Bennington, VT

August 1996 to September 1997
Physician Assistant General Surgery
E. Scott Frost, M.D., F.A.C.S.
Bennington, VT

EDUCATIONAL HISTORY

June 2017
Qualified Teacher of Mindfulness Based Stress Reduction
USCD Center for Mindfulness

April 2014
12th International Conference on Integrating Mindfulness in Medicine, Health Care and Society
University of Massachusetts Medical School

June 2013
Lifestyle Medicine: Tools for Promoting Healthy Change
Harvard Medical School and Massachusetts General Hospital

March 2012
Building Resilience: The Mind Body Revolution in Health and Healing
Harvard Medical School

Benjamin Tipton MPA-C

October 2011
Neurobiology of Personal Transformation
Dr Dan Seigel
Omega Institute Retreat

January 2011
Center for Mind Body Medicine
Washington DC
Advanced Training in Mind Body Medicine

September 2010
Center for Mind Body Medicine
Washington DC
Mind-Body Medicine Professional Training Program

August 2002
University of Nebraska College of Medicine
Master of Physician Assistant Studies in Emergency Medicine

August 1996
HVCC/Albany Medical College, Albany, NY
Physician Assistant Certificate
High Honors

May 1992
Castleton State College, Castleton, VT
Bachelor of Science Degree
Summa cum Laude
Sports Medicine Athletic Training/Physical Education

References available upon request

Holly Owsianik

Medication Nurse

Work Experience

Medication Nursing Assistant

Kendal at Hanover - Hanover, NH
October 1999 to Present

Answer patient call lights to determine patients' needs.
Change bed linens or make beds.
Apply clean dressings, slings, stockings, or support bandages, under direction of nurse or physician.
Collect specimens, such as urine, feces, or sputum.
Communicate with patients to ascertain feelings or need for assistance or social and emotional support.
Document or otherwise report observations of patient behavior, complaints, or physical symptoms to nurses.
Feed patients or assist patients to eat or drink.
Gather information from caregivers, nurses, or physicians about patient condition, treatment plans, or appropriate activities.
Measure and record food and liquid intake or urinary and fecal output, reporting changes to medical or nursing staff.
Observe or examine patients to detect symptoms that may require medical attention, such as bruises, open
wounds, or blood in urine.
Prepare or serve food.
Provide physical support to assist patients to perform daily living activities, such as getting out of bed, bathing, dressing, using the toilet, standing, walking, or exercising.
Record height or weight of patients.
Record vital signs, such as temperature, blood pressure, pulse, or respiration rate, as directed by medical or nursing staff.
Remind patients to take medications or nutritional supplements.
Restock patient rooms with personal hygiene items, such as towels, washcloths, soap, or toilet paper.
Review patients' dietary restrictions, food allergies, and preferences to ensure patient receives appropriate
diet.
Turn or reposition bedridden patients.
Undress, wash, and dress patients who are unable to do so for themselves.
Exercise patients who are comatose, paralyzed, or have restricted mobility.
Explain medical instructions to patients or family members.
Provide information such as directions, visiting hours, or patient status information to visitors or callers.

Transport residents to their medical appointments or to the emergency room.

Assist nursing supervisor on medical emergencies/e-calls.
Ordering of residents medications which includes faxes and telephone orders.
Medication preparation and administration

Education

Licensed Nursing Assistant
Hartford Area Career and Technology Center - Hartford, VT
September 1998

High School Diploma
Lebanon High School - Lebanon, NH
June 1992

Skills

Detail-oriented (Less than 1 year), Time Management (Less than 1 year)

Certifications/Licenses

CPR

Certified Nursing Assistant (CNA)

Additional Information

Communication
Adaptability
Time Management
Leadership
Ability to Work Under Pressure
Multi-tasking
Efficient
Detail-oriented
Flexible
Responsible
Quick Learner
Organized

LORI COMEAU

SUMMARY

Driven LNA and compassionate healthcare professional with 15 years hands-on experience in residential and hospital environments as an EMS provider and patient caregiver as well as 12 years in hospital Admitting Communications with knowledge of medical terminology and hospital procedures . Accountable and responsible with a strong focus on patient care & wellness. Excellent documentation skills with a strong ability to communicate and gain patient trust of all ages , genders and mental abilities.

SKILLS

- Experienced in Patient information documentation
- Patient and family focus
- Critical thinking & working in trauma situations
- CPR and BLS certified
- Well experienced in obtaining/charting vital signs
- Medical Terminology
- Strong work ethic and willingness to always learn new skills and cover shifts for call ins when needed
- Well experienced in Registration and client appointment scheduling

EXPERIENCE

04/2004 to Current — **EMS Provider**

Lancaster Fire Department — Lancaster, NH

- Served as a first responder to over [300] scenes a year and provide life support to victims, including taking blood pressure, observing skin changes, taking pulses , Blood glucose levels, and other forms of emergency care.
- Provided care and treatment to patients with traumatic injuries to include burns, amputations, spinal injuries, open wounds and fractures as well as chronic and acute health problems such as MI, asthma, COPD, hypoglycemia.
- Communicated extensively with patients to provide assistance, support and instructions.
- Assists with administering nitroglycerin, glucose, oxygen, Setting up an IV bag with a line bled and ready to administer.
- Setting up and placing 12 lead on patient for an EKG
- Verified and entered necessary information accurately such as Name, Date of Birth , address , phone, known allergies and any medications into the patient documentation system.

04/2004 to Current — **EMS Provider**

Whitefield Fire Department — Whitefield, NH

Served as a first responder to over [300] scenes a year and provide life support to victims, including taking blood pressure, observing skin changes, taking pulses ,

Blood glucose levels, temperatu

•Provided care and treatment
amputations, spinal injuries, ope
acute health problems such as

•Communicated extensively wi
instructions.

•Assists with administering nitroç
with a line bled and ready to ac

•Setting up and placing 12 leac

•Verified and entered necessar
Birth , address , phone, known a
documentation system.

07/2004 to 10/2016 **Admitting / Communications**
Weeks Medical Center — Lanc

- Set and managed patier
- Verified and entered nec
phone, DOB and insuranc
registering.
- Collected and processec
- Worked with nurses and c
them to the appropriate
- Jumped in to fill gaps for
- Maintained patient chart
- Ensured HIPAA complianc
- Answered high call volur
appropriate location.
- Documented calls in ECW

EDUCATION AND TRAINING

2018 **NH BON Licence**: Licenced Nurs
WMCC — Littleton, NH, USA

2004 **National Registry- EMS**: EMS
NH Bureau of EMS — Berlin, NH,

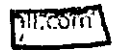
1989 **NH Licensed Cosmetologist**: Co
Empire Beauty Academy — Lac

1984 **High School Diploma**: Basic Req
Littleton High School — Littleton,

ACTIVITIES AND HONORS

Lancaster Fire Department
Whitefield Fire-Rescue
American Heart Association- CF

Rebecca Hutchinson



Authorized to work in the US for any employer

Work Experience

Physician Assistant
Lassen Medical Clinic - Red Bluff, CA
December 2016 to Present

Internal medicine, urgent care, occupational health

Education

Master of Physician Assistant Studies in Physician Assistant Studies
Franklin Pierce University - West Lebanon, NH
November 2013 to March 2016

Bachelor of Science in Biology in Biology
University of Maine - Orono, ME
September 2007 to May 2011

Skills

- Suturing
- Pelvic exams
- I&D

Certifications and Licenses

NRCME
November 2019 to November 2029

DOT physicals

SARA MOONEY

SUMMARY

Dependable Emergency Medical Responder, LNA/ MA recognized for consistency in productivity and attendance while exhibiting a positive attitude in light of challenging situations, Exhibits exemplary work ethic and willingness to learn new processes and techniques which enhance business and team efforts,

SKILLS

- Medical terminology knowledge
- Collecting specimens
- Collecting vital signs
- Infection control procedures
- First Aid/CPR
- Extensive background working with people of all ages in training situations
- Patient and caring personality
- Positive attitude
- 13+ years of medical experience

EXPERIENCE

LITTLETON REGIONAL HEALTHCARE

Littleton, NH

LNA/MA 05/2020 to Current

work at a covid 19 testing site, registering patients, obtaining, vital signs and drawing patients blood

LITTLETON REGIONAL HEALTHCARE

Littleton, NH

LNA/MA 06/2019 to 03/2020

worked in an urgent care, triage and obtaining vital signs, running rapid lab testing, assisting with providers during procedures.

LITTLTON REGIONAL HOSPITAL

Littleton, NH

Surgical Service Aide 05/2017 to 06/2019

- Managed and maintained surgical suites by sterilizing equipment and [illegible].
- Cleaned and sterilized operating rooms.
- Organized supply room and ordered supplies and equipment as needed.
- Communicated with professionalism and compassion when interacting with surgical team and patients.

PRIDE SUPPORT SERVICES

Barre, VT

LSA 01/2017 to 05/2017

Assisting clients with Traumatic Brain Injuries cope with daily activities,

EDUCATION AND TRAINING

EMERGENCY MEDICAL RESPONDER: EMERGENCY CARE ATTENDANCE 04/2016
Northwoods Center For Continuing Education, Whitefield, NH

LNA: NURSING ASSISTANCE 03/1994
Lafayette Nursing Home, Franconia, NH

RIDING INSTRUCTOR, TRAINER,BARN MANAGER: EQUINE STUDIES 07/1989
Ogontz Equestrian Center, Lyman,NH

HIGH SCHOOL DIPLOMA 06/1988
Trumbull High School, Trumbull, CT

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Alyssa Presby	RN/Phlebotomist	93,600	100	31,200
Lauren St. Cyr	Parking Lot Attendant	41,600	100	13.866.67
Lori Comeau	Medical Assistant	52,000	100	17,333.33
Sara Mooney	Registrar	47,760	100	15,920
Holly Owsianik	Registrar	47,760	100	15,920
Benjamin Tipton	Physician Assistant	74,256	42	10,395.84
Rebecca Hutchinson	Physician Assistant	65,520	42	9,172.80
Andrew Borghese	Physician Assistant	63,773	42	8,928.22
Amy Lucas	Physician Assistant	63,773	42	8,928.22

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 3rd Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #3") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and LRGHealthcare, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 80 Highland Street, Laconia, NH 03246.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 31, 2018 (Item #17A), as amended on September 18, 2019, (Item #20), and on June 24, 2020, (Item #31) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Paragraph 3. Renewal, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement and increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $2,317,076.

3. Modify Exhibit A Amendment #1, Scope of Services, by replacing in its entirety with Exhibit A Amendment #3, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.

4. Modify Exhibit B Amendment #1, Methods and Conditions Precedent to Payment, by replacing in its entirety with Exhibit B Amendment #3, Methods and Conditions Precedent to Payment, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein,.

5. Modify Exhibit B-1, Budget by reducing the total budget amount by $115,000 , which is identified as unspent funding that is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020) in the amount of $115,000, as specified, in part, in Exhibit B-4 Amendment #3 NCE.

6. Modify Exhibit B-2 Amendment #1 Budget by reducing the total budget amount by $525,559, which is identified as unspent funding of which $63,000 is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020), as specified, in part, in Exhibit B-4 Amendment #3 NCE; and of which $430,000 is being carried forward to fund the activities in this Agreement for SFY 21 (January 1, 2021 through June 30, 2021) ,as specified in Exhibit B-6 Amendment #3 SOR II;and of which $32,559 is being carried forward to fund the activities in this Agreement for SFY22 (July 1, 2021 through September 29, 2021), as specified in Exhibit B-8 Amendment #3 SOR II .

7. Add Exhibit B-4 Amendment #3 NCE, which is attached hereto and incorporated by reference

herein.

8. Add Exhibit B-5 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.
9. Add Exhibit B-6 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.
10. Add Exhibit B-7 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.
11. Add Exhibit B-8 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective retroactive to September 29, 2020 upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/23/2020
Date

DocuSigned by:
Katja Fox
ED9D05B0D1C9342...
Name: Katja Fox
Title: Director

LRGHealthcare

12/23/2020
Date

DocuSigned by:
Kevin Donovan
2179627527 9F418...
Name: Kevin Donovan
Title: CEO

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/29/2020
Date

DocuSigned by:
D5GA8202E32C4AE...
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. All Exhibits B Amendment #3 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Laconia Region with access to referrals to SUD treatment and recovery support services and other health and social services.

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

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

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

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

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

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

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

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

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

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

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

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

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

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

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

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

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

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

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

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

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff, capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

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

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

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

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

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

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

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

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

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

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

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

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

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

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

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

3.1.10.5.4.1.1. A Doorway client;

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

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

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

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

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

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

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service

provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

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

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

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

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

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

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

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

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

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

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

3.1.11.8.3. Upon discharge from the initially referred service.

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

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

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare,

and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

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

3.3. The Contractor shall provide services in accordance with:

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

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

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

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

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

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

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

4. Subcontracting for the Doorways

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

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

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

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

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

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

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

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

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

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

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

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

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

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

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

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

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

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

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

5.7.4.1. The contract requirements.

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

5.8. The Contractor shall provide staff, subcontractors, or end users as defined in Exhibit K with periodic training in practices and procedures to ensure compliance with information

security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (7) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

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

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

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

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

7. Health Insurance Portability and Accountability Act and Confidentiality:

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

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

8. Reporting Requirements.

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

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

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

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

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

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

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s)

must collect and share data with the Department in a format specified by the Department.

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

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

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

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

11.4. The Contractor and referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal

management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

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

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

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

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

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

13. Termination Report/Transition Plan

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

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

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

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

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

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

14. Credits and Copyright Ownership

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

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

15. Operation of Facilities: Compliance with Laws and Regulations

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

16. Equal Employment Opportunity Plan (EEOP)

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

17. Equipment Purchases

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

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

18. Compliance with Federal and State Laws

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

18.2. Time and Manner of Determination.

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

18.3. Documentation

18.3.1. In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The

Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

18.4. Fair Hearings

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

Methods and Conditions Precedent to Payment

1. This Agreement is funded by:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI083326..
   1.2. 2.72% Other Funds from Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment Funds
2. Governor Commission Funds
   2.1. The Contractor shall utilze funds in Exhibit B-5 Amendment #3 GovComm and Exhibit B-7 Amendment #3 GovComm for the purpose of providing services and supports to clients whose needs to not make them eliglbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit B-1, Budget through Exhibit B-8 Amendment #3 SOR II.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or other payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

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

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

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

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

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

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

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported:

6.1.3.1. Unallowable expenses include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

6.1.3.1.7. Per SAMSHA requirements, meals are generally

unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

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

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

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

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

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

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

11. 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.

12. The Contractor must provide the services in Exhibit A Amendment #3, Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A, Amendment #3 Scope of Services, including failure to submit required monthly and/or quartery reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

    15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

        15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

        15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

        15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

    15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

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

    15.5. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for

any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

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

Contractor Name: LRGHealthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-06

Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 66,500.00	$ -	$ 66,500.00	$ 1,500.00	$ -	$ 1,500.00	$ 65,000.00	$ -	$ 65,000.00
2. Employee Benefits	$ 11,640.51	$ -	$ 11,640.51	$ 405.00	$ -	$ 405.00	$ 11,235.51	$ -	$ 11,235.51
3. Consultants	$ 3.00	$ -	$ 3.00	$ -	$ -	$ -	$ 3.00	$ -	$ 3.00
4. Equipment:	$ 3.00	$ -	$ 3.00	$ -	$ -	$ -	$ 3.00	$ -	$ 3.00
5. Supplies:	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
6. Travel	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00	$ -	$ 500.00
7. Occupancy	$ 31,260.00	$ -	$ 31,260.00	$ 1,260.00	$ -	$ 1,260.00	$ 30,000.00	$ -	$ 30,000.00
8. Current Expenses	$ 753.00	$ -	$ 753.00	$ 750.00	$ -	$ 750.00	$ 3.00	$ -	$ 3.00
9. Software	$ 3,249.99	$ -	$ 3,249.99	$ -	$ -	$ -	$ 3,249.99	$ -	$ 3,249.99
10. Marketing/Communications	$ 3.00	$ -	$ 3.00	$ -	$ -	$ -	$ 3.00	$ -	$ 3.00
11. Staff Education and Training	$ 2,250.00	$ -	$ 2,250.00	$ -	$ -	$ -	$ 2,250.00	$ -	$ 2,250.00
12. Subcontracts/Agreements	$ 25,000.00	$ -	$ 25,000.00	$ -	$ -	$ -	$ 25,000.00	$ -	$ 25,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex	$ 12,000.00	$ -	$ 12,000.00	$ -	$ -	$ -	$ 12,000.00	$ -	$ 12,000.00
Respite Housing	$ 9,252.50	$ -	$ 9,252.50	$ -	$ -	$ -	$ 9,252.50	$ -	$ 9,252.50
Naloxone	$ 18,000.00	$ -	$ 18,000.00	$ -	$ -	$ -	$ 18,000.00	$ -	$ 18,000.00
TOTAL	$ 181,915.00	$ -	$ 181,915.00	$ 3,915.00	$ -	$ 3,915.00	$ 178,000.00	$ -	$ 178,000.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS

Date 12/23/2020

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

Contractor Name: LRGHealthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-06

Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 10,000.00	$ -	$ 10,000.00	$ -	$ -	$ -	$ 10,000.00	$ -	$ 10,000.00
12. Subcontracts/Agreements	$ 50,222.00	$ -	$ 50,222.00	$ -	$ -	$ -	$ 50,222.00	$ -	$ 50,222.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex (Non-Opioid Related)	$ 25,000.00	$ -	$ 25,000.00	$ -	$ -	$ -	$ 25,000.00	$ -	$ 25,000.00
Respite Housing (Non-Opiod Related)	$ 25,000.00	$ -	$ 25,000.00	$ -	$ -	$ -	$ 25,000.00	$ -	$ 25,000.00
Naloxone	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
TOTAL	$ 110,222.00	$ -	$ 110,222.00	$ -	$ -	$ -	$ 110,222.00	$ -	$ 110,222.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS

Date 12/23/2020

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

Contractor Name: LRGHealthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-06
Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 160,000.00	$ -	$ 160,000.00	$ 30,000.00	$ -	$ 30,000.00	$ 130,000.00	$ -	$ 130,000.00
2. Employee Benefits	$ 23,308.80	$ -	$ 23,308.80	$ 810.00	$ -	$ 810.00	$ 22,498.80	$ -	$ 22,498.80
3. Consultants	$ 6.00	$ -	$ 6.00	$ -	$ -	$ -	$ 6.00	$ -	$ 6.00
4. Equipment:	$ 6.00	$ -	$ 6.00	$ -	$ -	$ -	$ 6.00	$ -	$ 6.00
5. Supplies:	$ 3,000.00	$ -	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00	$ -	$ 3,000.00
6. Travel	$ 1,000.00	$ -	$ 1,000.00	$ -	$ -	$ -	$ 1,000.00	$ -	$ 1,000.00
7. Occupancy	$ 62,520.00	$ -	$ 62,520.00	$ 2,520.00	$ -	$ 2,520.00	$ 60,000.00	$ -	$ 60,000.00
8. Current Expenses	$ 1,506.00	$ -	$ 1,506.00	$ 1,500.00	$ -	$ 1,500.00	$ 6.00	$ -	$ 6.00
9. Software	$ 6,499.98	$ -	$ 6,499.98	$ -	$ -	$ -	$ 6,499.98	$ -	$ 6,499.98
10. Marketing/Communications	$ 6.00	$ -	$ 6.00	$ -	$ -	$ -	$ 6.00	$ -	$ 6.00
11. Staff Education and Training	$ 3,000.00	$ -	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00	$ -	$ 3,000.00
12. Subcontracts/Agreements	$ 72,000.00	$ -	$ 72,000.00	$ -	$ -	$ -	$ 72,000.00	$ -	$ 72,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex	$ 50,000.00	$ -	$ 50,000.00	$ -	$ -	$ -	$ 50,000.00	$ -	$ 50,000.00
Respite Housing	$ 45,977.22	$ -	$ 45,977.22	$ -	$ -	$ -	$ 45,977.22	$ -	$ 45,977.22
Naloxone	$ 36,000.00	$ -	$ 36,000.00	$ -	$ -	$ -	$ 36,000.00	$ -	$ 36,000.00
TOTAL	$ 464,830.00	$ -	$ 464,830.00	$ 34,830.00	$ -	$ 34,830.00	$ 430,000.00	$ -	$ 430,000.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS

Date 12/23/2020

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

Contractor Name: LRGHealthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-06

Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 3,000.00	$ -	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00	$ -	$ 3,000.00
12. Subcontracts/Agreements	$ 19,740.00	$ -	$ 19,740.00	$ -	$ -	$ -	$ 19,740.00	$ -	$ 19,740.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex (Non-Opioid Related)	$ 7,000.00	$ -	$ 7,000.00	$ -	$ -	$ -	$ 7,000.00	$ -	$ 7,000.00
Respite Housing (Non-Opiod Related)	$ 7,000.00	$ -	$ 7,000.00	$ -	$ -	$ -	$ 7,000.00	$ -	$ 7,000.00
Naloxone	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
TOTAL	$ 36,740.00	$ -	$ 36,740.00	$ -	$ -	$ -	$ 36,740.00	$ -	$ 36,740.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS

Date 12/23/2020

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

Contractor Name: LRGHealthcare

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-06
Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 66,500.01	$ -	$ 66,500.01	$ 1,500.00	$ -	$ 1,500.00	$ 65,000.01	$ -	$ 65,000.01
2. Employee Benefits	$ 11,640.51	$ -	$ 11,640.51	$ 405.00	$ -	$ 405.00	$ 11,235.51	$ -	$ 11,235.51
3. Consultants	$ 3.00	$ -	$ 3.00		$ -	$ -	$ 3.00	$ -	$ 3.00
4. Equipment:	$ 3.00	$ -	$ 3.00	$ -	$ -	$ -	$ 3.00	$ -	$ 3.00
5. Supplies:	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
6. Travel	$ 1,050.00	$ -	$ 1,050.00	$ -	$ -	$ -	$ 1,050.00	$ -	$ 1,050.00
7. Occupancy	$ 31,260.00	$ -	$ 31,260.00	$ 1,260.00	$ -	$ 1,260.00	$ 30,000.00	$ -	$ 30,000.00
8. Current Expenses	$ 753.00	$ -	$ 753.00	$ 750.00	$ -	$ 750.00	$ 3.00	$ -	$ 3.00
9. Software	$ 3,249.90	$ -	$ 3,249.90	$ -	$ -	$ -	$ 3,249.90	$ -	$ 3,249.90
10. Marketing/Communications	$ 3.00	$ -	$ 3.00	$ -	$ -	$ -	$ 3.00	$ -	$ 3.00
11. Staff Education and Training	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
12. Subcontracts/Agreements	$ 36,000.00	$ -	$ 36,000.00	$ -	$ -	$ -	$ 36,000.00	$ -	$ 36,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
Flex	$ 24,192.57	$ -	$ 24,192.57	$ -	$ -	$ -	$ 24,192.57	$ -	$ 24,192.57
Respite Housing	$ 23,260.01	$ -	$ 23,260.01	$ -	$ -	$ -	$ 23,260.01	$ -	$ 23,260.01
Naloxone	$ 18,000.00	$ -	$ 18,000.00	$ -	$ -	$ -	$ 18,000.00	$ -	$ 18,000.00
TOTAL	$ 218,915.00	$ -	$ 218,915.00	$ 3,915.00	$ -	$ 3,915.00	$ 215,000.00	$ -	$ 215,000.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS

Date 12/23/2020

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 LRGHEALTHCARE is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on November 15, 1893. 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: **64122**

Certificate Number: **0005043011**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 16th day of November A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Golda L. Schohan, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of LRGHealthcare.

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 December 1, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Kevin W. Donovan, President and CEO is duly authorized on behalf of LRGHealthcare to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 12/1/20

Signature of Elected Officer
Name: Golda L. Schohan
Title: Secretary/Treasurer, Board of Trustees

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/28/2020

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 MARSH USA, INC. 99 HIGH STREET BOSTON, MA 02110 Attn: Boston.certrequest@Marsh.com CN107277084-LRG-gener-21-22	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED LRGHealthcare 80 Highland Street Laconia, NH 03246	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Granite Shield Insurance Exchange INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** NYC-010705943-03 **REVISION NUMBER:** 1

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			GSIE-PRIM-2021-103	01/01/2021	01/01/2022	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 12,000,000
	POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			GSIE-PRIM-2021-103	01/01/2021	01/01/2022		SEE ABOVE

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
of Marsh USA Inc.

Elizabeth Stapleton

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/05/2020

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	CONTACT NAME: Tracy Andriski, CISR	
CROSS INSURANCE - LACONIA 155 Court Street Laconia NH 03246	PHONE (A/C, No, Ext): (603) 524-2425	FAX (A/C, No): (603) 524-3666
	E-MAIL ADDRESS: tandriski@crossagency.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: MEMIC Indemnity Company	11030
INSURED LRGHealthcare 80 Highland Street Laconia NH 03246	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** CL2091733955 **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		3102806692	10/01/2020	10/01/2021	☒ PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

CERTIFICATE HOLDER

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

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Tracy Andriski

LRGHealthcare

care. compassion. community.

MISSION STATEMENT

PURPOSE: LRGHealthcare's purpose shall be as recited in Article II of the Amended and Restated Articles of Agreement.

MISSION: To provide quality, compassionate care and to strengthen the well-being of our community.

VISION: The LRGHealthcare Organization shall be the preeminent provider of high levels of Quality Health Care, Patient Safety, and overall community satisfaction throughout the Lakes Region of New Hampshire.

July 1, 2002
Reaffirmed by the Members at the Annual Meeting on 01/20/03; 01/26/04; 01/24/05; 01/23/06; 01/22/07; 01/28/08; 01/26/09; 04/07/10; 04/06/11; 04/04/12; 04/03/13; 04/02/14; 04/08/15; 04/27/16; 04/05/17; 04/11/18

BAKER NEWMAN NOYES

LRGHealthcare and Subsidiary

Audited Consolidated Financial Statements

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

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

LRGHEALTHCARE AND SUBSIDIARY

AUDITED CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2019 and 2018

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BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
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INDEPENDENT AUDITORS' REPORT

To the Trustees
LRGHealthcare and Subsidiary

We have audited the accompanying consolidated financial statements of LRGHealthcare and Subsidiary, which comprise the consolidated statements of financial position as of September 30, 2019 and 2018, and the related consolidated statements of operations, changes in net (deficit) assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

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

To the Trustees
LRGHealthcare and Subsidiary

Opinion

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

Emphasis of Matter Regarding Going Concern

The accompanying consolidated financial statements have been prepared assuming that LRGHealthcare and Subsidiary will continue as a going concern. As discussed in Note 1 to the consolidated financial statements, LRGHealthcare has incurred significant net operating losses, has negative working capital, and has a net asset deficit, which raise substantial doubt about its ability to continue as a going concern. Management's evaluation of the events and conditions and management's plans regarding these matters are also described in Note 1. The consolidated financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to this matter.

Other Emphasis of Matter

As discussed in Note 1 to the financial statements, in 2019, LRGHealthcare and Subsidiary adopted Financial Accounting Standards Board Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities*, and applied the guidance retrospectively to all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 5, 2020

LRGHEALTHCARE AND SUBSIDIARY

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets:		
Cash and cash equivalents	$ 4,061,560	$ 6,987,814
Accounts receivable, net of allowance for doubtful accounts of $9.7 million in 2019 and $8.1 million in 2018	19,387,150	21,442,686
Other receivables	3,345,926	7,706,852
Inventories	4,454,276	5,015,712
Current portion of deferred system development costs	4,999,717	4,999,717
Other prepaid expenses	2,767,736	3,081,592
Total current assets	39,016,365	49,234,373
Assets whose use is limited:		
Under mortgage indenture	12,151,588	12,098,511
Under workers' compensation trust agreement	1,106,094	1,115,128
Under deferred compensation plan	213,866	1,054,999
By donors or grantors for specific purposes	231,115	328,142
By donors for capital improvements	2,070,130	5,104,158
By donors for permanent endowment funds	2,199,737	2,199,737
Total assets whose use is limited	17,972,530	21,900,675
Long-term investments	203,089	256,505
Property, plant and equipment, net	94,082,178	95,452,710
Other assets	6,759,645	4,385,401
Deferred system development costs, less current portion	8,365,360	13,365,077
Prepaid pension\retirement cost	–	1,661,869
Total assets	$166,399,167	$186,256,610

LIABILITIES AND NET (DEFICIT) ASSETS

	2019	2018
Current liabilities:		
Accounts payable and other accrued expenses	$ 21,832,653	$ 24,737,843
Estimated third-party payor settlements payable	12,815,598	12,383,798
Accrued employee compensation:		
Payroll	4,352,971	4,104,145
Compensated absences	3,649,382	4,068,753
Healthcare and other accrued benefits	1,456,466	969,891
Current portion of long-term debt	174,705	4,543,906
Total current liabilities	44,281,775	50,808,336
Long-term debt:		
Notes payable	668,333	552,758
Mortgage payable	110,761,260	113,726,076
Less current installments	(174,705)	(4,543,906)
Long-term debt, net of current portion	111,254,888	109,734,928
Other long-term liabilities:		
Workers' compensation and other liabilities	8,270,866	5,950,999
Accrued pension/retirement costs	11,816,508	–
Total long-term liabilities	131,342,262	115,685,927
Total liabilities	175,624,037	166,494,263
LRGHealthcare net (deficit) assets:		
Without donor restrictions	(18,339,579)	11,703,364
With donor restrictions	9,024,656	7,632,037
Total LRGHealthcare net (deficit) assets	(9,314,923)	19,335,401
Noncontrolling interest in consolidated subsidiary	90,053	426,946
Total net (deficit) assets	(9,224,870)	19,762,347
Total liabilities and net (deficit) assets	$166,399,167	$186,256,610

See accompanying notes.

LRGHEALTHCARE AND SUBSIDIARY

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018

	2019	2018
Unrestricted revenue and other support:		
Net patient service revenue, net of contractual allowances and discounts	$202,014,030	$209,293,926
Less provision for doubtful accounts	(13,891,630)	(13,775,232)
Total net patient service revenue less provision for doubtful accounts	188,122,400	195,518,694
Disproportionate share funding	10,771,930	13,440,797
Net assets released from restrictions for operations	493,510	881,760
Other revenue	6,607,927	6,512,135
Total revenue	205,995,767	216,353,386
Expenses:		
Salaries	102,455,377	105,187,559
Payroll taxes	5,581,321	5,486,360
Employee benefits	15,178,327	13,421,864
Purchased services and contracted physicians	31,947,960	29,221,274
Pharmacy supplies	14,862,620	14,936,304
Chargeable supplies	9,919,127	10,764,081
Nonchargeable supplies	6,324,848	7,297,637
Depreciation and amortization	7,161,840	7,574,797
Amortization of deferred system development costs	4,999,717	6,206,105
Rent and occupancy expenses	5,781,893	6,464,655
Professional services	1,837,806	1,201,261
Interest expense	4,984,184	5,216,580
Insurance	3,107,899	2,781,432
Repairs	1,411,322	1,583,598
Tuition, advertising and other	1,857,672	2,036,664
Dues, travel and education	966,072	1,241,530
New Hampshire Medicaid Enhancement Tax	7,836,489	9,058,586
Total expenses	226,214,474	229,680,287
Loss from operations	(20,218,707)	(13,326,901)
Nonoperating gains (losses):		
Gifts, bequests and contributions	–	33,425
Interest and dividend income	198,889	98,686
Gain (loss) on disposal of property, plant and equipment	302,403	(16,607)
Other nonoperating loss	(416,241)	(226,998)
Nonoperating gains (losses), net	85,051	(111,494)
Consolidated deficiency of revenue and nonoperating gains (losses) over expenses	(20,133,656)	(13,438,395)
Excess of revenue and nonoperating (gains) losses over expenses attributable to noncontrolling interest in consolidated subsidiary	(146,677)	(770,938)
Deficiency of revenue and nonoperating gains (losses) over expenses attributable to LRGHealthcare	$(20,280,333)	$(14,209,333)

See accompanying notes.

LRGHEALTHCARE AND SUBSIDIARY

CONSOLIDATED STATEMENTS OF CHANGES IN NET (DEFICIT) ASSETS

Years Ended September 30, 2019 and 2018

	2019	2018
LRGHealthcare net (deficit) assets without donor restrictions:		
Deficiency of revenue and nonoperating gains (losses) over expenses attributable to LRGHealthcare	$(20,280,333)	$(14,209,333)
Adjustment to pension liability	(9,828,737)	3,599,932
Net assets released from restrictions for equipment purchases and property improvements	48,227	359,960
Unrealized gains on investments, net	17,900	41,750
Decrease in LRGHealthcare net (deficit) assets without donor restrictions	(30,042,943)	(10,207,691)
LRGHealthcare net assets with donor restrictions:		
Restricted contributions and pledges	1,934,356	3,012,987
Net assets released from restrictions for:		
Equipment purchases and property improvements	(48,227)	(359,960)
Operating purposes	(493,510)	(881,760)
Increase in LRGHealthcare net assets with donor restrictions	1,392,619	1,771,267
Decrease in LRGHealthcare net (deficit) assets	(28,650,324)	(8,436,424)
Noncontrolling interest in consolidated subsidiary:		
Excess of revenue and nonoperating gains over expenses attributable to noncontrolling interest in consolidated subsidiary	146,677	770,938
Contributions, distributions and other changes in noncontrolling interest	(483,570)	(509,568)
(Decrease) increase in noncontrolling interest in consolidated subsidiary	(336,893)	261,370
Decrease in total net (deficit) assets	(28,987,217)	(8,175,054)
Net assets, beginning of year	19,762,347	27,937,401
Net (deficit) assets, end of year	$ (9,224,870)	$ 19,762,347

See accompanying notes.

LRGHEALTHCARE AND SUBSIDIARY

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018

	2019	2018
Cash flows from operating activities:		
Decrease in total net (deficit) assets	$(28,987,217)	$ (8,175,054)
Adjustments to reconcile decrease in total net (deficit) assets to net cash provided by operating activities:		
Depreciation and amortization	7,161,840	7,574,797
(Gain) loss on disposal of property, plant and equipment	(302,403)	16,607
Provision for doubtful accounts	13,891,630	13,775,232
Adjustment to pension liability	9,828,737	(3,599,932)
Contributions, distributions and other changes in noncontrolling interest in consolidated subsidiary	483,570	509,568
Restricted contributions, pledges and grants	(1,934,356)	(3,012,987)
Amortization of deferred system development costs	4,999,717	6,206,105
Unrealized gains on investments, net	(17,900)	(41,750)
Changes in operating assets and liabilities:		
Accounts receivable	(11,836,094)	(9,866,183)
Estimated third-party settlements payable	431,800	(2,185,606)
Other receivables	4,360,926	(830,402)
Inventories	561,436	599,573
Deferred system development costs	–	(5,626,130)
Other prepaid expenses	313,856	11,642
Other assets	(2,154,000)	409,000
Accounts payable and other accrued expenses	(2,905,190)	10,161,325
Accrued employee compensation	316,030	82,656
Workers' compensation and other liabilities	2,319,867	181,639
Accrued pension/retirement costs	3,649,640	1,897,477
Net cash provided by operating activities	181,889	8,087,577
Cash flows from investing activities:		
Acquisition of property, plant and equipment	(5,848,528)	(1,270,023)
Proceeds from sale of property, plant and equipment	359,623	–
Net (increase) decrease in other noncurrent assets	(220,244)	718,639
Decrease (increase) in assets whose use is limited and long-term investments, net	3,999,461	(3,053,726)
Net cash used by investing activities	(1,709,688)	(3,605,110)
Cash flows from financing activities:		
Proceeds from issuance of note payable	238,000	–
Repayment of long-term debt	(3,087,241)	(4,014,487)
Restricted contributions, pledges and grants	1,934,356	3,040,685
Noncontrolling interest in consolidated subsidiary	(483,570)	(509,568)
Net cash used by financing activities	(1,398,455)	(1,483,370)
Net (decrease) increase in cash and cash equivalents	(2,926,254)	2,999,097
Cash and cash equivalents, beginning of year	6,987,814	3,988,717
Cash and cash equivalents, end of year	$ 4,061,560	$ 6,987,814
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 4,918,057	$ 4,636,363

See accompanying notes.

1. Description of Organization and Summary of Significant Accounting Policies

Organization

LRGHealthcare's mission is to provide accessible, quality, compassionate care and to strengthen the well being of its communities. LRGHealthcare operates two acute care hospitals located in Franklin and Laconia, New Hampshire. The Franklin facility was designated a Critical Access Hospital effective July 1, 2004 and includes 25 acute care beds. Also, on October 1, 2013, the Franklin facility opened a 10 bed designated psychiatric receiving facility. The Laconia facility includes 137 acute care beds and was designated a Rural Referral Center in 1986 and a Sole Community Hospital in 2009. The facilities provide emergency care, ambulatory surgical units and medical practices.

LRGHealthcare is a New Hampshire nonprofit corporation formed in November 1893 and is classified as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code.

The accompanying consolidated financial statements include the accounts of LRGHealthcare's wholly-owned workers' compensation trust (see note 11). The accompanying consolidated financial statements also include the accounts of Hillside ASC, LLC (Hillside). LRGHealthcare owns a 65.3% interest in Hillside at September 30, 2019 and 2018. Hillside is an ambulatory surgical center located in Gilford, New Hampshire. The consolidated group is collectively referred to herein as "the Hospitals."

Effective June 25, 2015, the Hospitals and Speare Memorial Hospital formed Asquam Community Health Collaborative, LLC (ACHC). ACHC was initially capitalized by contributions of $5,000 made by each member. ACHC has two equal members and may admit additional members in the future with the consent of the original members. ACHC's purpose is to conduct (1) joint purchasing, management and use arrangements involving information technology and other major equipment; (2) shared administrative and other supportive services; (3) the exchange of wage, price, cost and/or clinical outcomes (i.e., quality data) as permitted by law; (4) development and/or participation in innovative healthcare delivery platforms; and (5) other activities as determined by consent of the members. ACHC's initial activity is to jointly purchase an Electronic Healthcare Record (EHR) system. The Hospitals are accounting for ACHC under the equity method and have recorded their share of the ownership interest in ACHC of $48,293 and $4,110 at September 30, 2019 and 2018, respectively, in other assets in the accompanying consolidated statements of financial position. ACHC entered into a noninterest bearing note payable in 2017 with an unrelated party. The members are a guarantor of the note payable. The note payable was paid off and had no outstanding liability balance at September 30, 2019 and was approximately $1,270,000 at September 30, 2018.

LRGHealthcare has recently incurred significant net operating losses, which have continued into 2020 through the date of these consolidated financial statements. Additionally, LRGHealthcare had a net deficit in net assets without donor restrictions and negative working capital at September 30, 2019. Management believes that cost cutting measures have continued to be implemented which have resulted in some stability of cash on hand at the date of these consolidated financial statements. However, there continues to be uncertainty of availability of future cash to meet operating needs.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Management completed its assessment whether substantial doubt exists regarding LRGHealthcare's ability to continue as a going concern for the twelve months after the date of issuance of these consolidated financial statements. LRGHealthcare has incurred losses in 2019 of approximately $20.2 million. Losses have continued since September 30, 2019 through the date of these consolidated financial statements and LRGHealthcare expects that they will continue for the foreseeable future. LRGHealthcare continues to explore cost cutting measures and strategic affiliations for LRGHealthcare's future, however, these items are not guaranteed. Management concluded that these events or conditions, considered in the aggregate, raise substantial doubt about LRGHealthcare's ability to continue as a going concern for the twelve months after the date of issuance of these consolidated financial statements. No amounts have been recorded in these consolidated financial statements related to this uncertainty.

Principles of Consolidation

All significant intercompany balances and transactions have been eliminated in the consolidation. Noncontrolling interests in the less-than-wholly-owned consolidated subsidiary of LRGHealthcare are presented as a component of total equity to distinguish between the interests of LRGHealthcare and the interests of the noncontrolling owners. Revenues, expenses and nonoperating gains from this subsidiary are included in the consolidated amounts presented on the consolidated statements of operations. Deficiency of revenue and nonoperating gains (losses) over expenses attributable to LRGHealthcare separately presents the amounts attributable to the controlling interest for each of the years presented.

Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to a parent. LRGHealthcare's accompanying consolidated financial statements include all assets, liabilities, revenues and expenses at their consolidated amounts, which include the amounts attributable to LRGHealthcare and the noncontrolling interest. LRGHealthcare recognizes as a separate component of equity (net assets) and earnings (deficiency of revenue and nonoperating gains/losses over expenses) the portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by LRGHealthcare.

Cash and Cash Equivalents

Cash and cash equivalents include money market funds and short-term investments with original maturities of three months or less, excluding assets whose use is limited and long-term investments.

The Hospitals maintain their cash in bank deposit accounts, which at times may exceed federally insured limits. The Hospitals have not experienced any losses on such accounts.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Accounts Receivable and the Allowance for Doubtful Accounts

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the Hospitals analyze their past history and identify trends for each of their major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for doubtful accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospitals analyze contractually due amounts and provide an allowance for doubtful accounts and a provision for doubtful accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospitals record a provision for doubtful accounts in the period of service on the basis of their past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Hospitals' allowance for doubtful accounts for self-pay patients increased from 93% of self-pay accounts receivable at September 30, 2018 to 96% of self-pay accounts receivable at September 30, 2019. The Hospitals' net self-pay bad debt writeoffs decreased $1,095,828 from $13,431,829 in 2018 to $12,336,001 in 2019. The change in the allowance as a percentage of self-pay accounts receivable and bad debt writeoffs was a result of collection trends, payor mix and the overall balance in self-pay accounts receivable.

Investments and Investment Income

Investments, including funds under mortgage indenture, are carried at fair value in the accompanying consolidated statements of financial position. Realized gains or losses on the sale of investment securities are determined by the specific identification method. Except as described in the following paragraph, investment interest and dividends on unrestricted funds are treated as nonoperating gains and losses. Unrealized gains and losses on investments are excluded from the deficiency of revenue and nonoperating gains (losses) over expenses unless the losses are considered other-than-temporary. Periodically, management reviews investments for which the market value has fallen significantly below cost and recognizes impairment losses where they believe these declines are other-than-temporary.

The investments in joint ventures are reported on the equity method of accounting and are recorded at amounts that approximate the Hospitals' equity in the underlying net assets of the entities.

Interest income attributable to operating funds are reported within other revenue in the accompanying consolidated statements of operations. Operating funds are determined by the Hospitals as being 20 days or less of working capital requirements.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Investment Policies

The Hospitals' 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 (without donor restrictions) 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.

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

The goal with respect to the management of endowment funds is to increase, with minimum risk, the inflation adjusted principal and income of the endowment funds over the long term. The Hospitals target a diversified asset allocation that places emphasis on achieving their long-term return objectives within prudent risk constraints.

Assets Whose Use is Limited

Assets whose use is limited include assets held under mortgage indenture, workers' compensation reserves, employee deferred compensation plan and donor-restricted investments.

Inventories

Inventories of supplies and pharmaceuticals are carried at the lower of cost, determined using the "first-in, first-out" (FIFO) method, or net realizable value.

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase, or fair value at time of donation, less reductions in carrying value based upon impairment and less accumulated depreciation. The Hospitals' 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. See also note 6. Assets which have been purchased but not yet placed in service are included in construction in progress and no depreciation expense is recorded.

Donations of fixed assets, or funds received to acquire property and equipment, are reported at fair value when received in net assets with donor restrictions and transferred to net assets without donor restrictions when the asset is placed in service.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Net Patient Service Revenue

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

The Hospitals recognize 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 Hospitals provide a discount approximately equal to that of their largest private insurance payors. On the basis of historical experience, a significant portion of the Hospitals' uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospitals record a significant provision for doubtful accounts related to uninsured patients in the period the services are provided.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospitals believe that they are in compliance with all applicable laws and regulations and are not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. See also note 4.

Deficiency of Revenue and Nonoperating Gains (Losses) Over Expenses

The Hospitals have deemed all activities as ongoing, major or central to the provision of healthcare services and, accordingly, they are reported as operating revenue and expenses. Peripheral transactions are reported as nonoperating gains or losses.

The consolidated statements of operations include deficiency of revenue and nonoperating gains (losses) over expenses. Changes in net assets without donor restrictions which are excluded from deficiency of revenue and nonoperating gains (losses) over expenses, consistent with industry practice, include the change in net unrealized gains and losses on investments, other than losses considered other-than-temporary, the pension liability adjustments and contributions of long-lived assets, including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Charity Care

The Hospitals provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates (see note 2). Because the Hospitals do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the Hospitals' total expenses divided by gross patient service revenue.

Classification of Net Assets

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

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

In accordance with the *Uniform Prudent Management Institutional Funds Act* (UPMIFA), the Hospitals consider 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 Policy for Appropriation of Assets for Expenditure

Spending policies may be adopted by the Hospitals, 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 Hospitals evaluate their spending policies on an annual basis.

Estimated Workers' Compensation and Healthcare Claims

The Hospitals are self-insured with respect to certain employee workers' compensation (through September 30, 2019) and healthcare costs. The provision for estimated workers' compensation and healthcare claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported (see note 11).

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Volunteer Hours (Unaudited)

Volunteers contributed approximately 12,500 and 17,000 hours in donated services in 2019 and 2018, respectively. Volunteers perform a number of varied activities for the Hospitals including pharmacy, patient and mail transport as well as filing and reception duties. The monetary value of such services has not been reflected in the accompanying consolidated financial statements.

Grant Revenue and Expenditures

Revenues and expenses under grant programs are recognized as the related expenditures are incurred.

Advertising, Marketing Costs and Community Affairs

Advertising, marketing and related costs are charged to operations when incurred. Such amounts totaled approximately $358,000 in 2019 and $669,000 in 2018.

Income Taxes

The Hospitals, with the exception of Hillside, 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 Hospitals' tax positions and concluded the Hospitals have maintained their tax-exempt status, do not have any significant unrelated business income and have taken no uncertain tax positions that require adjustment to or disclosure in the consolidated financial statements. Hillside is a for-profit subsidiary and is a limited liability company. As such, the subsidiary is subject to state taxation but is not subject to federal taxation. Deferred taxes are not significant at September 30, 2019 and 2018.

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. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The most significant areas which are affected by the use of estimates include the allowance for doubtful accounts and contractual adjustments, estimated third-party payor settlements, malpractice and health insurance reserves, and actuarial assumptions used in determining pension obligations and expense and workers' compensation costs.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Recent Accounting Pronouncements

In August 2016, the Financial Accounting Standards Board (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 Hospitals for the year ended September 30, 2019. The Hospitals have adjusted the presentation of these consolidated financial statements and related footnotes accordingly. The ASU has been applied retrospectively to all periods presented.

In May 2014, the 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 Hospitals expect 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 Hospitals on October 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The Hospitals continue to evaluate the impact that ASU 2014-09 will have on their consolidated financial statements and related disclosures, but do not expect that the new pronouncement will have a material impact on its consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842).* Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. The guidance is effective for the Hospitals on October 1, 2020, with early adoption permitted. Subsequently, the FASB issued ASU 2018-11, *Leases (Topic 842): Targeted Improvements*, which is intended to reduce costs and ease implementation of the leases standard for financial statement preparers. Under these standards, lessees (for capital and operating leases) may initially apply the new leases standard at the adoption date and recognize a cumulative-effect adjustment in the opening balance of net assets while continuing to present comparative periods in accordance with current GAAP in Topic 840, *Leases.* In November 2019, the FASB issued ASU 2019-10, which extended the original effective date from October 1, 2020 to October 1, 2021. The Hospitals are currently evaluating the impact of the pending adoption of these standards on the consolidated financial statements.

In March 2017, the FASB issued ASU No. 2017-07, *Compensation — Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* (ASU 2017-07). ASU 2017-07 will require that an employer report the service cost component of net periodic pension cost in the same line item as other compensation costs arising from services rendered by employees during the period. The other components of net periodic pension cost are required to be presented in the statement of operations separately and outside a subtotal of income from operations, if one is presented. ASU 2017-07 is effective for the Hospitals on October 1, 2019. The Hospitals would have presented net periodic pension cost of approximately $4,500,000 and $2,763,000 for years ended September 30, 2019 and 2018, respectively, as a separate line item in the consolidated statement of operations, outside a subtotal of loss from operations had ASU 2017-07 been adopted.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

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 Hospitals on October 1, 2019. The Hospitals are currently evaluating the impact that ASU 2018-08 will have on their consolidated financial statements, but does not expect that the new pronouncement will have a material impact on its consolidated financial statements.

Reclassifications

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

Subsequent Events

Management of the Hospitals evaluated events occurring between the end of the Hospitals' fiscal year and February 5, 2020, the date the consolidated financial statements were available to be issued.

2. Charity Care and Community Benefits (Unaudited)

The mission of the Hospitals is to provide quality, accessible healthcare services to patients regardless of their ability to pay. The Hospitals subsidize certain healthcare services, provide outreach and educational programs, build community population partnerships, provide free and discounted healthcare services and subsidize costs exceeding government sponsored healthcare reimbursement.

The estimated costs of providing community benefits and charity care for the years ended September 30 are:

	2019	2018
Charity care	$ 3,059,000	$ 847,000
Community programs and subsidized services	23,625,000	23,625,000
Government sponsored healthcare	17,811,000	17,811,000
	$44,495,000	$42,283,000

3. Concentrations

Financial instruments which subject the Hospitals to concentrations of credit risk consist of cash equivalents, patient accounts receivable and investments, including assets whose use is limited. The risk with respect to cash equivalents is minimized by the Hospitals' policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The Hospitals have not experienced any losses on cash equivalents. The Hospitals' patient accounts receivable are primarily due from third-party payors and amounts are presented net of expected contractual allowances and uncollectible amounts. Investments do not represent significant concentrations of specific market risk inasmuch as the Hospitals' investment portfolio is adequately diversified among various issues. No investments exceeded 10% of investments as of September 30, 2019.

Additionally, the Hospitals' patient mix consists of local residents and vacationing tourists, many of whom are insured under third-party payor agreements. The mix of payors including revenue, discounts and allowances granted excluding community care and the provision for doubtful accounts follows for fiscal years ended September 30 (in millions):

	2019			2018		
	Rev-enue	Discount and Allow-ances	Net Patient Rev-enue	Rev-enue	Discount and Allow-ances	Net Patient Rev-enue
Medicare	$288.4	$(202.6)	$ 85.8	$285.1	$(194.2)	$ 90.9
Medicaid	62.0	(55.4)	6.6	54.0	(48.4)	5.6
Insurance – fees for service	163.5	(71.7)	91.8	185.2	(86.2)	99.0
Patients and Healthlink	19.3	(8.8)	10.5	12.7	(6.2)	6.5
Employee health plan	11.0	(3.7)	7.3	9.8	(2.5)	7.3
	$544.2	$(342.2)	$202.0	$546.8	$(337.5)	$209.3

Concentrations of credit risk from gross receivables from patients and third-party payors are as follows at September 30:

	2019	2018
Medicare	44.30%	44.67%
Medicaid	9.11	8.99
Commercial insurers	28.78	31.36
Patients	17.81	14.98
	100.00%	100.00%

4. Net Patient Service Revenue

The Hospitals have agreements with third-party payors that provide for payments to the Hospitals at amounts different from their established rates. Similarly, patients are offered prompt payment discounts through the Hospitals' Patient Advantage Program. A summary of the payment arrangements with major third-party payors follows:

Medicare

Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge (DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis and other factors. Inpatient non-acute services are paid based on a fixed prospective payment system, again varying according to clinical diagnosis and other factors. As a Sole Community Hospital, the payment is the higher of the hospital specific or federal specific rate.

Since August 2000, outpatient services are reimbursed under the Medicare Outpatient Prospective Payment System (OPPS). Payments are made at a fixed rate based upon each service as categorized by Medicare's Ambulatory Payment Classifications (APCs). As a result, the materiality of prospectively determined settlement adjustments diminished. The Hospitals' classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review. In 2009, LRGHealthcare was designated a Sole Community Hospital by Medicare adding to its previous designation as a Rural Referral Center.

Effective July 1, 2004, the Franklin facility was classified as a Critical Access Hospital. Thereafter, inpatient, non-acute services related to Medicare beneficiaries are paid based on a blended rate comprised of fixed fee schedules for laboratory services to non-patients and a cost reimbursement methodology. The Franklin facility is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are reimbursed at rates prospectively determined per discharge (DRGs). Outpatient services are reimbursed under a cost reimbursement methodology and a fixed laboratory fee schedule. The Hospitals are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospitals subject to audits thereof by the Medicaid fiscal intermediary.

Settlements

The accrual for estimated third-party payor settlements reflected on the accompanying consolidated statements of financial position represents the estimated net amounts to be received/paid under reimbursement contracts with the Centers for Medicare and Medicaid Services (CMS) (Medicare), the New Hampshire Department of Welfare (Medicaid) and any commercial payors with settlement provisions. Settlements for the Franklin facility have been finalized through 2016 for Medicare and 2014 for Medicaid. Settlements for the Laconia facility have been finalized through 2015 for Medicare and Medicaid. Income from operations increased by approximately $667,000 for the year ended September 30, 2019 and $4,931,000 for the year ended September 30, 2018 (primarily due to a change in reserves for disproportionate share payments as discussed below), respectively, due to actual settlements and changes in assumptions underlying estimated future third-party settlements.

4. Net Patient Service Revenue (Continued)

Other

The Hospitals have also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Hospitals under these agreements includes discounts from established charges, DRG indexed payments, fee schedule based payments and retrospective cost based reimbursement.

Medicaid Enhancement Tax and Medicaid Disproportionate Share

Under the State of New Hampshire's tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.5% of the Hospitals' net patient service revenues, with certain exclusions. The amount of tax incurred by the Hospitals for fiscal 2019 and 2018 was $7,836,489 and $9,058,586, respectively. The Hospitals have accrued approximately $1,972,000 and $2,222,000 in MET at September 30, 2019 and 2018, respectively. These amounts are included in accounts payable and other accrued expenses in the accompanying consolidated statements of financial position at September 30, 2019 and 2018.

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. In 2019 and 2018, the Hospitals recognized disproportionate share funding totaling $10,771,930 and $13,440,797, respectively.

As part of the State's biennial budget process for the two-year period ending June 30, 2013, it eliminated disproportionate share payments to certain New Hampshire hospitals, excluding hospitals classified as critical access. For the periods ending June 30, 2019 and 2018, the State included the hospitals not classified as critical access as qualifying for disproportionate share payments. The Hospitals have recorded receivables totaling approximately $2,784,000 and $3,150,000 at September 30, 2019 and 2018, respectively, representing the portion of disproportionate share payments expected to be received related to the Hospitals' fiscal year.

CMS has completed preliminary audits through 2016, however, no final settlements have occurred; therefore, all years starting in 2011 continue to be open which are 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 Hospitals have recorded reserves to address their exposure based on CMS's audit results to date. Approximately $3,100,000 in reserves relating to these audits is included in estimated third-party payor settlements payable in the accompanying consolidated statements of financial position at both September 30, 2019 and 2018.

4. Net Patient Service Revenue (Continued)

Summary of Patient Service Revenues

An estimated breakdown of patient service revenue, net of contractual allowances, discounts and provision for doubtful accounts recognized in 2019 and 2018 from these major payor sources, is as follows (in millions):

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2019				
Private payors (includes coinsurance and deductibles)	$163.5	$ (71.7)	$ (5.4)	$ 86.4
Medicaid	62.0	(55.4)	(0.2)	6.4
Medicare	288.4	(202.6)	(2.5)	83.3
Self-pay and Healthlink	19.3	(8.8)	(5.7)	4.8
Employee health plan	11.0	(3.7)	(0.1)	7.2
	$544.2	$(342.2)	$(13.9)	$188.1
2018				
Private payors (includes coinsurance and deductibles)	$185.2	$ (86.2)	$ (5.4)	$ 93.6
Medicaid	54.0	(48.4)	(0.5)	5.1
Medicare	285.1	(194.2)	(2.6)	88.3
Self-pay and Healthlink	12.7	(6.2)	(5.2)	1.3
Employee health plan	9.8	(2.5)	(0.1)	7.2
	$546.8	$(337.5)	$(13.8)	$195.5

5. Assets Whose Use is Limited and Long-Term Investments

The composition of investments at September 30, 2019 and 2018 is set forth in the table shown below at fair value.

	2019	2018
Assets whose use is limited:		
Under mortgage indenture:		
Cash and cash equivalents (see note 7)	$12,151,588	$12,098,511
Under workers' compensation trust agreement:		
Cash and cash equivalents	500	111,473
Mutual funds	956,135	915,419
Nonfinancial assets	149,459	88,236
	1,106,094	1,115,128
Under deferred compensation plan:		
Mutual funds	213,866	1,054,999
Donor restricted assets:		
Cash and cash equivalents	4,500,982	7,632,037
Total assets whose use is limited	17,972,530	21,900,675
Long-term investments:		
Cash and cash equivalents	201,128	254,544
Marketable equity securities	1,961	1,961
Total long-term investments	203,089	256,505
Total assets whose use is limited and long-term investments	$18,175,619	$22,157,180

The following schedule summarizes total investment return and its classification for the year ended September 30; 2019, with totals for comparative purposes shown for 2018:

	2019			
	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	2019 Total	2018 Total
Interest and dividends	$198,889	$ –	$198,889	$ 98,686
Unrealized gains, net	17,900	–	17,900	41,750
Total investment return	$216,789	$ –	$216,789	$140,436

5. Assets Whose Use is Limited and Long-Term Investments (Continued)

In evaluating whether the investments have suffered an other-than-temporary decline, based on input from outside investment advisors, management evaluated the amount of the decline compared to cost, the length of time and extent to which fair value has been less than cost, the underlying creditworthiness of the issuer, the fair values exhibited during the year, estimated future fair values and the Hospitals' intent and ability to hold the security until a recovery in fair value or maturity. There were no securities in an unrealized loss position at September 30, 2019 and 2018.

6. Property, Plant and Equipment

Property, plant and equipment consists of the following:

	September 30, 2019 (In Millions)			September 30, 2018 (In Millions)		
	Cost	Accum. Depre.	Net	Cost	Accum. Depre.	Net
Land	$ 1.8	$ -	$ 1.8	$ 1.8	$ -	$ 1.8
Land improvements	3.7	(3.1)	0.6	3.8	(3.0)	0.8
Buildings	82.6	(34.7)	47.9	82.2	(33.8)	48.4
Equipment – major	85.9	(69.5)	16.4	85.6	(66.3)	19.3
Equipment – fixed	56.6	(35.9)	20.7	56.6	(33.4)	23.2
	230.6	(143.2)	87.4	230.0	(136.5)	93.5
Construction in process and deposits	6.7	–	6.7	2.0	–	2.0
Total property, plant and equipment	$237.3	$(143.2)	$ 94.1	$232.0	$(136.5)	$ 95.5

The Hospitals own real property which is leased to providers of health services, several small business concerns and charitable organizations. As of September 30, 2019, the cost basis of rented property was $5,179,281 and accumulated depreciation was $2,761,777. Gross rents received during the years ended 2019 and 2018 included in other revenue were $225,226 and $192,330, respectively.

The Hospitals entered into a construction contract in 2019 with a total commitment of approximately $5,600,000 related to the renovation of the emergency department, of which remaining expected costs are approximately $1,835,000 at September 30, 2019. The Hospitals anticipate the project to be completed by the spring of 2020.

7. Long-Term Debt

The following debt issues have primarily been used to finance or refinance construction projects, renovations and capital acquisitions of property and equipment.

2015 Mortgage Payable

On September 30, 2015, the Hospitals refunded their existing 2010 Series Bonds outstanding (see below) of $133,265,000 through the issuance of $125,871,960 in fixed rate Federal Housing and Urban Development Insured Mortgage Payable with an interest rate of 3.70%. The balance of this mortgage at September 30, 2019 and 2018 was $110,761,260 and $113,726,076, respectively. The refunding transaction reduces the Hospitals' total interest costs through the maturity of the refunded bonds. As of September 30, 2019, the amount of defeased 2010 Series Bonds payable not included in the accompanying consolidated statements of financial position was approximately $122,804,000. In May 2019, the Hospitals amended the payment terms on this agreement to interest only payments from June 2019 through May 2024. Principal payments will resume at that time through the mortgage's anticipated payoff in November 2036.

The Hospitals have granted as collateral for the 2015 mortgage payable substantially all property and equipment (excluding the assets of Hillside) and are required to comply with certain restrictive financial covenants defined by Section 41, and the method of calculating the mortgage reserve fund balance defined by Section 21, of the *Regulatory Agreement* between the Hospitals and the U.S. Department of Housing and Urban Development Federal Housing Administration dated December 9, 2010. For the year ended September 30, 2019, the Hospitals were in compliance with all required financial covenants as defined in the *Regulatory Agreement*.

Notes Payable

During 2014, LRGHealthcare entered into a note payable with the State of New Hampshire Department of Health and Human Services in the amount of $829,138 for the construction of a Designated Receiving Facility on the Franklin campus. The note is noninterest bearing and requires annual payments of $55,276 over a fifteen year period. The balance of this note at September 30, 2019 and 2018 was $497,483 and $552,758, respectively.

During 2019, LRGHealthcare entered into a two-year 4.65% note payable with a third party in the amount of $238,000 for the purchase of a property. The balance of this note at September 30, 2019 was $170,850.

Interest expense incurred on the mortgage and notes payable was approximately $4,984,000 and $5,217,000 in 2019 and 2018, respectively.

Principal payments on the mortgage and notes payable outstanding at September 30, 2019 for each of the following years ending September 30 are as follows:

2020	$ 174,705
2021	106,697
2022	55,276
2023	55,276
2024	2,393,603
Thereafter	108,644,036
	$ 111,429,593

7. Long-Term Debt (Continued)

Revolving Lines of Credit

On October 9, 2015, the Hospitals entered into a $6,000,000 unsecured revolving line of credit agreement with a bank, which is due on demand and has no date of expiration. The line of credit agreement bears interest at the Wall Street Journal prime rate (5.00% at September 30, 2019). As of September 30, 2019 and 2018, there was no outstanding balance on this line of credit.

On August 17, 2017, the Hospitals entered into a $9,000,000 180 day short-term revolving line of credit agreement with a bank, which was subsequently extended and expired on July 1, 2019. The line of credit was secured by the Hospitals' accounts receivable with a bank, was due on demand or upon expiration, and bore interest at the Wall Street Journal prime rate plus one-half percent. As of September 30, 2018, there was no outstanding balance on this line of credit.

Amounts Held

The Hospitals are required to maintain escrow funds for the monthly payments made by the Hospitals which, in turn, enable the funding of a debt service reserve and required semi-annual interest payments, annual principal payments, private mortgage insurance, taxes and other insurance due on the Series 2015 mortgage at September 30, 2019 and 2018. Amounts held in escrow funds totaled $12,151,588 and $12,098,511 at September 30, 2019 and 2018, respectively.

8. Retirement Plans

The Hospitals have two retirement plans covering substantially all of their employees.

The Hospitals have a tax sheltered annuity based retirement plan (TSA plan). The TSA plan is a defined contribution plan available to all employees of the Hospitals. There are no employer contributions made to the TSA plan. At September 31, 2019 and 2018, the Hospitals have recorded $213,866 and $1,054,999 on the accompanying consolidated statements of financial position in assets whose use is limited and other liabilities.

The Hospitals also have a defined benefit plan. During 2019, the mortality assumption was updated to use the RP-2014 mortality tables to reflect a modified MP-2019 mortality improvement scale. During 2018, the mortality assumption was updated to use the RP-2014 mortality tables to reflect a modified MP-2018 mortality improvement scale.

The defined benefit plan has received a favorable determination letter dated March 15, 2012.

The defined benefit plan accruals ended December 31, 2004. Those accruals provided for a plan benefit payable upon normal retirement (age 65) of 1.625% of the employee's average highest five consecutive years' earnings during the employee's last 10 years of employment for each year of service up to 25 years. Participants may elect a lump sum form of payment. Beginning January 1, 2005, under the 2005 amendment, a new account was established to accumulate employer contributions and investment credits to be added to the grandfathered defined benefit amount. Those additions will be identical to the cash balance credits described below.

8. Retirement Plans (Continued)

At retirement, grandfathered employees receive the greater of benefits under the defined benefit plan as described above or the cash balance plan. Under the cash balance plan, a participant's January 1, 1995 plan benefit was present valued into a separate account balance in the participant's name which then became the employee's retirement benefit. Thereafter, account additions are determined at 7% of compensation up to $25,000 and 3% thereafter for participants with less than 10 years of service or 4% for participants with 10 or greater years of service. Interest additions are credited at a predetermined rate of interest not to exceed 5.5%. However, ad hoc increases have been made. The interest rate credits for fiscal years 2019 and 2018 were 1.34% and 0.74%, respectively.

The following table sets forth the principal actuarial assumptions used to compute the net periodic pension cost and pension benefit obligations at September 30.

	2019	2018
Principal actuarial assumptions used to determine net periodic pension cost:		
Discount rate	4.54%	4.01%
Expected return on plan assets	7.00	7.00
Salary increases	3.00	3.00
Principal actuarial assumptions used to determine benefit obligations:		
Discount rate	3.54%	4.54%
Salary increases	3.00	3.00

The expected long-term return on asset assumption is reviewed annually, taking into consideration the current and expected future allocation of assets, and the expected long-term return on these asset classes. Historical real returns and expected future inflation are considered as factors in estimating the expected long-term return on these asset classes. The difference between actual investment return and the 7.00% long-term return assumption is amortized over five years. Were the plan to terminate, different assumptions and other factors might be applicable in determining the projected benefit obligation.

The following table sets forth the changes in projected benefit obligations, changes in plan assets, components of net periodic benefit cost and reconciliation of prepaid or accrued pension cost:

	September 30	
	2019	2018
Change in projected benefit obligation:		
Projected benefit obligation at the beginning of the year	$ 64,769,679	$ 67,589,901
Service cost	2,595,979	2,762,813
Interest cost	2,855,227	2,629,827
Distributions	(7,955,562)	(6,342,064)
Assumption changes	6,196,942	(3,374,796)
Experience loss	2,350,912	1,503,998
Projected benefit obligation at the end of the year	$ 70,813,177	$ 64,769,679

8. Retirement Plans (Continued)

	September 30 2019	September 30 2018
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	$ 66,431,548	$ 67,549,315
Actual return on plan assets	242,111	5,224,297
Administrative expenses	(452,562)	(275,452)
Benefits paid	(7,224,428)	(6,066,612)
Fair value of plan assets at the end of the year	$ 58,996,669	$ 66,431,548
Funded status	$(11,816,508)	$ 1,661,869
Components of net periodic pension cost:		
Service cost	$ 2,595,979	$ 2,762,813
Interest cost	2,855,227	2,629,827
Expected return on plan assets	(4,387,309)	(4,467,137)
Net prior service cost amortization	10,901	10,901
Amortization of loss	671,151	960,943
Immediate recognition triggered by settlement	1,903,692	–
Net periodic pension cost	$ 3,649,641	$ 1,897,347
Reconciliation of net statement of financial position liability:		
Net statement of financial position liability at beginning of year	$ 1,661,869	$ (40,586)
Amount recognized in accumulated other comprehensive liability at end of prior year	11,928,423	15,528,225
Prepaid benefit cost (before adjustment) at end of prior year	13,590,292	15,487,639
Immediate recognition triggered by settlement	(1,903,692)	–
Net periodic benefit cost for fiscal year	(1,745,949)	(1,897,347)
Prepaid benefit cost (before adjustment) at end of current year	9,940,651	13,590,292
Amount recognized in accumulated other comprehensive liability at end of current year	(21,757,159)	(11,928,423)
Net statement of financial position (liability) asset at end of current year	$(11,816,508)	$ 1,661,869

The accumulated benefit obligation was $66,833,310 and $61,412,099 at September 30, 2019 and 2018, respectively.

During 2019, the defined benefit plan settled 8.05% of the projected benefit obligation, therefore triggering the net loss for immediate recognition of settlement of $1,903,962, which is included in the net periodic pension cost in the accompanying consolidated statements of operations at September 30, 2019.

8. Retirement Plans (Continued)

The PPA legislates funding levels for defined benefit plans that will exceed the Plan's projected benefit obligation within the next seven years. There was no contribution for 2019. There is no expected contribution for 2020. Benefits expected to be paid by the Plan during the ensuing five years and five years thereafter are approximately as follows:

2020	$ 3,480,500
2021	4,148,700
2022	4,364,500
2023	4,417,300
2024	4,641,600
Five year period thereafter	20,321,600

The total unrecognized loss and prior year service cost are $21,744,651 and $12,508 at September 30, 2019. The loss and prior year service cost amount expected to be recognized in net periodic benefit cost in 2020 are as follows:

Actuarial loss	$1,345,260
Prior service cost	10,901
	$1,356,161

Pension Plan Assets

The primary investment objective of the Hospitals' Retirement Plan is to provide pension benefits for their members and their beneficiaries by ensuring a sufficient pool of assets to meet the Plan's current and future benefit obligations. These funds are managed as permanent funds with disciplined longer-term investment objectives and strategies designed to meet cash flow requirements of the plan. Funds are managed in accordance with ERISA and all other regulatory requirements.

Management of plan 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. Total annualized return, adjusted for trading costs and management fees, achieved by each investment manager of an actively managed portfolio, is expected to equal or exceed an index comprised of 60% of the Vanguard Index Trust 500 Fund and 40% of the Vanguard Total Bond Market Fund.

The Plan aims to assume a moderate level of risk and a diversified portfolio. The Plan invests in one money market account and two mutual funds at September 30, 2019. A periodic review is performed of the pension plan's investments in various asset classes.

8. Retirement Plans (Continued)

The fair values of the assets at September 30, 2019 are as follows (see note 15 for level definitions):

	Level 1	Level 2	Level 3	Total
Money market fund	$33,035,246	$ –	$ –	$33,035,246
Mutual funds:				
Index funds - fixed income	25,961,423	–	–	25,961,423
Total assets at fair value	$58,996,669	$ –	$ –	$58,996,669

The fair values of the assets at September 30, 2018 are as follows (see note 15 for level definitions):

	Level 1	Level 2	Level 3	Total
Money market fund	$ 1,739,905	$ –	$ –	$ 1,739,905
Mutual funds:				
Index fund - domestic	32,991,272	–	–	32,991,272
Index fund - international	7,206,966	–	–	7,206,966
Index fund - fixed income	24,493,405	–	–	24,493,405
	64,691,643	–	–	64,691,643
Total assets at fair value	$66,431,548	$ –	$ –	$66,431,548

9. Leases

The Hospitals have a number of lease agreements with noncancellable terms of more than one year. These include various family health practices and properties leased pursuant to professional service agreements. Leases extend for varying periods and most include renewal options subject to adjustment in the rental amount. Leases that expire are generally expected to be renewed or replaced by other leases, or the Hospitals' owned property will be utilized if available.

The future annual minimum rental payments required under noncancellable operating leases are as follows:

2020	$ 700,637
2021	701,717
2022	270,710
2023	231,767
2024	233,704
Thereafter	1,104,550

9. Leases (Continued)

Rent expense for all operating leases including month-to-month rentals for 2019 and 2018 was approximately $1,628,305 and $1,812,000, respectively.

10. Functional Expenses

The Hospitals provide general healthcare services to residents and vacationing tourists within their geographic area. Expenses related to providing these services are as follows for the year ended September 30:

	Health Services	General and Administrative	Total
2019			
Salaries	$ 84,665,106	$17,790,271	$102,455,377
Payroll taxes	4,332,985	1,248,336	5,581,321
Employee benefits	5,189,068	9,989,259	15,178,327
Purchases services and contracted physicians	14,978,954	16,969,006	31,947,960
Pharmacy supplies	14,862,620	–	14,862,620
Chargeable supplies	9,859,760	59,367	9,919,127
Nonchargeable supplies	4,805,602	1,519,246	6,324,848
Depreciation and amortization	50,207	7,111,633	7,161,840
Amortization of deferred system development costs	–	4,999,717	4,999,717
Rent and occupancy expenses	2,515,833	3,266,060	5,781,893
Professional services	256,198	1,581,608	1,837,806
Interest expense	168,640	4,815,544	4,984,184
Insurance	2,564,265	543,634	3,107,899
Repairs	845,382	565,940	1,411,322
Tuition, advertising and other	487,331	1,370,341	1,857,672
Dues, travel and education	446,026	520,046	966,072
New Hampshire Medicaid Enhancement tax	7,836,489	–	7,836,489
	$153,864,466	$72,350,008	$226,214,474

10. Functional Expenses (Continued)

	Health Services	General and Administrative	Total
2018			
Salaries	$ 78,766,990	$26,420,569	$105,187,559
Payroll taxes	3,765,736	1,720,624	5,486,360
Employee benefits	5,739,332	7,682,532	13,421,864
Purchases services and contracted physicians	14,481,029	14,740,245	29,221,274
Pharmacy supplies	14,286,972	649,332	14,936,304
Chargeable supplies	10,379,754	384,327	10,764,081
Nonchargeable supplies	5,049,994	2,247,643	7,297,637
Depreciation and amortization	–	7,574,797	7,574,797
Amortization of deferred system development costs	–	6,206,105	6,206,105
Rent and occupancy expenses	3,165,979	3,298,676	6,464,655
Professional services	175,308	1,025,953	1,201,261
Interest expense	205,594	5,010,986	5,216,580
Insurance	2,342,717	438,715	2,781,432
Repairs	913,220	670,378	1,583,598
Tuition, advertising and other	505,854	1,530,810	2,036,664
Dues, travel and education	549,401	692,129	1,241,530
New Hampshire Medicaid Enhancement tax	9,058,586	–	9,058,586
	$149,386,466	$80,293,821	$229,680,287

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

11. Self Insurance

Employee Health Insurance

The Hospitals have a self-funded health insurance plan. The plan is administered by an insurance company which assists in determining the current funding requirements of participants under the terms of the plan and the liability for claims and assessments that would be payable at any given point in time. The Hospitals recognize revenue for services provided to employees of the Hospitals during the year. The Hospitals are insured above a stop-loss amount of $300,000 on individual claims. Estimated unpaid claims, and those claims incurred but not reported at September 30, 2019 and 2018, have been recorded as a liability of approximately $700,000 and $450,000, respectively, and are reflected in the accompanying consolidated statements of financial position within healthcare and other accrued benefits.

11. Self Insurance (Continued)

Workers' Compensation Trust

The Hospitals self-insure their workers' compensation claims incurred prior to October 1, 2018 through a tax-exempt trust, revocable subject to State law retained funding level restrictions for the payment of workers' compensation settlements. Professional insurance consultants have been engaged to assist the Hospitals with determining funding amounts. The financial position and operations of the Trust have been consolidated with these statements. A stop loss policy is in place to limit liability exposure to $600,000 per occurrence. Effective October 1, 2018, the Hospitals are now insured under a commercial claims incurred insurance policy for workers' compensation claims.

Losses from asserted claims and from unasserted claims identified under the Hospitals' incident reporting system are accrued as reported based on estimates that incorporate industry past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. Accruals for possible losses attributable to incidents that may have occurred but that have not been identified under the incident reporting system have been made based upon industry experience and management's judgment. The Trust's estimate for all claims outstanding was $3,692,000 and $2,685,000 as of September 30, 2019 and 2018, respectively. Assets held in trust to meet such claims amounted to $1,106,094 and $1,115,128 at September 30, 2019 and 2018, respectively.

12. Commitments

In addition to commitments made in the ordinary course of business, the Hospitals have entered into the following agreements:

Participation Agreement Between ACHC and the Hospitals

In conjunction with the formation of ACHC, the Hospitals have entered into a participation agreement with ACHC whereby the Hospitals, as an ACHC member, have agreed to participate in ACHC's agreements with Cerner Corporation (Cerner) and S&P Consultants, Inc. (S&P) and share in 80% of the costs of the services as defined in the Cerner and S&P agreements related to the implementation of an EHR system to provide services to the Hospitals and Speare Memorial Hospital. Speare Memorial Hospital has agreed to participate in approximately 20% of those costs. The Cerner agreement has an initial term of seven years with successive 36-month terms, and the S&P agreement is a continuous agreement. In September 2017, ACHC terminated its agreement with S&P. In August 2017, ACHC entered into a three year agreement with Huntzinger Management Group, Inc. (Huntzinger). In November 2018, ACHC entered into a new agreement with Huntzinger for a minimum three year commitment. The annual fixed fee is approximately $8.3 million subject to 3% annual increases, of which LRGHealthcare is expected to pay approximately 77%. The following schedule reflects the Hospitals' share of future minimum payments to ACHC under the Cerner agreements as of September 30, 2019:

2020	$ 8,583,966
2021	8,770,106
2022	4,530,460
	$21,884,532

12. Commitments (Continued)

Based on the terms of the participation agreement with ACHC, the original costs paid for by the Hospitals for the implementation of the Cerner system are being treated as deferred system development costs and are being expensed over the remaining term of the agreement over the estimated useful life of the assets. Deferred system development costs as of September 30, 2019 and 2018 were $13,365,077 and $18,364,794, respectively. Amounts amortized in the accompanying consolidated statements of operations under this agreement were $4,999,717 and $6,206,105 in 2019 and 2018, respectively.

Purchased Services

The Hospitals contract for services with various specialty practice healthcare providers. The professional service agreements secure access to providers of obstetric, occupational health, surgical, emergency, integrated multi-specialty and other services for patients in the community. Contract terms vary but all provide for trial periods (which have lapsed) with cancellation clauses followed by longer term commitments with remaining terms ranging from one to three years. These agreements, prepared in accordance with Medicare anti-fraud and abuse laws, include employee lease arrangements, real and personal property leases and individual physician compensation agreements based upon nationally based medical procedure surveys. Consistent with the Hospitals' mission, the physician organizations agree to extend their services to patients without regard to the ability to personally pay and expand coverage areas to all communities served by the Hospitals. The contractual gross obligations, excluding benefits of such arrangements, are projected to be $26.6 million for the year ended September 30, 2020 and similar amounts for subsequent years.

Repurchase Contracts

Repurchase contracts on condominium units within the Laconia medical office building and High Street condominium units obligate the Hospitals to reacquire units which have previously been sold. At September 30, 2019, this commitment amounted to approximately $1.2 million.

13. Net Assets

Net Assets With Donor Restrictions

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

	2019	2018
Purpose restriction:		
Capital improvements	$6,593,804	$5,104,158
Other special purpose funds	231,115	328,142
	6,824,919	5,432,300
Perpetual in nature:		
Charity care	1,294,034	1,294,034
General Hospital use	750,699	750,699
Other purposes	155,004	155,004
	2,199,737	2,199,737
Total net assets with donor restrictions	$9,024,656	$7,632,037

13. Net Assets (Continued)

In 2019 and 2018, the Hospitals released $493,510 and $881,760, respectively, from net assets with donor restrictions for operations and $48,227 and $359,960 in 2019 and 2018, respectively, released from net assets with donor restrictions for capital improvements.

There was no activity related to endowment funds within net assets with donor restrictions in 2019 and 2018.

14. Contingencies

Medical Malpractice Claims

Prior to January 1, 2011, the Hospitals were insured against malpractice loss contingencies under claims-made insurance policies. A claims-made policy provides specific coverage for claims made during the policy period. Effective January 1, 2011, the Hospitals insure their medical malpractice risks through a multiprovider captive insurance company. Premiums paid are based upon actuarially determined amounts to adequately fund for expected losses. At September 30, 2019, there were no known malpractice claims outstanding for the Hospitals 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, except as noted below. The captive retains and funds up to actuarial expected loss amounts, and obtains reinsurance at various attachment points for individual and aggregate claims in excess of funding in accordance with industry practices. The Hospitals' interest in the captive represents approximately 20% of the captive at September 30, 2019 and 2018, although control of the captive is equally shared by participating hospitals. The Hospitals have recorded their interest in the captive's equity, totaling approximately $1,945,000 in 2019 and $1,714,000 at September 30, 2018, in other assets on the accompanying consolidated statements of financial position. Changes in the Hospitals' interest are included in nonoperating gains (losses) on the accompanying consolidated statements of operations. The Hospitals have established reserves to cover professional liability exposures for incurred but unpaid or unreported claims. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the Hospitals.

In accordance with ASU No. 2010-24, at September 30, 2019 and 2018, the Hospitals recorded a liability of approximately $4,840,000 and $2,686,000, respectively, related to estimated professional liability losses. At September 30, 2019 and 2018, the Hospitals also recorded a receivable of approximately $4,365,000 and $2,211,000, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in workers' compensation and other liabilities, and other assets, respectively, on the consolidated statements of financial position.

14. Contingencies (Continued)

New Hampshire Medical Malpractice Joint Underwriting Association Settlement

On August 12, 2011, pursuant to a legislative mandate, the New Hampshire Medical Malpractice Joint Underwriting Association (JUA) set aside $85 million of excess surplus funds for return to JUA policyholders. This amount was transferred to the policyholders' claims administrator on November 15, 2012. The JUA also segregated additional funds totaling $25 million pending resolution of certain JUA tax matters which was released in 2013. The entirety of these funds totaling $110 million had been the subject of a dispute between the JUA's policyholders and the state of New Hampshire (the State) with respect to the State's intent to transfer $110 million of JUA excess surplus to the State's general fund. This dispute resulted in a state of New Hampshire Supreme Court ruling in 2011 which held that the State's intended transfer would unconstitutionally impair JUA policyholders' contractual rights. In 2015, the New Hampshire legislature approved in the 2015 session both the ending of the JUA and taking no claim in the remaining assets after liquidation of liabilities. There was an estimate at the time of the legislation of $23 million in liability for the JUA. At December 31, 2014, the JUA had assets of greater than $117 million. Class action litigation was filed in December 2015 to recover the monies in a structure similar to the prior recovery and LRGHealthcare is again a lead plaintiff. Subsequently, net of a payment of $23,156,298 to MedPro on closing of an Assumption Agreement, the JUA's booked liabilities, the return of tail premium, and paid or accrued JUA expenses, the Insurance Commission of the State of New Hampshire (the Receiver) now has custody of liquid assets of the JUA constituting its remaining surplus funds in excess of $87 million. Further, the Receiver and the plaintiffs, through external counsel, negotiated a holdback or reserve of a portion of this surplus to secure or fund, if necessary, any theoretical liability on the Receiver's contractual liabilities, the JUA's one year covenants to MedPro under the Assumption Agreement expiring August 25, 2017 and/or the JUA's final tax returns. This holdback agreement, if approved by the court, permits the Receiver's immediate interpleader of $50 million for distribution to policyholders with the balance of funds to follow in subsequent transfers by the Receiver before the Receiver is finally discharged, in a manner similar to that accomplished in the prior class proceeding. Net of this holdback, therefore, the Receiver has liquid funds the Receiver is submitting forthwith by interpleader to the jurisdiction of this Receiver Court in the amount of $50 million. In 2018, this was approved and partial distributions of approximately $4,200,000 were received in 2019. Final distributions are expected in 2020 and are not expected to be significant.

15. Fair Value Measurements

Fair value of a financial instrument is defined as the price that would be received upon sale of an asset or paid upon transfer of a liability in an orderly transaction between market participants at the measurement date and in the principal or most advantageous market for that asset or liability. The fair value should be calculated based on assumptions that market participants would use in pricing the asset or liability, not on assumptions specific to the entity. In addition, the fair value of liabilities should include consideration of nonperformance risk including the Hospitals' own credit risk.

15. Fair Value Measurements (Continued)

The FASB's codification establishes a fair value hierarchy for valuation inputs. The hierarchy prioritizes the inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels which is determined by the lowest level input that is significant to the fair value measurement in its entirety. These levels are:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

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

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

In determining the appropriate levels, the Hospitals perform a detailed analysis of their assets and liabilities. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3.

For the fiscal year ended September 30, 2019, the application of valuation techniques applied to similar assets and liabilities has been consistent with prior years.

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

	Level 1	Level 2	Level 3	Total
2019				
Long-term investments:				
Cash and cash equivalents	$ 201,128	$ –	$ –	$ 201,128
Marketable equity securities	1,961	–	–	1,961
	$ 203,089	$ –	$ –	$ 203,089
Assets whose use is limited:				
Cash and cash equivalents	$16,653,070	$ –	$ –	$16,653,070
Mutual funds	1,170,001	–	–	1,170,001
Other	149,459	–	–	149,459
	$17,972,530	$ –	$ –	$17,972,530

15. Fair Value Measurements (Continued)

	Level 1	Level 2	Level 3	Total
2018				
Long-term investments:				
Cash and cash equivalents	$ 254,544	$ –	$ –	$ 254,544
Marketable equity securities	1,961	–	–	1,961
	$ 256,505	$ –	$ –	$ 256,505
Assets whose use is limited:				
Cash and cash equivalents	$19,842,021	$ –	$ –	$19,842,021
Mutual funds	1,970,418	–	–	1,970,418
Other	88,236	–	–	88,236
	$21,900,675	$ –	$ –	$21,900,675

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 consolidated statements of financial position and statements of operations.

Other financial instruments consist of cash and cash equivalents, patient accounts receivable, other receivables, pledges receivable, accounts payable, estimated third-party payor settlements and long-term debt. The fair value of all financial instruments approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value.

16. Financial Assets and Liquidity Resources

As of September 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	$ 4,061,560
Accounts receivable	19,387,150
Long-term investments	203,089
	$23,651,799

To manage liquidity, the Hospitals maintain 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 Hospitals. The financial assets and liquidity resources included above exclude $12,151,588 and $1,106,094 recorded as assets whose use is limited under mortgage indenture (see note 7) and under worker's compensation trust agreement (see note 11), respectively, at September 30, 2019. These funds are available to the Hospitals to settle debt payments, workers' compensation claims and related amounts as allowed under the trustee agreements.

LRGHealthcare
2020 BOARD OF TRUSTEES

CHAIR
Cynthia P. Baron

VICE CHAIR
William Bald

SECRETARY / TREASURER
Golda L. Schohan

TRUSTEES

Scott Clarenbach

James Clements

Nancy LeRoy

K. Mark Primeau

Scott Sullivan

Stuart Trachy

MEDICAL STAFF REPRESENTATIVES – EX-OFFICIO BOARD MEMBERS
Vercin Ephrem, MD, President of the Medical Staff

Jason Mangiardi, MD, Vice President of the Medical Staff

Paul Racicot, MD, Past President of the Medical Staff

BRIAN B. WINSLOW CFRE

[redacted]

WORK EXPERIENCE:

- *2019 – Present*
  Central New Hampshire VNA & Hospice, Laconia, NH
  Vice President of Advancement & Business Development
  Serving on the Senior Leadership Team and reporting directly to the CEO of Central New Hampshire VNA & Hospice. Responsible for all advancement and Business Development activities including Inside and Outside Sales, Philanthropy, Public Relations, Marketing, and Strategic Partnerships.

- *2019 – Present*
  LRGHealthcare, Laconia, NH
  Director of Special Projects
  Reporting to President & CEO of LRGHealthcare, the Director of Special Projects is a per diem position responsible for oversight and management of specific assigned projects directly related to the expenditure of philanthropically raised funds and grant management.

- *2017 – 2019*
  LRGHealthcare, Laconia, NH
  Executive Director, Philanthropy
  Reporting directly to the President & CEO of LRGHealthcare, the Executive Director is responsible for all aspects of philanthropic support. Leading a team of development professionals, successfully increasing annual fundraising by almost 400% in the first two years, all while planning, launching, and completing a Capital Project Campaign in the amount of $8,000,000. Most recently launching a grants program that successfully procured a multi-year $2,000,000 grant to provide Opioid Treatment and Prevention throughout Central New Hampshire.

- *2007 – 2017*
  Central New Hampshire VNA & Hospice, Laconia, NH
  Director of Fund Development
  Serving on the Senior Leadership Team I was responsible for the strategic management of a comprehensive Philanthropy and Marketing Program. During my tenure I transformed a lackluster fundraising program into a sustainable, robust and diverse department that routinely outperformed previous efforts by almost 300%; Served on a task force that resulted in the merger of two homecare and hospice agencies; and contributed to the agency routinely achieving CMS 4 Star Ratings, Home Care Elite Top Agency Awards and a BusinessNH Business of the Year Award. In addition, created the agency's first integrated marketing program that allowed for increased program market share and enhanced mission fulfillment.

- *2015 – 2017*
  Southern New Hampshire University, Manchester, NH
  Adjunct Instructor
  Responsible for teaching graduate and undergraduate classes including Introduction to Marketing, Strategic Nonprofit Marketing, Nonprofit Management, Healthcare Marketing and Grant Writing.

- *2002-2007*
  The Animal Welfare Society, Kennebunk, ME
  Director of Development
  As a member of the Senior Management Team I was responsible for the startup of the development program and the supervision of three development professionals. This included an annual giving program, major donor program, planned giving program as well as public relations, outreach and marketing. As Director of Development I successfully increased funds raised from philanthropic sources by 20% annually.

- *2000-2002*
  Natural Resources Council of Maine, Augusta, ME
  Membership Coordinator
  Responsible for designing, implementing, and maintaining a personalized outreach/ membership program. Intended to build long-lasting relationships, this position coordinated high touch cultivation with acquisition and annual appeal direct mail/telemarketing campaigns as well as fulfillment of gifts associated with these campaigns. As a member of the development team I helped to reach a $4 million capital campaign goal by staffing board campaign committees and working with volunteers.

EDUCATION:

Southern New Hampshire University Manchester, NH
Master of Science, *Marketing,* 2015
Cert. of Graduate Studies: Social Media Marketing 2014, *Marketing,* 2012
University of Southern Maine Portland, ME
Master of Public Policy and Management, 2008.
Cert. of Graduate Studies: Non-Profit Management 1998.
Iowa State University Ames, IA
Bachelor of Science, Fisheries and Wildlife Biology, 1994.

TRAININGS, CERTIFICATIONS and AWARDS:

- Certified Fund Raising Executive (CFRE)
- Blackbaud Certified Raiser's Edge Fundamentals (bCRE)
- Grant Writing Institute, National Organization of State Offices of Rural Health, 2018
- Certificate of Volunteer Management, 2016 (Maine Commission for Community Service)
- FEMA, ICS 100 Incident Command System & FEMA IS 10 Animals in Disaster
- 2012 Kiwanian of the Year, Kiwanis Club of Laconia, NH
- AHP Institute for Healthcare Philanthropy at Madison, 2009
- 2008-2009 Distinguished Leadership Award, Kiwanis Club of Laconia, NH
- 2009 NEAHP T. Richardson Miner Scholarship recipient
- Leadership Lakes Region, Laconia, NH, *Class of 2008*
- Maine Leadership Institute, Orono, ME, *Class of 2000*

MEMBERSHIPS and ACTIVITIES:

- Leadership Lakes Region Board of Directors, Current
- Kiwanis International, Kiwanis Club of Laconia, NH, Current
- Association of Healthcare Philanthropy (AHP)
- New England Association of Healthcare Philanthropy Member (NEAHP)
- Association of Fundraising Professionals (AFP) & AFP Northern New England (AFPNNE)
- AFPNNE Mentor 2018 - 2020
- New Hampshire Center for Nonprofits Hoffman-Haas Mentor, 2016
- Santa Fund of the Greater Lakes Region Board of Directors, 2010 – 2013
- The Belknap Mill Society; Board of Directors, 2011 – 2013, Advisory Board, Current

Corey E. Gately
[redacted]

Education

Springfield College School for Human Services, Manchester, NH
Master's of Science in Human Services, concentration in Community Psychology
Graduated May 1995
GPA: 3.9

Keene State College, Keene, NH
Bachelor of Arts in Psychology and Sociology
Associate's in Chemical Dependency
Psychology Honor Society
Graduated May 1993

Experience

August 2018 – Present
LRGHealthcare
Director of Substance Use Services
The Doorway at LRGHealthcare
LRGHealthcare Recovery Clinic

January 2018 – December 2018
Plymouth State University
Teaching Lecturer

May 2015 – present
Lakes Region General Healthcare Recovery Clinic – Laconia, NH
Clinical Program Coordinator
Master's Licensed Alcohol and Drug Counselor
DOT Substance Abuse Professional

September 2012 – May 2015
Horizons Counseling Center, Gilford, NH
Intensive Outpatient Substance Abuse Counselor
Master's Licensed Alcohol and Drug Counselor
DOT Substance Abuse Professional

June 2001 - August 2012
Lakes Region General Healthcare, Laconia, NH
Intensive Outpatient Substance Abuse Counselor
Master's Licensed Alcohol and Drug Counselor
DOT Substance Abuse Professional

Current Activities

Franklin Mayor's Task Force
Gilford Together Committee Member
St. Baldrick's Committee Member
Gilford School District Parent Volunteer

NAADAC Member and NHADACA Member
2011 New Hampshire 40 under 40 Award
2012 NHADACA Counselor of the Year
2016 Leadership Lakes Region Participant

Erika Houten

[redacted]

Authorized to work in the US for any employer

Work Experience

Patient Navigator

The Doorway at LRGH - Laconia, NH
February 2019 to Present

Helping people access and get to all treatment types for substance use disorder. Following up with these people as well as the facilities and programs which they may have applied for. Working with DCYF as well as probation and parole and other area agencies.

Shared Family Living Provider

Lakes Region Community Service Council
August 2008 to Present

Shared Family Living Provider (Adult w/Disabilities in my home)

- Bathing
- Toileting (some incontinence)
- All personal care
- Dressing
- Supporting in community and personal relationships
- Active Part of her Care Team
- Assistance with all ADLs
- Scheduling appointments
- Assisting with communication (she is non verbal/uses minimal sign)

ER Technician

LRGHealthcare - Laconia, NH
September 2016 to February 2019

I am a Mental Health worker in the emergency psych department. I help patients with substance misuse disorders and mental health issues.

LNA

Concord Hospital - Concord, NH
November 2015 to May 2017

Per diem LNA on an adult Med-Surge unit. All responsibilities of an LNA working as part of a team to provide the best patient care possible.

Adult & Senior Psychiatric Patient Care

Franklin Region Hospital & Lakes Region General Hospital - Franklin, NH
October 2013 to April 2015

Per diem LNA on an Adult DRF, also per diem in Gero Psych, Med Surge and ICU

- Adult & Senior Psychiatric Patient Care
- Bathing
- Toileting
- All personal care
- Supporting Adults and Seniors with Psychiatric and Mental Health Issues
- Deescalating patients that may be aggressive verbally or physically
- Reporting behaviors and complaints to the RN
- Monitoring agitation levels, sleep, and safety for all patients
- CPI certified

Front Desk Receptionist

Riverbend Community Mental Health - Concord, NH
July 2007 to June 2008

Answering Phones

- Scheduling Appointment thru Computerized system
- Assisting clients with mental health emergencies, by calming them and contacting appropriate team members
- Filing
- Billing
- Active Part of the Administrative Team to support the Mental Health Office

Customer Service Associate

Cigna Healthcare - Hooksett, NH
November 2005 to July 2007

High Volume call center for Cigna Healthcare.

- Premium Billing.
- Handle over 100+ inbound calls per shift.
- Take incoming calls from both providers and members answering questions about benefits and claims.
- Resolving eligibility claims and benefits issues using industry software and tools.
- Document all activities to ensure accurate reporting of plan issues.
- Provide timely resolution of claim issues within company standards.
- Troubleshooting claims to find out why they were processed incorrect.
- Verify whether or not the providers are in network.
- Data entry.
- Processing returned claims.

Administrative Assistant

M&D Paving Enterprises - Belmont, NH
April 2001 to November 2005

Seasonal, Light Quick Books exp.

- Payroll, filing, banking (deposits)
- Answering heavy call volume relating to sales and customer concerns
- Setting appointments
- Direct interaction with the president on a daily basis and other work related errands.

Education

In progress of obtaining my BA in Psychology
SNHU - Manchester, NH
2012 to 2016

Certifications and Licenses

CPR

Additional Information

TECHNICAL SKILLS:

- Windows NT 4.0/2000/XP • MS Outlook • PC's
- Microsoft Office, • Color Laser Printers • Quick books • Fax machine
- Xerox & Cannon Copiers

MARK DORMAN

mdorman@lrgh.org

I have strived to perform at my optimum potential. Throughout my work experience, I have always been reliable and have always been the person that people have looked up to. I have been trusted with various duties and obligations that I have taken on with enthusiasm and a willingness that many people have admired. I take pride in the job that I do and find reward in helping people that need help.

EXPERIENCE

JULY 2019 – PRESENT

Administrative Assistant, THE DOORWAY AT LRGHEALTHCARE

- **ANSWERED PHONES AND RELAYED CORRESPONDENCE WHEN NECESSARY**
- **RECEIVED AND SUBMITTED BILLING FOR ALL DOORWAY EXSPENSES.**
- **MAINTAINED A CALL LOG FOR THE DEPARTMENT**
- **MAINTAINED AND COMPLETED VARIOUS STATE REPORTS ON A MONTHLY BASIS.**
  - **MONTHY DOORWAY NUMBERS REPORT**
  - **FLEXIBLE SPENDING REPORT**
  - **NALOXONE BALANCE REPORT**
- **DATA ENTRY FOR ALL CLIENTS**
- **REGISTRATION OF CLIENTS/ENCOUNTER INTO THE HOSPITAL PLATFORMS**
- **INPUTTING CHARGES FOR CLIENTS PER ENCOUNTER**
- **ASSIST IN MAINTAINING GREAT WORKING RELATIONSHIPS WITH COMMUNITY PARTNERS**
- **DISTRABUTION OF NALOXONE TO VARIOUS COMMUNITY PARTNERS**

DECEMBER 2016-PRESENT

REALTOR, KELLER WILLIAMS METROPOLITAN

- Prepared market analysis statistics, bid presentation for buyers & sellers, researched listings, set up title searches and home inspections
- Promoted sales through advertising; worked with multiple websites to promote seller's home, hosted open house events, and participated in the multiple listing services
- Established positive flow of communication with agents, clients, and all personnel involved in closing transactions
- Negotiated contracts with agents representing buyers and sellers
- Educated sellers and buyers concerning legal disclosures
- Facilitated the closing process on behalf of the clients and insured that all parts of the contracts were met prior to closing

NOVEMBER 2005 – JULY 2019

MASTER SECURITY OFFICER, LAKES REGION GENERAL HOSPITAL

- I help maintain a safe environment for patients, visitors, and employees.
- I have to be ready for any disturbances that may put patients, visitors, and employees in

danger.
- I conduct various rounds to insure the security of the hospital and the outside practices of the hospital.
- I have dealt and continue to deal with mental health patients on a daily basis.
- I have restrained patients, via 4-point, that have become out of control and are either suicidal, a flight risk, or another form of risk that may be harmful to themselves or others.
- I am in charge of key disbursement through requisitions forms that come into the security department.
- I have conducted restraint training to various departments throughout the organization.
- I have conducted the monthly duress alarm testing in the facility.
- I have conducted fire extinguisher checks on a monthly basis.
- With the role of Master Security Officer, I am the Officer in charge when there is not a Security Sergeant on duty.

MAY 2001 – OCTOBER 2005
HEAD COUNSILOR, RECREATION LEADER, THE BALSAMS GRAND RESORT

- In the summer time, I was the head Counselor for the children's camp.
- I led, organized, and controlled activities for the children.
- I was also a Lifeguard for our outdoor pool.
- My responsibilities were to maintain a safe environment for the guests in and around the pool.
- In the winter season, I was the Recreation Leader.
- My responsibilities were to lead and help organize the winter activities for the guests.

EDUCATION

SEPTEMBER 2000 – JANUARY 2002
STUDIED SPORTS MANAGEMENT, NICHOLS COLLEGE

SEPTEMBER 2002 – MAY 2004
ASSOCIATES IN BUISNESS ADMINISTRATION WITH A SPECIALIZATION IN SPORTS MANAGEMENT, NEW HAMPSHIRE TECHNICAL INSTITUTE

SKILLS

- People-person
- Microsoft Excel, Word, and PowerPoint
- Sales
- Organizational
- Communication and Listening
- Customer Service

ACTIVITIES

There are many things in life that I find truly happy. One of them being spending as much time as I can with my family. Another passion I have is softball and basketball. I enjoy playing in the local leagues and really developing team building.

CERTIFICATIONS/LICENSES

- Real Estate Salesperson
- IAHSS – Supervisory
- CPR/AED

CURRICULUM VITAE

PAUL F. RACICOT, MD
August 2016

HOME: [redacted]

OFFICE: Lakes Region General Hospital
Emergency Department
80 Highland Street
Laconia, NH 03246
Tel. (603) 527-2819

EDUCATION

6/77	**BA**, Bowdoin College, Brunswick, ME Phi Beta Kappa
6/82	**MD**, University of Massachusetts Medical School, Worcester, MA

POST GRADUATE TRAINING

1982 - 1983	**Internship - Internal Medicine**
1983 - 1985	**Residency - Internal Medicine** Berkshire Medical Center, Pittsfield, Massachusetts (a major teaching hospital of UMass Medical School)
1985	* Recipient of "Outstanding Resident Teacher Award"

PRACTICE EXPERIENCE

1985 - 1986	**Emergency Room Physician** (Full Time) • Hillcrest Hospital, Pittsfield, MA
1986 - 2006	**Director, Emergency Room Services** **Active Staff** with privileges in **Emergency Medicine** **Courtesy Staff** with privileges in **Internal Medicine** • Franklin Regional Hospital, Franklin, NH
1986 - 1992	**Visiting Staff** with privileges in **Emergency Medicine** • Lakes Region General Hospital, Laconia, NH
1989 - 1995	**Courtesy Staff** with privileges in **Emergency Medicine** • Concord Hospital, Concord, NH • Huggins Hospital, Wolfeboro, NH
1989 - Present	**Director, Employee/Occupational Health Department** • Franklin Regional Hospital, Franklin, NH
1992 - 2006	**Chief, Emergency Services** **Active Staff** with privileges in **Emergency Medicine** • Lakes Region General Hospital, Laconia, NH
1997 - 2014	**President, Central NH ER Associates** 174 Philbrook Road, Sanbornton, NH
2000, 2001, 2002	**NH Top ER Doc 2000, 2001, and 2002** *New Hampshire* magazine
2000 – Present	**Medical Director, Nathan Brody Outpatient Chemical Dependency Program** 73 Daniel Webster hwy, Belmont, NH 03220
2002 - Present	**Chairman, Department of Medicine** • LRGHealthcare, Laconia, NH
2006 – Present	**Assistant Director ER Services** • Lakes Region General Hospital • Franklin Regional Hospital

PRACTICE EXPERIENCE

2009 – Present	**Clinical Coordinator, 3rd Year Medical Students** • LRGHealthcare, Laconia, NH
2010-Present	Regional Clinical Dean UNE Medical School, • Biddeford, ME
2015—Present	**President of the Medical Staff of LRGHealthcare** • Lakes Region General Hospital • Franklin Regional Hospital

CERTIFICATIONS

09/11/85	**American Board of Internal Medicine**
12/08/89	**American Board of Emergency Medicine**
12/98 – Present	**Certified Medical Review Officer**

TRUSTEE

1988 - 1994	**New Hampshire Hospital Association** 125 Airport Road, Concord, NH
1991 - 2002	**Franklin Regional Hospital** 15 Aiken Avenue, Franklin, NH
2009 - Present	**LRGHealthcare** **Lakes Region General Hospital** 80 Highland Street, Laconia, NH

MEMBERSHIP

1986 - Present	**Member, New Hampshire Medical Society**
1995 - 1997	**Member, New Hampshire Board of Medicine**
1997 - Present	**Member, American College of ER Physicians**
2013 – Present	**Treasurer, New Hampshire Medical Society**

PERSONAL DATA

Born in Oxford, MA - 1955
Married with two children

REFERENCES

Personal and professional references provided on request

LORI L. SEOG, LADC

[redacted]

EMPLOYMENT

September 2019 to Present

LRGHEALTHCARE LLC/FRANKLIN REGIONAL HOSPITAL
14 Aiken Street, Franklin, NH
Recovery Clinic Counselor

- Provide clinical screening, assessment and counseling to adult men and women related to substance use disorders
- Conduct clinical evaluations for clients accessing emergency substance use disorder services
- In collaboration with clients, create meaningful treatment plans to support desired personal recovery outcomes
- Facilitate group counseling sessions to include psycho-education
- Identify resources and provide case management to clients needing supports such as housing, insurance, food, etc.
- Manage data, files, and required client documentation
- Prepare comprehensive clinical evaluations regarding client history of misuse and identification of appropriate recommendations
- Work with community providers to identify crisis interventions as required

April 2017 to Present

CHANGING POINT COUNSELING, LLC
20 Canal Street, Suite 315, Franklin, NH
Licensed Alcohol and Drug Counselor

- Provide clinical screening, assessment and counseling to adolescent/adult men and women related to substance use disorders
- Work in collaboration with clients to create meaningful treatment plans
- Identify resources and provide case management to clients needing supports such as housing, insurance, food, etc.
- Manage data, files, and required client documentation
- Prepare comprehensive clinical evaluations regarding client history of misuse and identification of appropriate recommendations
- Authorized by State of New Hampshire as an Impaired Driver Services Provider
- Instruct psycho-educational classes related to trauma, substance misuse, and life skills
- Work with community providers to identify crisis interventions as required
- Full-time position through September 2019 and presently working part-time in this role

December 2010 - February 2017

MERRIMACK COUNTY DEPARTMENT OF CORRECTIONS
314 Daniel Webster Highway, Boscawen, NH
Chief/Administrator of Programs and Services

- Provided oversight of inmate management to include community corrections, mental health services, substance use disorder services, and rehabilitative services
- Created, modified and recommended programs, policies, and procedures to support agency operations
- Facilitated individual and group substance use disorder counseling sessions
- Instructed psycho-educational classes related to trauma, substance misuse, and life skills
- Participated as member of the Department's executive staff
- Conducted inspections of correctional facility to assess operations
- Developed and monitored budget and grants for Programs and Services Section
- Ensured regulatory compliance with local, state, and federal laws
- Handled inmate grievances and personnel investigations as directed by the Superintendent
- Interpreted and enforced policies, rules, and regulations of the agency
- Provided comprehensive case management to male and female offenders as needed
- Collaborated with community partners to identify resources to support inmates' transition from jail to community
- Provided crisis intervention to inmates with co-occurring disorders

December 2007 - January 2011
STATE OF NEW HAMPSHIRE, DEPARTMENT OF CORRECTIONS
105 Pleasant Street, Concord, NH
Administrator III, Director of Programs, Bureau of Programs

- Interpreted the needs of and provided oversight of service delivery for all male and female offenders in the content areas of education, career and technical education, family support, substance use disorder services, recreation, library, chaplaincy, volunteer services, and case management within each of the Department's state prisons
- Worked directly with the Assistant Commissioner and Commissioner of the Department to strategize and achieve agency goals and objectives
- Developed, implemented and reviewed policies and procedures for long-term administration of departmental programs
- Ensured regulatory and legal compliance was achieved and maintained in areas of oversight
- Monitored operational activities throughout the Bureau for efficient and effective allocation of agency resources by evaluating programs and implementing changes as necessary
- Managed staffing plans for up to 85 employees as well as personnel policies to accomplish organizational objectives
- Represented the Department at legislative hearings and public speaking engagements
- Responsible for budget development and accountability as related to the Bureau of Programs

July 2007 - December 2007
STATE OF NEW HAMPSHIRE, DEPARTMENT OF CORRECTIONS
105 Pleasant Street, Concord, NH
Administrator III, Administrator of Women Offenders and Family Services

- Developed and coordinated programs within the NH Department of Corrections State Prison for Women to ensure gender responsive and evidence based measures were utilized to meet the specific needs of women
- Developed, implemented and reviewed policies, procedures and programs related to women
- Monitored operational activities for efficient and effective allocation of agency resources by evaluating programs and authored changes as necessary
- Planned, developed and provided training for successful program implementation
- Evaluated quality assurance for all Department of Corrections' treatment programs and any contracted programs to maintain program consistency
- Conferred with and made recommendations to the Commissioner, Assistant Commissioner or designee, regarding program services and management strategies for any changes to meet agency objectives
- Provided input regarding necessary data collection and evaluation to measure effective programming and supervision
- Acted as Interim Director of Programs, Bureau of Programs for the NH Department of Corrections

November 2004 - July 2007
STATE OF NEW HAMPSHIRE, DEPARTMENT OF CORRECTIONS
1 Right Way Path, Laconia, NH
Case Counselor/Case Manager

- Observed inmates and collaborated with colleagues to develop programs for assessing resident treatment and rehabilitation services
- Established treatment goals and developed individualized treatment programs for incarcerated offenders in preparation for release
- Prepared reports and case summaries for Office of Parole and the Courts
- Provided consultation services to other professionals, employers, probation and parole officers, police and others regarding program objectives of incarcerated participants
- Developed and taught life skills educational opportunities; facilitated peer support groups

March 2003 - December 2004
LAKES REGION COMMUNITY SERVICES COUNCIL
635 Main Street, Laconia, NH
Family Support Manager

- Interpreted the needs of the community to develop and evaluate relevant programming for children, adolescents, adults, and families
- Directed operation of Family Resource Center programs and services to at-risk families and in-home supports

- Engaged in public speaking, workshop leadership, and education
- Responsible for developing, implementing grants and monitoring program budgets
- Supervised and implemented State of New Hampshire's Comprehensive Family Support Grant
- Supervised staff and volunteers
- Researched, developed, managed and implemented grants

February 2001 - June 2002

CHIROPRACTIC ASSOCIATES OF BEDFORD
39 So. River Road, Bedford, NH
Marketing and Promotions Outreach Specialist

- Developed and implemented all aspects of marketing strategy for three doctor practice and supporting services
- Created and implemented special events and educational offerings both on and off-site
- Maintained and provided oversight of computer systems
- Responsible for management and purchasing of business supplies
- In absence of Business Administrator, responsible for all levels of business operations to include payroll, accounts receivables, banking, and personnel management

March 1994 - December 2000

PENACOOK COMMUNITY CENTER
76 Community Drive, Penacook, NH
Executive Director

- Chief Executive Officer of a non-profit agency that provided educational, social, and recreational needs within the community for children, adolescents, adults, and senior citizens
- Responsible for fiscal management to include budgeting, fundraising and grant development as well as oversight implementation of organization policies and personnel management to include hiring, firing and staff development
- Interpreted the needs of the community to develop relevant programming for children, teens, adults, and senior citizens
- Supervised juvenile diversion program for adjudicated and pre-adjudicated youth
- Set guidelines for supervision of youth behavior within all programs
- Collaborated with various local, county, school district and social service agencies to develop and implement programs for children, adolescents, adults and senior citizens
- Insure agency met all state, local and county government licensing requirements
- Developed strategic, long-range plans for organization in collaboration with Board of Directors

EDUCATION

Southern New Hampshire University, Manchester, NH
January 2012 – March 2013, Master of Science, Justice Studies/Public Administration

American Jail Association and Correctional Management Institute of Texas at
Sam Houston University, Huntsville, TX
National Jail Leadership Command Academy Class #11
Graduate, November 2012

National Institute of Corrections, Aurora, CO
Executive Excellence Class #14
Graduate, January 2011

State of New Hampshire Police Standards and Training Council, Concord, NH
New Hampshire Department of Corrections Academy Class #79
Graduate, May 2005

Franklin Pierce University, Concord, NH
December 2004, Bachelor of Arts, Human Services/Social Work, *Magna Cum Laude*
May 2000, Associate of Arts Degree, Management
October 1988, Certificate, Business Management

PERSONAL

State of New Hampshire, Licensed Alcohol and Drug Counselor, License #0124 (LADC)
State of New Hampshire authorized Impaired Driver Service Provider
Certified Recovery Coach, Connecticut Community for Addiction Recovery
Notary Public
Justice of the Peace
Leadership Greater Concord Program Graduate, 2015-2016
Member, New Hampshire Association of Alcohol and Drug Counselors
Member, New Hampshire Providers Association
Franklin Animal Shelter Volunteer, Former Board Member/Officer
Employee of the Year 2004, Lakes Region Facility, NH Department of Corrections
Employee of the Quarter, Merrimack County Department of Corrections
Computer Literate to include Microsoft Word, Excel, Publisher, Visio, and PowerPoint
Former Board Member Good Life/Centennial Senior Center; Merrimack Valley Little League; Merrimack Valley Youth Soccer; Appalachian Mountain Teen Project and Very Special Arts New Hampshire

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Paul Racicot MD	Medical Director	$247,000	10%	$24,700.00
Corey Gately	Director Substance Use Services	$108,078.40	70%	$75,654.88
Brian Winslow	Special Projects/ Grants	$61.54/hr	100%	$24,919.48
Lori Seog	Licensed Alcohol and Drug Counselor	$45,393.92	100%	$45,393.92
Mark Dorman	Administrative Assistant	$37,752.00	100%	$37,752.00
Erika Houten	Patient Navigator	$43,160.00	100%	43,160.00

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 3rd Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #3") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and The Cheshire Medical Center, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 580 Court Street, Keene, NH 03431.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 31, 2018 (Item #17A), as amended on September 18, 2019, (Item #20), and on June 24, 2020, (Item #31) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Paragraph 3. Renewal, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement or increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $3,063,740

3. Modify Exhibit A Amendment #1, Scope of Services, by replacing in its entirety with Exhibit A Amendment #3, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.
4. Modify Exhibit B Amendment #1, Methods and Conditions Precedent to Payment, by replacing in its entirety with Exhibit B Amendment #3, Methods and Conditions Precedent to Payment, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein.
5. Modify Exhibit B-1, Budget by reducing the total budget amount by $3,813, which is identified as unspent funding that is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020), as specified, in part, in Exhibit B-4 Amendment #3 NCE.
6. Add Exhibit B-4 Amendment #3 NCE, which is attached hereto and incorporated by reference herein.
7. Add Exhibit B-5 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.
8. Add Exhibit B-6 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.
9. Add Exhibit B-7 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.

10. Add Exhibit B-8 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective retroactive to September 29, 2020, upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/5/2021
Date

DocuSigned by:
Katja Fox
ED9D05B04C83442...
Name: Katja Fox
Title: Director

The Cheshire Medical Center

12/31/2020
Date

DocuSigned by:
Kathy Willbarger
5E51E2D191364FE...
Name: Kathy Willbarger
Title: Senior VP Finance

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

1/15/2021
Date

DocuSigned by:
D5CA0303E33C4AE...
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. All Exhibits B Amendment #3 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Keene Region with access to referrals to SUD treatment and recovery support services and other health and social services.

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

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

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

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

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

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

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

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

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

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

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

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

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

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

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

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

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

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

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

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

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff, capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

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

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

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

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

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

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

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

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

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

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

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

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

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

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

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

3.1.10.5.4.1.1. A Doorway client;

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

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

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

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

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

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

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service

provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

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

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

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

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

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

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

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

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

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

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

3.1.11.8.3. Upon discharge from the initially referred service.

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

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

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare,

and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

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

3.3. The Contractor shall provide services in accordance with:

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

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

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

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

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

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

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

3.7. The Contractor shall provide comprehensive MAT for individuals with OUD. Comprehensive MAT shall include, but not be limited to delivering outpatient or intensive outpatient treatment to individuals with OUD in accordance with ASAM criteria.

3.8. The Contractor shall provide MAT information as a distinct part of reports and invoice documentation on clients receiving MAT and services provided in a format approved by the Department.

4. Subcontracting for the Doorways

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

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

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

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

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

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

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

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

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

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

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

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

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

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

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

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

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

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

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

5.7.4.1. The contract requirements.

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

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

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (7) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

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

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

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

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

7. Health Insurance Portability and Accountability Act and Confidentiality:

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

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

8. Reporting Requirements.

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

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

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

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

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

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

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s) must collect and share data with the Department in a format specified by the Department:

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

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

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

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

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

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

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

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

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

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

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

13. Termination Report/Transition Plan

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

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

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

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

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

14. Credits and Copyright Ownership

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

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

15. Operation of Facilities: Compliance with Laws and Regulations

15.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be

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

16. Equal Employment Opportunity Plan (EEOP)

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

17. Equipment Purchases

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

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

18. Compliance with Federal and State Laws

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

18.2. Time and Manner of Determination.

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

18.3. Documentation

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

18.4. Fair Hearings

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

Methods and Conditions Precedent to Payment

1. This Agreement is funded by:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN TI083326.
   1.2. 2.72% Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery Funds.
2. Governor Commission Funds
   2.1. The Contractor shall utilize funds in Exhibit B-5 Amendment #3 GovComm and Exhibit B-7 Amendment #3 GovComm for the purpose of providing services and supports to clients whose needs to not make them eligIbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit B-1, Budget through Exhibit B-8 Amendment #3 SOR II.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or other payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

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

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

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

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

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

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

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported:

6.1.3.1. Unallowable expenses include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

6.1.3.1.7. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference

grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

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

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

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

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

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

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

11. 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.

12. The Contractor must provide the services in Exhibit A, Amendment #3, Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A, Amendment #3 Scope of Services, including failure to submit required monthly and/or quarterly reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

    15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

        15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

        15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

        15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

    15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

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

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

Exhibit B-4 Amendment #3 NCE

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

Contractor Name: The Cheshire Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-02

Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 134,450	$ 13,445	$ 147,896	$ 10,371	$ -	$ 10,371	$ 124,079	$ 13,445	$ 137,524
2. Employee Benefits	$ 39,663	$ 3,966	$ 43,629	$ -	$ -	$ -	$ 39,663	$ 3,966	$ 43,629
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ 2,000	$ 200	$ 2,200	$ -	$ -	$ -	$ 2,000	$ 200	$ 2,200
5. Supplies:	$ 6,850	$ 685	$ 7,535	$ -	$ -	$ -	$ 6,850	$ 685	$ 7,535
6. Travel	$ 1,756	$ 176	$ 1,932	$ -	$ -	$ -	$ 1,756	$ 176	$ 1,932
7. Occupancy	$ 13,875	$ 1,388	$ 15,263	$ -	$ -	$ -	$ 13,875	$ 1,388	$ 15,263
8. Current Expenses	$ 2,491	$ 249	$ 2,741	$ -	$ -	$ -	$ 2,491	$ 249	$ 2,741
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 3,000	$ 300	$ 3,300	$ -	$ -	$ -	$ 3,000	$ 300	$ 3,300
11. Staff Education and Training	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medications	$ 3,000	$ 300	$ 3,300	$ -	$ -	$ -	$ 3,000	$ 300	$ 3,300
Flex Funds	$ 6,000	$ 1,500	$ 7,500	$ -	$ -	$ -	$ 6,000	$ 1,500	$ 7,500
Respite Housing	$ 3,541	$ 360	$ 3,901	$ -	$ -	$ -	$ 3,541	$ 360	$ 3,901
TOTAL	$ 217,627	$ 22,669	$ 240,296	$ 10,371	$ -	$ 10,371	$ 207,256	$ 22,669	$ 229,925
Indirect As A Percent of Direct		10.4%							

Contractor Initials DS

Date 12/31/2020

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

Contractor Name: The Cheshire Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-02
Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex Funds	$ 62,374.55	$ 6,237.45	$ 68,612.00	$ -	$ -	$ -	$ 62,374.55	$ 6,237.45	$ 68,612.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 62,374.55	$ 6,237.45	$ 68,612.00	$ -	$ -	$ -	$ 62,374.55	$ 6,237.45	$ 68,612.00
Indirect As A Percent of Direct		10.0%							

DS

Contractor Initials

Date 12/31/2020

Exhibit B-6 Amendment #3 SOR II

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

Contractor Name: The Cheshire Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-02

Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 251,733	$ 25,173	$ 276,906	$ 29,484	$ -	$ 29,484	$ 222,249	$ 25,173	$ 247,422
2. Employee Benefits	$ 74,261	$ 7,426	$ 81,687	$ -	$ -	$ -	$ 74,261	$ 7,426	$ 81,687
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ 4,000	$ 400	$ 4,400	$ -	$ -	$ -	$ 4,000	$ 400	$ 4,400
5. Supplies:	$ 25,671	$ 2,567	$ 28,238	$ -	$ -	$ -	$ 25,671	$ 2,567	$ 28,238
6. Travel	$ 3,510	$ 351	$ 3,861	$ -	$ -	$ -	$ 3,510	$ 351	$ 3,861
7. Occupancy	$ 26,250	$ 2,625	$ 28,875	$ -	$ -	$ -	$ 26,250	$ 2,625	$ 28,875
8. Current Expenses	$ 4,033	$ 403	$ 4,436	$ -	$ -	$ -	$ 4,033	$ 403	$ 4,436
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 5,500	$ 550	$ 6,050	$ -	$ -	$ -	$ 5,500	$ 550	$ 6,050
11. Staff Education and Training	$ 3,000	$ 300	$ 3,300	$ -	$ -	$ -	$ 3,000	$ 300	$ 3,300
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Naloxone	$ 89,500	$ 9,000	$ 98,500	$ -	$ -	$ -	$ 89,500	$ 9,000	$ 98,500
Flex Funds	$ 6,000	$ 600	$ 6,600	$ -	$ -	$ -	$ 6,000	$ 600	$ 6,600
Respite Housing	$ 17,225	$ 1,710	$ 18,935	$ -	$ -	$ -	$ 17,225	$ 1,710	$ 18,935
TOTAL	$ 510,683	$ 51,106	$ 561,789	$ 29,484	$ -	$ 29,484	$ 481,199	$ 51,106	$ 532,304
Indirect As A Percent of Direct		10.0%							

Contractor Initials DS

Date 12/31/2020

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

Contractor Name: The Cheshire Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-02

Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex Funds	$ 20,790.91	$ 2,079.09	$ 22,870.00	$ -	$ -	$ -	$ 20,790.91	$ 2,079.09	$ 22,870.00
Respite Housing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 20,790.91	$ 2,079.09	$ 22,870.00	$ -	$ -	$ -	$ 20,790.91	$ 2,079.09	$ 22,870.00
Indirect As A Percent of Direct		10.0%							

DS
KW
Contractor Initials
Date 12/31/2020

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

Contractor Name: The Cheshire Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BOAS-05-ACCES-02

Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 134,359	$ 13,436	$ 147,795	$ -	$ -	$ -	$ 134,359	$ 13,436	$ 147,795
2. Employee Benefits	$ 39,636	$ 3,964	$ 43,599	$ -	$ -	$ -	$ 39,636	$ 3,964	$ 43,599
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ 3,789	$ 379	$ 4,168	$ -	$ -	$ -	$ 3,789	$ 379	$ 4,168
5. Supplies:	$ 7,300	$ 730	$ 8,030	$ -	$ -	$ -	$ 7,300	$ 730	$ 8,030
6. Travel	$ 1,756	$ 176	$ 1,932	$ -	$ -	$ -	$ 1,756	$ 176	$ 1,932
7. Occupancy	$ 16,375	$ 1,638	$ 18,013	$ -	$ -	$ -	$ 16,375	$ 1,638	$ 18,013
8. Current Expenses	$ 1,741	$ 174	$ 1,916	$ -	$ -	$ -	$ 1,741	$ 174	$ 1,916
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 3,000	$ 300	$ 3,300	$ -	$ -	$ -	$ 3,000	$ 300	$ 3,300
11. Staff Education and Training	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex Funds	$ 18,000	$ 1,800	$ 19,800	$ -	$ -	$ -	$ 18,000	$ 1,800	$ 19,800
Medications	$ 6,000	$ 600	$ 6,600	$ -	$ -	$ -	$ 6,000	$ 600	$ 6,600
Respite Housing	$ 9,000	$ 900	$ 9,900	$ -	$ -	$ -	$ 9,000	$ 900	$ 9,900
TOTAL	$ 241,956	$ 24,196	$ 266,152	$ -	$ -	$ -	$ 241,956	$ 24,196	$ 266,152
Indirect As A Percent of Direct		10.0%							

Contractor Initials DS

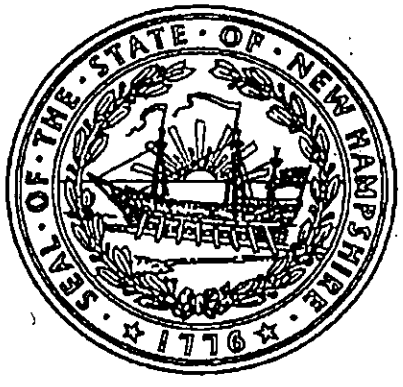
Date 12/31/2020

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 THE CHESHIRE MEDICAL CENTER is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on October 31, 1980. 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 62567
Certificate Number: 0004964839



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 24th day of July A.D. 2020

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Nathalie Houder, hereby certify that
(Name of the elected Officer of the Corporation/LLC, cannot be contract signatory)

1 I am a duly elected Officer of Cheshire Medical Center
(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 October 15, 2018, at which a quorum of the Directors/shareholders were present and voting
(Date)

VOTED: That Don Caruso, MD or Kathryn Willbarger (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Cheshire Medical Center to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

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

3 I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein

Dated 12/17/2020

Nathalie Houder
Signature of Elected Officer
Name Nathalie Houder
Title Chair - Board of Trustees

CERTIFICATE OF INSURANCE

DATE: January 6, 2021

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

INSURED
Cheshire Medical Center
580 Court St
Keene, NH 03431

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

COVERAGES

The Policy listed below has been issued to the Named Insured above for the Policy Period notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued. The insurance afforded by the policy is subject to all the terms, exclusions and conditions of the policy. Limits shown may have been reduced by paid claims.

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002020-A	07/01/2020	07/01/2021	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$100,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY		0002020-A	07/01/2020	07/01/2021	EACH CLAIM	$1,000,000
X	CLAIMS MADE				ANNUAL AGGREGATE	$3,000,000
	OCCURENCE					
OTHER						

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

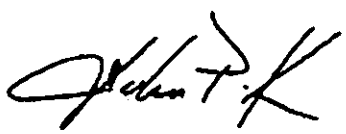
Certificate is provided as evidence of insurance only.

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, the issuing company will endeavor to mail 30 DAYS written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.

AUTHORIZED REPRESENTATIVES



DARTHIT-01 LSTILES

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 1/5/2021

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

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

PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: Lauren Stiles PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: Lauren.Stiles@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐	N / A		AGC4063394	7/1/2020	7/1/2021	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

Evidence of Workers Compensation coverage for

Cheshire Medical Center
Dartmouth-Hitchcock Health
Mary Hitchcock Memorial Hospital
Alice Peck Day Memorial Hospital
New London Hospital Association
Mt. Ascutney Hospital and Health Center

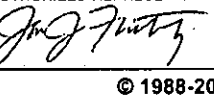
CERTIFICATE HOLDER

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



RESOLUTION

OF THE BOARD OF TRUSTEES

OF

CHESHIRE MEDICAL CENTER

Be it resolved that the Board of Trustees of the Cheshire Medical Center authorizes Don Caruso, MD or Kathryn Willbarger, Vice President, Finance, on behalf of Cheshire Medical Center to enter into a contract with the State of New Hampshire for System of Care for Substance Use Services to address the Opioid Epidemic in New Hampshire and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he may deem necessary, desirable or appropriate.

Dated: October 15, 2018

H. Roger Hansen, Chair
Cheshire Medical Center
Board of Trustees

Cheshire Medical Center
Dartmouth-Hitchcock

OUR MISSION: To lead our community to optimal health and wellness through our clinical and service excellence, collaboration, and compassion for every patient, every time.

OUR VISION: To continually improve the health outcomes of the people we care for through our role in providing high-value health care; remaining a sustainable resource for our region.

Approved by the
Cheshire Medical Center Board of Trustees
June 7, 2017

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2020 and 2019

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2020 and 2019

Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2020 and 2019, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2020 and 2019, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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

Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for leases and the presentation of net periodic pension costs in 2020. Our opinion is not modified with respect to these matters.

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 17, 2020

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Assets		
Current assets		
Cash and cash equivalents	$ 453,223	$ 143,587
Patient accounts receivable (Note 4)	183,819	221,125
Prepaid expenses and other current assets	161,906	95,495
Total current assets	798,948	460,207
Assets limited as to use (Notes 5 and 7)	1,134,526	876,249
Other investments for restricted activities (Notes 5 and 7)	140,580	134,119
Property, plant, and equipment, net (Note 6)	643,586	621,256
Right of use assets, net (Note 16)	57,585	-
Other assets	137,338	124,471
Total assets	$ 2,912,563	$ 2,216,302
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 9,467	$ 10,914
Current portion of right of use obligations (Note 16)	11,775	-
Current portion of liability for pension and other postretirement plan benefits (Note 11 and 14)	3,468	3,468
Accounts payable and accrued expenses	129,016	113,817
Accrued compensation and related benefits	142,991	128,408
Estimated third-party settlements (Note 4 and 17)	302,525	41,570
Total current liabilities	599,242	298,177
Long-term debt, excluding current portion (Note 10)	1,138,530	752,180
Long-term right of use obligations, excluding current portion (Note 16)	46,456	-
Insurance deposits and related liabilities (Note 12)	77,146	58,407
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11 and 14)	324,257	281,009
Other liabilities	143,678	124,136
Total liabilities	2,329,309	1,513,909
Commitments and contingencies (Notes 4, 6, 7, 10, 13, 16 and 17)		
Net assets		
Net assets without donor restrictions (Note 9)	431,026	559,933
Net assets with donor restrictions (Notes 8 and 9)	152,228	142,460
Total net assets	583,254	702,393
Total liabilities and net assets	$ 2,912,563	$ 2,216,302

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Operating revenue and other support		
Patient service revenue (Note 4)	$ 1,880,025	$ 1,999,323
Contracted revenue	74,028	75,017
Other operating revenue (Note 5)	374,622	210,698
Net assets released from restrictions	16,260	14,105
Total operating revenue and other support	2,344,935	2,299,143
Operating expenses		
Salaries	1,144,823	1,062,551
Employee benefits	272,872	262,812
Medications and medical supplies	455,381	407,875
Purchased services and other	360,496	323,435
Medicaid enhancement tax (Note 4)	76,010	70,061
Depreciation and amortization	92,164	88,414
Interest (Note 10)	27,322	25,514
Total operating expenses	2,429,068	2,240,662
Operating (loss) income	(84,133)	58,481
Non-operating gains (losses)		
Investment income, net (Note 5)	27,047	40,052
Other components of net periodic pension and post retirement benefit income (Note 11)	10,810	11,221
Other losses, net (Note 10)	(2,707)	(3,562)
Loss on early extinguishment of debt	-	(87)
Total non-operating gains, net	35,150	47,624
(Deficiency) excess of revenue over expenses	$ (48,983)	$ 106,105

Consolidated Statements of Operations and Changes in Net Assets – Continues on Next Page

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets - Continued
Years Ended June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Net assets without donor restrictions		
(Deficiency) excess of revenue over expenses	$ (48,983)	$ 106,105
Net assets released from restrictions for capital	1,414	1,769
Change in funded status of pension and other postretirement benefits (Note 11)	(79,022)	(72,043)
Other changes in net assets	(2,316)	-
(Decrease) increase in net assets without donor restrictions	(128,907)	35,831
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	26,312	17,436
Investment income, net	1,130	2,682
Net assets released from restrictions	(17,674)	(15,874)
Contribution of assets with donor restrictions from acquisition	-	383
Increase in net assets with donor restrictions	9,768	4,627
Change in net assets	(119,139)	40,458
Net assets		
Beginning of year	702,393	661,935
End of year	$ 583,254	$ 702,393

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Cash flows from operating activities		
Change in net assets	$ (119,139)	$ 40,458
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	93,857	88,770
Amortization of right of use asset	8,218	-
Payments on right of use lease obligations - operating	(7,941)	-
Change in funded status of pension and other postretirement benefits	79,022	72,043
Gain on disposal of fixed assets	(39)	(1,101)
Net realized gains and change in net unrealized gains on investments	(14,060)	(31,397)
Restricted contributions and investment earnings	(3,605)	(2,292)
Proceeds from sales of securities	-	1,167
Changes in assets and liabilities		
Patient accounts receivable	37,306	(1,803)
Prepaid expenses and other current assets	(78,907)	2,149
Other assets, net	(13,385)	(9,052)
Accounts payable and accrued expenses	9,772	17,898
Accrued compensation and related benefits	14,583	2,335
Estimated third-party settlements	260,955	429
Insurance deposits and related liabilities	18,739	2,378
Liability for pension and other postretirement benefits	(35,774)	(33,104)
Other liabilities	19,542	12,267
Net cash provided by operating and non-operating activities	269,144	161,145
Cash flows from investing activities		
Purchase of property, plant, and equipment	(128,019)	(82,279)
Proceeds from sale of property, plant, and equipment	2,987	2,188
Purchases of investments	(321,152)	(361,407)
Proceeds from maturities and sales of investments	82,986	219,996
Cash received through acquisition	-	4,863
Net cash used in investing activities	(363,198)	(216,639)
Cash flows from financing activities		
Proceeds from line of credit	35,000	30,000
Payments on line of credit	(35,000)	(30,000)
Repayment of long-term debt	(10,665)	(29,490)
Proceeds from issuance of debt	415,336	26,338
Repayment of finance lease	(2,429)	-
Payment of debt issuance costs	(2,157)	(228)
Restricted contributions and investment earnings	3,605	2,292
Net cash provided by (used in) financing activities	403,690	(1,088)
Increase (decrease) in cash and cash equivalents	309,636	(56,582)
Cash and cash equivalents		
Beginning of year	143,587	200,169
End of year	$ 453,223	$ 143,587
Supplemental cash flow information		
Interest paid	$ 22,562	$ 23,977
Net assets acquired as part of acquisition, net of cash aquired	-	(4,863)
Construction in progress included in accounts payable and accrued expenses	17,177	1,546
Donated securities	-	1,167

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

1. Organization and Community Benefit Commitments

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of the following entities: Dartmouth-Hitchcock Clinic and Subsidiaries (DHC), Mary Hitchcock Memorial Hospital and Subsidiaries (MHMH), (DHC and MHMH together are referred to as D-H), The New London Hospital Association and Subsidiaries (NLH), Windsor Hospital Corporation (d/b/a Mt. Ascutney Hospital and Health Center) and Subsidiaries (MAHHC), Cheshire Medical Center and Subsidiaries (Cheshire), Alice Peck Day Memorial Hospital and Subsidiary (APD), and the Visiting Nurse and Hospice for Vermont and New Hampshire and Subsidiaries (VNH). The "Health System" consists of D-HH, its members and their subsidiaries.

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

D-HH, Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, The New London Hospital Association, Cheshire Medical Center, and Alice Peck Day Memorial Hospital are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Windsor Hospital Corporation and the Visiting Nurse and Hospice for VT and NH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

On September 30, 2019, D-HH and GraniteOne Health ("GOH") entered into an agreement ("The Combination Agreement") to combine their respective healthcare systems. The GOH system is comprised of Catholic Medical Center ("CMC"), an acute care community hospital in Manchester, New Hampshire, Huggins Hospital ("HH") located in Wolfeboro, NH and Monadnock Community Hospital, ("MCH") located in Petersborough, NH. Both HH and MCH are designated as Critical Access Hospitals. The three member hospitals of GOH have a combined licensed bed count of 380 beds. GOH is a non-profit, community based health care system. The overarching rationale for the proposed combination is to improve access to high quality primary and specialty care in the most convenient, cost-effective sites of service for patients and the communities served by D-HH and GOH. Other stated benefits of the combination include reinforcing the rural health network, investing in needed capacity to accommodate unmet and anticipated demand, and drawing on our combined strengths to attract the necessary health care workforce. The parties have submitted regulatory filings with the Federal Trade Commission and the New Hampshire Attorney General's office seeking approval of the proposed transaction.

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

Consistent with this mission, the Health System provides high quality, cost effective, comprehensive, and integrated healthcare to individuals, families, and the communities it serves regardless of a patient's ability to pay. The Health System actively supports community-based healthcare and promotes the coordination of services among healthcare providers and social services organizations. In addition, the Health System also seeks to work collaboratively with other

area healthcare providers to improve the health status of the region. As a component of an integrated academic medical center, the Health System provides significant support for academic and research programs.

Certain member hospitals of the Health System file annual Community Benefits Reports with the State of NH which outline the community and charitable benefits each provides. VT hospitals are not required by law to file a state community benefit report. The categories used in the Community Benefit Reports to summarize these benefits are as follows:

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

- *Health Professions Education* includes uncompensated costs of training medical students, Residents, nurses, and other health care professionals

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

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

- *Financial Contributions* include financial contributions of cash, as well as in-kind contributions such as time, supplies, and expertise to local organizations to address community health needs.

- *Community-Building Activities* include expenses incurred to support the development of programs and partnerships intended to address public health challenges as well as social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement.

- *Community Benefit Operations* includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.

- *Charity Care and Costs of Government Sponsored Health Care* includes losses, at-cost, incurred by providing health care services to persons qualifying for hospital financial assistance programs, and uncompensated costs of providing health care services to patients who are Medicaid Beneficiaries.

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2019 was approximately $143,013,000. The 2020 Community Benefits Reports are expected to be filed in February 2021.

The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2019:

(in thousands of dollars)

Government-sponsored healthcare services	$	291,013
Health professional education		40,621
Charity care		15,281
Subsidized health services		15,165
Community health services		6,895
Research		5,238
Community building activities		3,777
Financial contributions		1,597
Community benefit operations		1,219
Total community benefit value	$	380,806

In fiscal years 2020 and 2019, funds received to offset or subsidize charity care costs provided were $1,224,000 and $487,000, respectively.

2. Summary of Significant Accounting Policies

Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America, and have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 954, *Healthcare Entities*, which addresses the accounting for healthcare entities. The net assets, revenue, expenses, and gains and losses of healthcare entities are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets without donor restrictions are amounts not subject to donor-imposed stipulations and are available for operations. Net assets with donor restrictions are those whose use has been limited by donors to a specific time period or purpose, or whose use has been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

Use of Estimates

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

(Deficiency) Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include the (deficiency) excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on investments of net assets without donor restrictions, which are utilized to provide charity and other operational support. Peripheral activities, including contribution of net assets without donor restrictions from acquisitions, loss on early extinguishment of debt, realized gains/losses on sales of investment securities and changes in unrealized gains/losses on investments are reported as non-operating gains (losses).

Changes in net assets without donor restrictions which are excluded from the (deficiency) excess of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets, and change in funded status of pension and other postretirement benefit plans.

Charity Care

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

The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. The amount of charges for implicit price concessions is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 1 and 4).

Patient Service Revenue
The Health System applies the accounting provisions of ASC 606, *Revenue from Contracts with Customers* (ASC 606). Patient service revenue is reported at the amount of consideration to which the Health System expects to be entitled from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and implicit pricing concessions. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as estimates change or final settlements are determined (Note 4).

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

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes the Department of Health and Human Services ("HHS") Coronavirus Aid, Relief, and Economic Securities Act ("CARES Act" Provider Relief Funds ("Provider Relief Funds") operating agreements, grant revenue, cafeteria sales and other support service revenue.

Cash Equivalents
Cash and cash equivalents include amounts on deposit with financial institutions; short-term investments with maturities of three months or less at the time of purchase and other highly liquid investments, primarily cash management funds. Short-term highly liquid investments held within the endowment and similar investment pools are classified as investments rather than cash equivalents and restricted cash is defined as that which is legally restricted to withdrawal and usage.

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

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the (deficiency) excess of revenues over expenses. All investments, whether

held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a non-distressed basis.

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

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

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

Level 1 — Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.

Level 2 — Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.

Level 3 — Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

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

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

Property, Plant, and Equipment
Property, plant, and equipment, and other real estate are stated at cost at the time of purchase or fair value at the time of donation, less accumulated depreciation. The Health System's policy is to capitalize expenditures for major improvements and to charge expense for maintenance and repair expenditures which do not extend the lives of the related assets. The provision for depreciation has been determined using the straight-line method at rates which are intended to amortize the cost of assets over their estimated useful lives which range from 10 to 40 years for buildings and improvements, 2 to 20 years for equipment, and the shorter of the lease term, or 5 to 12 years, for

leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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

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

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

Intangible Assets and Goodwill
The Health System records within other assets on the consolidated balance sheets goodwill and intangible assets such as trade names and leases-in-place. The Health System considers trade names and goodwill to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $10,007,000 and $10,524,000 as intangible assets associated with its affiliations as of June 30, 2020 and 2019, respectively.

Gifts
Gifts without donor restrictions are recorded net of related expenses as non-operating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair value at the date the gift is received. Gifts are reported with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Recently Issued Accounting Pronouncements

In January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which addresses certain aspects of recognition, measurement, presentation and disclosure of financial instruments. This guidance allows an entity to choose, investment-by-investment, to report an equity investment that neither has a readily determinable fair value, nor qualifies for the practical expedient for fair value estimation using NAV, at its cost minus impairment (if any), plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issue. Impairment of such investments must be assessed qualitatively at each reporting period. Entities must disclose their financial assets and liabilities by measurement category and form of asset either on the face of the balance sheet or in the accompanying notes. The ASU is effective for annual reporting periods beginning after December 15, 2018 or fiscal year 2020 for the Health System. The provision to eliminate the requirement to disclose the fair value of financial instruments measured at cost (such as the fair value of debt) was early adopted during the year ended June 30, 2017. The standard has been adopted during the current fiscal year and no material impact was noted.

In February 2016, the FASB issued *ASU 2016-02 – Leases (Topic 842)*. Under the new guidance, lessees are required to recognize the following for all leases (with the exception of leases with a term of twelve months or less) at the commencement date: (a) a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis; and (b) a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. Leases are classified as either operating or finance. Operating leases result in straight-line expense in the statement of operations (similar to previous operating leases), while finance leases result in more expense being recognized in the earlier years of the lease term (similar to previous capital leases). The Health System adopted the new standard on July 1, 2019 using the modified retrospective approach. The Health System elected the transition method that allows for the application of the standard at the adoption date rather than at the beginning of the earliest comparative period presented in the consolidated financial statements. The Health System also elected available practical expedients (Note 16).

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits* (Topic 715): *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. Under the new standard, the service cost component of the net benefit cost will be included within income from operations as a component of benefits expenses and the other components of net benefit cost as defined by ASC 715 will be reported in non-operating activities within the consolidated statements of operations and changes in net assets. The standard also prohibits reporting of the other components of net benefit cost in the same line as other pension related changes on the statements of operations and changes in net assets. ASU 2017-07 is effective for the fiscal year ended June 30, 2020 and is applied on a retrospective basis.

Reclassifications

As a result of adopting the provisions of ASU 2017-07, the Health System reclassified $11,221,000 from benefits expense to non-operating activities within the consolidated statements of operations and changes in net assets for the fiscal year ended June 30, 2019. The amount included in non-operating activities for the fiscal year ending June 30, 2020 was $10,810,000.

3. Acquisition

Effective July 1, 2018, Alice Peck Day Memorial Hospital became the sole corporate member of APD LifeCare Center Inc. (LifeCare). LifeCare owns and operates Harvest Hill, an assisted living facility, the Woodlands, a residential living community and the Elizabeth S. Hughes Care Unit, which provides hospice care.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, Alice Peck Day Memorial Hospital recorded goodwill related to the acquisition of LifeCare of approximately $5,131,000. Restricted contribution income of $383,000 was recorded within net assets with donor restrictions in the accompanying consolidated statement of changes in net assets. Included in the transaction was LifeCare's cash balance of $4,863,000. No consideration was exchanged for the net assets assumed and acquisition costs were expensed as incurred.

4. Patient Service Revenue and Accounts Receivable

The Health System reports patient service revenue at amounts that reflect the consideration to which it expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payers (including managed care payers and government programs), and others; and they include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Health System bills patients and third-party payers several days after the services were performed or shortly after discharge. Revenue is recognized as performance obligations are satisfied under contracts by providing healthcare services to patients.

The Health System determines performance obligations based on the nature of the services provided. Revenues for performance obligations satisfied over time are recognized based on actual charges incurred in relation to total expected charges as this method provides a reasonable estimate of the transfer of services over the term of performance obligations based on inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services. For inpatient services, performance obligations are measured from admission to the point when there are no further services required for the patient, which is generally the time of discharge. For outpatient services and physician services, performance obligations are recognized at a point in time when the services are provided and no further patient services are deemed necessary.

Generally, the Health System's patient service performance obligations relate to contracts with a duration of less than one year, therefore the Health System has elected to apply the optional exemption provided in ASC 606-10-50-14a and, therefore, we are not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. This generally refers to inpatient services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Established charges represent gross charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately entitled to for services it provides. Therefore, they are not displayed in the Health System's consolidated statements of operations and changes in net assets.

Hospitals are paid amounts negotiated with insurance companies or set by government entities, which are typically less than established or standard charges. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts. Gross charges are what hospitals charge all patients prior to the application of contractual adjustments and implicit price concessions.

Explicit Pricing Concessions
Revenues for the Health System under the traditional fee-for service Medicare and Medicaid programs are based on prospectively determined rates per discharge or visit, reasonable (allowable) cost, or prospective rates per episodic period, depending on the type of provider.

- Inpatient acute care services provided to Medicare program beneficiaries are paid using the prospective payment system ("PPS") to determine rates-per-discharge. These rates vary according to a patient classification system ("DRG"), based on diagnostic, clinical and other factors. In addition, inpatient capital costs (depreciation and interest) are reimbursed by Medicare on the basis of a prospectively determined rate per discharge. Medicare outpatient services are paid on a prospective payment system, based on a pre-determined amount for each outpatient procedure (APC), subject to various mandated modifications. Retrospectively determined cost-based revenues under these programs, such as indirect medical education, direct graduate medical education, disproportionate share hospital, transplant services, and bad debt reimbursement are based on the hospital's cost reports and are estimated using historical trends and current factors. The Health System's payments for inpatient services rendered to New Hampshire ("NH") and Vermont ("VT") Medicaid beneficiaries are based on PPS, while outpatient services are reimbursed on a retrospective cost basis or fee schedules for NH beneficiaries. VT outpatient beneficiaries are paid on a prospective basis per outpatient procedure.

- Inpatient acute, swing, and outpatient services furnished by critical access hospitals ("CAH") are reimbursed by Medicare at 101% of reasonable costs, subject to 2% sequestration, excluding ambulance services and inpatient hospice care.

- Providers of home health services to patients eligible for Medicare home health benefits are paid on a prospective basis, with no retrospective settlement. The prospective payment is based on the scoring attributed to the acuity level of the patient at a rate determined by federal guidelines.

- Hospice services to patients eligible for Medicare hospice benefits are paid on a per diem basis, with no retrospective settlement, provided the aggregate annual Medicare reimbursement is below a predetermined aggregate capitated rate.

- The Health System's cost based services to Medicare and Medicaid are reimbursed during the year based on varying interim payment methodologies. Final settlement is determined after the submission of an annual cost report and subject to audit of this report by Medicare and Medicaid auditors, as well as administrative and judicial review. Because the laws, regulations, and rule interpretations, governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change over time by material amounts.

- Revenues under Managed Care Plans (Plans) consist primarily of payment terms involving mutually agreed upon rates per diagnosis, discounted fee-for service rates, or similar contractual arrangements. These revenues are also subject to review and possible audit.

The Plans are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustments in accordance with contractual terms in place with the Plans following their review and adjudication of each bill.

The Health System is not aware of any claims, disputes, or unsettled matters with any payer that would materially affect its revenues for which it has not adequately provided in the accompanying Health System's consolidated financial statements.

The Health System provides charity care to patients who are unable to pay for healthcare services they receive as determined by financial conditions. Patients who qualify receive partial or full adjustments to charges for services rendered. The Health System's policy is to treat amounts qualified as charity care as explicit price concessions and as such are not reported in net patient service revenue.

Vermont imposes a provider tax on home health agencies in the amount of 4.25% of annual net patient revenue. In fiscal years 2020 and 2019, home health provider taxes paid were $624,000 and $628,000, respectively.

Medicaid Enhancement Tax & Disproportionate Share Hospital

On May 22, 2018, the State of New Hampshire and all New Hampshire hospitals (Hospitals) agreed to resolve disputed issues and enter into a seven-year agreement to stabilize Disproportionate Share Hospital (DSH) payments, with provisions for alternative payments in the event of legislative changes to the DSH program. Under the agreement, the State committed to make DSH payments to the Hospitals in an amount no less than 86% of the Medicaid Enhancement Tax (MET) proceeds collected in each fiscal year, in addition to providing for directed payments or increased rates for Hospitals in an amount equal to 5% of MET proceeds collected from state fiscal year (SFY) 2020 through SFY 2024. The agreement prioritizes DSH payments to critical access hospitals in an amount equal to 75% of allowable uncompensated care (UCC), with the remainder distributed to Hospitals without critical access designation in proportion to their allowable UCC amounts.

During the years ended June 30, 2020 and 2019, the Health System received DSH payments of approximately, $71,133,000 and $69,179,000 respectively. DSH payments are subject to audit and therefore, for the years ended June 30, 2020 and 2019, the Health System recognized as revenue DSH receipts of approximately $67,500,000 and approximately $64,864,000, respectively.

During the years ended June 30, 2020 and 2019, the Health System recorded State of NH MET and State of VT Provider taxes of $76,010,000 and $70,061,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain patient service revenues. The Provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

Implicit Price Concessions

Generally, patients who are covered by third-party payer contracts are responsible for related co-pays, co-insurance and deductibles, which vary depending on the contractual obligations of patients. The Health System also provides services to uninsured patients and offers those patients a discount from standard charges. The Health System estimates the transaction price for patients with co-pays, co-insurance, and deductibles and for those who are uninsured based on historical collection experience and current market conditions. The discount offered to uninsured patients reduces the transaction price at the time of billing. The uninsured and patient responsible

accounts, net of discounts recorded, are further reduced through implicit price concessions based on historical collection trends for similar accounts and other known factors that impact the estimation process. Subsequent changes to the estimate of transaction price are generally recorded as adjustments to net patient services revenue in the period of change.

The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Health System expects to collect based on collection history with similar patients. Although outcomes vary, the Health System's policy is to attempt to collect amounts due from patients, including co-pays, co-insurance and deductibles due from insurance at the time of service while complying with all federal and state statutes and regulations, including but not limited to, the Emergency Medical Treatment and Active Labor Act (EMTALA). Through various systems and processes the Health System estimates Medicare and Medicaid net patient service revenue and cost report settlements and accrues final expected settlements. For filed cost reports, the accrual is recorded based on those filings, subsequent activity, and on historical trends and other relevant evidence. For periods in which a cost report is yet to be filed, accruals are based on estimates of what is expected to be reported, and any trends and relevant evidence. Cost reports generally must be filed within five months of the closing period.

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely amount. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and historical settlement activity, including assessments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews or investigations. As of June 30, 2020 and 2019, the Health System had reserves of $302,525,000 and $41,570,000, respectively, recorded in Estimated third-party settlements. Included in the 2020 Estimated third party settlements is $239,500,000 of Medicare accelerated and advanced payments, received as working capital support during the novel coronavirus ("COVID-19") outbreak at June 30, 2020. In addition, $10,900,000 has been recorded in Other liabilities as of June 30, 2020 and 2019, respectively.

For the years ended June 30, 2020 and 2019, additional increases in revenue of $2,314,000 and $1,800,000, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

Net operating revenues for the hospital operations of the PPS and CAH, and other business segments consist primarily of patient service revenues, principally for patients covered by Medicare, Medicaid, managed care and other health plans as well as patients covered under the Health System's uninsured discount and charity care programs.

The table below shows the Health System's sources of net operating revenues presented at the net transaction price for the years ended June 30, 2020 and 2019.

(in thousands of dollars)	2020 PPS	2020 CAH	2020 Total
Hospital			
Medicare	$ 461,990	$ 64,087	$ 526,077
Medicaid	130,901	10,636	141,537
Commercial	718,576	60,715	779,291
Self Pay	2,962	2,501	5,463
Subtotal	1,314,429	137,939	1,452,368
Professional			
Professional	383,503	22,848	406,351
VNA	-	-	21,306
Other Revenue	-	-	376,185
Provider Relief Fund	-	-	88,725
Total operating revenue and other support	$ 1,697,932	$ 160,787	$ 2,344,935

(in thousands of dollars)	2019 PPS	2019 CAH	2019 Total
Hospital			
Medicare	$ 456,197	$ 72,193	$ 528,390
Medicaid	134,727	12,794	147,521
Commercial	746,647	64,981	811,628
Self Pay	8,811	2,313	11,124
Subtotal	1,346,382	152,281	1,498,663
Professional			
Professional	454,425	23,707	478,132
VNA	-	-	22,528
Other Revenue	-	-	299,820
Total operating revenue and other support	$ 1,800,807	$ 175,988	$ 2,299,143

Accounts Receivable
The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2020 and 2019:

	2020	2019
Medicare	36%	34%
Medicaid	13%	12%
Commercial	39%	41%
Self Pay	12%	13%
Patient accounts receivable	100%	100%

5. Investments

The composition of investments at June 30, 2020 and 2019 is set forth in the following table:

(in thousands of dollars)	2020	2019
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 9,646	$ 21,890
U.S. government securities	103,977	91,492
Domestic corporate debt securities	199,462	196,132
Global debt securities	70,145	83,580
Domestic equities	203,010	167,384
International equities	123,205	128,909
Emerging markets equities	22,879	23,086
Real Estate Investment Trust	313	213
Private equity funds	74,131	64,563
Hedge funds	36,964	32,287
	843,732	809,536
Investments held by captive insurance companies (Note 12)		
U.S. government securities	15,402	23,241
Domestic corporate debt securities	8,651	11,378
Global debt securities	8,166	10,080
Domestic equities	15,150	14,617
International equities	7,227	6,766
	54,596	66,082
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	236,198	631
Total assets limited as to use	1,134,526	876,249
Other investments for restricted activities		
Cash and short-term investments	7,186	6,113
U.S. government securities	28,055	32,479
Domestic corporate debt securities	35,440	29,089
Global debt securities	11,476	11,263
Domestic equities	26,723	20,981
International equities	15,402	15,531
Emerging markets equities	2,766	2,578
Private equity funds	9,483	7,638
Hedge funds	4,013	8,414
Other	36	33
Total other investments for restricted activities	140,580	134,119
Total investments	$ 1,275,106	$ 1,010,368

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

The following tables summarize the investments by the accounting method utilized, as of June 30, 2020 and 2019. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

	2020		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 253,030	$ -	$ 253,030
U.S. government securities	147,434	-	147,434
Domestic corporate debt securities	198,411	45,142	243,553
Global debt securities	44,255	45,532	89,787
Domestic equities	195,014	49,869	244,883
International equities	77,481	68,353	145,834
Emerging markets equities	1,257	24,388	25,645
Real Estate Investment Trust	313	-	313
Private equity funds	-	83,614	83,614
Hedge funds	-	40,977	40,977
Other	36	-	36
	$ 917,231	$ 357,875	$ 1,275,106

	2019		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 28,634	$ -	$ 28,634
U.S. government securities	147,212	-	147,212
Domestic corporate debt securities	164,996	71,603	236,599
Global debt securities	55,520	49,403	104,923
Domestic equities	178,720	24,262	202,982
International equities	76,328	74,878	151,206
Emerging markets equities	1,295	24,369	25,664
Real Estate Investment Trust	213	-	213
Private equity funds	-	72,201	72,201
Hedge funds	-	40,701	40,701
Other	33	-	33
	$ 652,951	$ 357,417	$ 1,010,368

For the years ended June 30, 2020 and 2019 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as other operating revenue of approximately $936,000 and $983,000 and as non-operating gains of approximately $27,047,000 and $40,052,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2020 and 2019, the Health System has committed to contribute approximately $172,819,000 and $164,319,000 to such funds, of which the Health System has contributed approximately $119,142,000 and $109,584,000 and has outstanding commitments of $53,677,000 and $54,735,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Land	$ 40,749	$ 38,232
Land improvements	39,820	42,607
Buildings and improvements	893,081	898,050
Equipment	927,233	888,138
Equipment under capital leases	-	15,809
	1,900,883	1,882,836
Less: Accumulated depreciation and amortization	1,356,521	1,276,746
Total depreciable assets, net	544,362	606,090
Construction in progress	99,224	15,166
	$ 643,586	$ 621,256

As of June 30, 2020, construction in progress primarily consists of two projects. The first project, started in fiscal 2019, consists of the addition of the ambulatory surgical center (ASC) located in Manchester, NH. The estimated cost to complete the project is $42 million. The anticipated completion date is the second quarter of fiscal 2021. The second project, involves the addition of the in-patient tower located in Lebanon, NH. The estimated cost to complete the tower project is $140 million over the next three fiscal years.

The construction in progress as of June 30, 2019, included both the ASC, as well as renovations taking place at the various pharmacy locations to bring their facilities compliant with Regulation USP800. The pharmacy upgrade was completed during the first quarter of fiscal year 2021. Capitalized interest of $2,297,000 and $0 is included in Construction in progress as of June 30, 2020 and 2019, respectively.

Depreciation and amortization expense included in operating and non-operating activities was approximately $92,217,000 and $88,496,000 for 2020 and 2019, respectively.

7. Fair Value Measurements

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

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

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

U.S. Government Securities, Domestic Corporate and Global Debt Securities
Consists of U.S. government securities, domestic corporate and global debt securities, mutual funds and pooled/commingled funds that invest in U.S. government securities, domestic corporate and global debt securities. Securities are valued based on quoted market prices or dealer quotes where available (Level 1 measurement). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings and maturities, rather than on specific bids and offers for a designated security. Investments in mutual funds are measured based on the quoted NAV as of the close of business in the respective active market (Level 1 measurements).

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2020 and 2019:

	2020					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 253,030	$ -	$ -	$ 253,030	Daily	1
U.S. government securities	147,434	-	-	147,434	Daily	1
Domestic corporate debt securities	17,577	180,834	-	198,411	Daily–Monthly	1–15
Global debt securities	22,797	21,458	-	44,255	Daily–Monthly	1–15
Domestic equities	187,354	7,660	-	195,014	Daily–Monthly	1–10
International equities	77,481	-	-	77,481	Daily–Monthly	1–11
Emerging market equities	1,257	-	-	1,257	Daily–Monthly	1–7
Real estate investment trust	313	-	-	313	Daily–Monthly	1–7
Other	2	34	-	36	Not applicable	Not applicable
Total investments	707,245	209,986	-	917,231		
Deferred compensation plan assets						
Cash and short-term investments	5,754	-	-	5,754		
U.S. government securities	51	-	-	51		
Domestic corporate debt securities	7,194	-	-	7,194		
Global debt securities	1,270	-	-	1,270		
Domestic equities	24,043	-	-	24,043		
International equities	3,571	-	-	3,571		
Emerging market equities	27	-	-	27		
Real estate	11	-	-	11		
Multi strategy fund	51,904	-	-	51,904		
Guaranteed contract	-	-	92	92		
Total deferred compensation plan assets	93,825	-	92	93,917	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,202	9,202	Not applicable	Not applicable
Total assets	$ 801,070	$ 209,986	$ 9,294	$ 1,020,350		

	2019					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 28,634	$ -	$ -	$ 28,634	Daily	1
U.S. government securities	147,212	-	-	147,212	Daily	1
Domestic corporate debt securities	34,723	130,273	-	164,996	Daily–Monthly	1–15
Global debt securities	28,412	27,108	-	55,520	Daily–Monthly	1–15
Domestic equities	171,318	7,402	-	178,720	Daily–Monthly	1–10
International equities	76,295	33	-	76,328	Daily–Monthly	1–11
Emerging market equities	1,295	-	-	1,295	Daily–Monthly	1–7
Real estate investment trust	213	-	-	213	Daily–Monthly	1–7
Other	-	33	-	33	Not applicable	Not applicable
Total investments	488,102	164,849	-	652,951		
Deferred compensation plan assets						
Cash and short-term investments	2,952	-	-	2,952		
U.S. government securities	45	-	-	45		
Domestic corporate debt securities	4,932	-	-	4,932		
Global debt securities	1,300	-	-	1,300		
Domestic equities	22,403	-	-	22,403		
International equities	3,576	-	-	3,576		
Emerging market equities	27	-	-	27		
Real estate	11	-	-	11		
Multi strategy fund	48,941	-	-	48,941		
Guaranteed contract	-	-	89	89		
Total deferred compensation plan assets	84,187	-	89	84,276	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,301	9,301	Not applicable	Not applicable
Total assets	$ 572,289	$ 164,849	$ 9,390	$ 746,528		

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

	2020		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,301	$ 89	$ 9,390
Net unrealized (losses) gains	(99)	3	(96)
Balances at end of year	$ 9,202	$ 92	$ 9,294

	2019		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,374	$ 86	$ 9,460
Net unrealized (losses) gains	(73)	3	(70)
Balances at end of year	$ 9,301	$ 89	$ 9,390

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2020 and 2019.

8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Investments held in perpetuity	$ 59,352	$ 56,383
Healthcare services	33,976	20,140
Research	22,116	26,496
Health education	16,849	19,833
Charity care	12,366	12,494
Other	4,488	3,841
Purchase of equipment	3,081	3,273
	$ 152,228	$ 142,460

Income earned on donor restricted net assets held in perpetuity is available for these purposes.

9. Board Designated and Endowment Funds

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

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

Net assets without donor restrictions include funds designated by the Board of Trustees to function as endowments, the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Net assets with donor restrictions that are temporary in nature, either restricted by time or purpose, include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the restrictions on these funds have been met, the funds are reclassified to net assets without donor restrictions.

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2020 and 2019.

Endowment net asset composition by type of fund consists of the following at June 30, 2020 and 2019:

(in thousands of dollars)	2020 Without Donor Restrictions	2020 With Donor Restrictions	2020 Total
Donor-restricted endowment funds	$ -	$ 80,039	$ 80,039
Board-designated endowment funds	33,714	-	33,714
Total endowed net assets	$ 33,714	$ 80,039	$ 113,753

(in thousands of dollars)	2019 Without Donor Restrictions	2019 With Donor Restrictions	2019 Total
Donor-restricted endowment funds	$ -	$ 78,268	$ 78,268
Board-designated endowment funds	31,421	-	31,421
Total endowed net assets	$ 31,421	$ 78,268	$ 109,689

Changes in endowment net assets for the years ended June 30, 2020 and 2019 are as follows:

(in thousands of dollars)	2020 Without Donor Restrictions	2020 With Donor Restrictions	2020 Total
Balances at beginning of year	$ 31,421	$ 78,268	$ 109,689
Net investment return	713	1,460	2,173
Contributions	890	2,990	3,880
Transfers	14	267	281
Release of appropriated funds	676	(2,946)	(2,270)
Balances at end of year	$ 33,714	$ 80,039	$ 113,753

Balances at end of year	80,039
Beneficial interest in perpetual trusts	6,782
Net assets with donor restrictions	$ 86,821

(in thousands of dollars)	2019 Without Donor Restrictions	2019 With Donor Restrictions	2019 Total
Balances at beginning of year	$ 29,506	$ 78,197	$ 107,703
Net investment return	1,184	2,491	3,675
Contributions	804	1,222	2,026
Transfers	(73)	(1,287)	(1,360)
Release of appropriated funds	-	(2,355)	(2,355)
Balances at end of year	$ 31,421	$ 78,268	$ 109,689

Balances at end of year	78,268
Beneficial interest in perpetual trusts	8,422
Net assets with donor restrictions	$ 86,690

10. Long-Term Debt

A summary of long-term debt at June 30, 2020 and 2019 is as follows:

(in thousands of dollars)	2020	2019
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	$ 83,355	$ 83,355
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2020A, principal maturing in varying annual amounts, through August 2059 (2)	125,000	-
Series 2017A, principal maturing in varying annual amounts, through August 2040 (3)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (3)	109,800	109,800
Series 2019A, principal maturing in varying annual amounts, through August 2043 (4)	99,165	-
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	25,160	25,865
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	24,315	25,145
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	19,765	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (7)	14,530	14,530
Series 2016B, principal maturing in varying annual amounts, through August 2045 (8)	10,970	10,970
Note payable		
Note payable to a financial institution due in monthly interest only payments through May 2023 (9)	125,000	-
Total obligated group debt	$ 1,062,597	$ 722,162

A summary of long-term debt at June 30, 2020 and 2019 is as follows (continued):

(in thousands of dollars)	2020	2019
Other		
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	$ 287	$ 445
Note payable to a financial institution with entire principal due June 2029 that is collateralized by land and building. The note payable is interest free	273	323
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046	2,560	2,629
Obligations under capital leases	-	17,526
Total nonobligated group debt	3,120	20,923
Total obligated group debt	1,062,597	722,162
Total long-term debt	1,065,717	743,085
Add: Original issue premium and discounts, net	89,542	25,542
Less: Current portion	9,467	10,914
Debt issuance costs, net	7,262	5,533
	$ 1,138,530	$ 752,180

Aggregate annual principal payments for the next five years ending June 30 and thereafter are as follows:

(in thousands of dollars)	2020
2021	$ 9,467
2022	9,419
2023	131,626
2024	1,871
2025	1,954
Thereafter	911,380
	$ 1,065,717

Dartmouth-Hitchcock Obligated Group (DHOG) Debt

MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group consist of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and, APD. D-HH is designated as the obligated group agent.

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

(1) Series 2018A and Series 2018B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018A and Series 2018B in February 2018. The Series 2018A Revenue Bonds were primarily used to refund a portion of Series 2015A and Series 2016A. The Series 2018B were primarily used to refund a portion of Series 2015A and Series 2016A, Revolving Line of Credit, Series 2012 Bank Loan and the Series 2015A and Series 2016A Swap terminations. A loss on the extinguishment of debt of approximately $578,000 was recognized in non-operating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2018A Revenue Bonds is variable with a current interest rate of 5.00% and matures in variable amounts through 2037. The interest on the Series 2018B Revenue Bonds is fixed with an interest rate of 4.18% and matures in variable amounts through 2048.

(2) Series 2020A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds Series 2020A in February, 2020. The proceeds from the Series 2020A Revenue Bonds are being used primarily to fund the construction of a 212,000 square foot inpatient pavilion in Lebanon, NH as well as various equipment. The interest on the Series 2020A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2059.

(3) Series 2017A and Series 2017B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

(4) Series 2019A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds Series 2019A in October, 2019. The proceeds from the Series 2019A Revenue Bonds are being used primarily to fund the construction of a 91,000 square foot expansion of facilities in Manchester, NH to include an Ambulatory Surgical Center as well as various equipment. The interest on the Series 2019A Revenue Bonds is fixed with an interest rate of 4.00% and matures in variable amounts through 2043.

(5) Series 2018C Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018C in August, 2018. The Series 2018C Revenue Bonds were used primarily to refinance the Series 2010 Revenue Bonds. The interest on the series 2018C Revenue Bonds is fixed with an interest rate of 3.22% and matures in variable amounts through 2030.

(6) Series 2012 Revenue Bonds

The NHHEFA issued $29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%), and matures in variable amounts through 2039.

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

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

(8) Series 2016B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2016B in July 2016 through a private placement with a financial institution. The Series 2016B Revenue Bonds were used to finance 2016 projects. The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2045.

(9) Note payable to financial institution

The DHOG issued a note payable to TD Bank in May 2020. Issued in response to the COVID-19 pandemic, the proceeds from the note will be used to fund working capital as needs require. The interest on the note payable is fixed with an interest rate of 2.02% and matures in 2023.

Outstanding joint and several indebtedness of the DHOG at June 30, 2020 and 2019 approximates $1,062,597,000 and $722,162,000, respectively.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $236,198,000 and $631,000 at June 30, 2020 and 2019, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 5). In addition, debt service reserves of approximately $9,286,000 and $1,331,000 at June 30, 2020 and 2019, respectively, are classified as other current assets in the accompanying consolidated balance sheets. The debt service reserves are mainly comprised of escrowed construction funds at June 30, 2020 and escrowed funds held for future principal and interest payments at June 30, 2019.

For the years ended June 30, 2020 and 2019 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately $27,322,000 and $25,514,000 and other non-operating losses of $3,784,000 and $3,784,000, respectively.

11. Employee Benefits

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

All of the defined benefit plans within the Health System have been frozen and therefore there are no remaining participants earning benefits in any of the Health System's defined benefit plans.

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

Defined Benefit Plans
Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Service cost for benefits earned during the year	$ 170	$ 150
Interest cost on projected benefit obligation	43,433	47,814
Expected return on plan assets	(62,436)	(65,270)
Net loss amortization	12,032	10,357
Total net periodic pension expense	$ (6,801)	$ (6,949)

The following assumptions were used to determine net periodic pension expense as of June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	3.90 % – 4.60%
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50%

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,135,523	$ 1,087,940
Service cost	170	150
Interest cost	43,433	47,814
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Actuarial loss	139,469	93,358
Settlements	(38,549)	(42,306)
Benefit obligation at end of year	1,209,100	1,135,523
Change in plan assets		
Fair value of plan assets at beginning of year	897,717	884,983
Actual return on plan assets	121,245	85,842
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Employer contributions	19,986	20,631
Settlements	(38,549)	(42,306)
Fair value of plan assets at end of year	929,453	897,717
Funded status of the plans	(279,647)	(237,806)
Less: Current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(279,601)	(237,760)
Liability for pension	$ (279,647)	$ (237,806)

As of June 30, 2020 and 2019, the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in net assets without donor restrictions include approximately $546,818,000 and $478,394,000 of net actuarial loss as of June 30, 2020 and 2019, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2021 for net actuarial losses is $12,752,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,209,282 and $1,135,770,000 at June 30, 2020 and 2019, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	4.20 % – 4.50 %
Rate of increase in compensation	N/A	N/A

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of both June 30, 2020 and 2019, it is expected that the LDI strategy will hedge approximately 60% of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5%	3%
U.S. government securities	0–10	5
Domestic debt securities	20–58	40
Global debt securities	6–26	7
Domestic equities	5–35	18
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	1
Private equity funds	0–5	0
Hedge funds	5–18	10

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

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

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

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Notes to Financial Statements
June 30, 2020 and 2019

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2020 and 2019:

	2020					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ -	$ 7,154	$ -	$ 7,154	Daily	1
U.S. government securities	49,843		-	49,843	Daily–Monthly	1–15
Domestic debt securities	133,794	318,259	-	452,053	Daily–Monthly	1–15
Global debt securities	-	69,076	-	69,076	Daily–Monthly	1–15
Domestic equities	152,688	24,947	-	177,635	Daily–Monthly	1–10
International equities	13,555	70,337	-	83,892	Daily–Monthly	1–11
Emerging market equities	-	39,984	-	39,984	Daily–Monthly	1–17
REIT funds	-	2,448	-	2,448	Daily–Monthly	1–17
Private equity funds	-	-	17	17	See Note 7	See Note 7
Hedge funds	-	-	47,351	47,351	Quarterly–Annual	60–96
Total investments	$ 349,880	$ 532,205	$ 47,368	$ 929,453		

	2019					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 166	$ 18,232	$ -	$ 18,398	Daily	1
U.S. government securities	48,580	-	-	48,580	Daily–Monthly	1–15
Domestic debt securities	122,178	273,424	-	395,602	Daily–Monthly	1–15
Global debt securities	428	75,146	-	75,574	Daily–Monthly	1–15
Domestic equities	159,259	18,316	-	177,575	Daily–Monthly	1–10
International equities	17,232	77,146	-	94,378	Daily–Monthly	1–11
Emerging market equities	321	39,902	-	40,223	Daily–Monthly	1–17
REIT funds	357	2,883	-	3,240	Daily–Monthly	1–17
Private equity funds	-	-	21	21	See Note 7	See Note 7
Hedge funds	-	-	44,126	44,126	Quarterly–Annual	60–96
Total investments	$ 348,521	$ 505,049	$ 44,147	$ 897,717		

The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2020 and 2019:

	2020		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 44,126	$ 21	$ 44,147
Net unrealized gains (losses)	3,225	(4)	3,221
Balances at end of year	$ 47,351	$ 17	$ 47,368

(in thousands of dollars)	2019 Hedge Funds	2019 Private Equity Funds	2019 Total
Balances at beginning of year	$ 44,250	$ 23	$ 44,273
Net unrealized losses	(124)	(2)	(126)
Balances at end of year	$ 44,126	$ 21	$ 44,147

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2020 and 2019 were approximately $18,261,000 and $14,617,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2020 and 2019.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2020 and 2019.

The weighted average asset allocation for the Health System's Plans at June 30, 2020 and 2019 by asset category is as follows:

	2020	2019
Cash and short-term investments	1 %	2 %
U.S. government securities	5	5
Domestic debt securities	49	44
Global debt securities	8	9
Domestic equities	19	20
International equities	9	11
Emerging market equities	4	4
Hedge funds	5	5
	100 %	100 %

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

The Health System is expected to contribute approximately $25,755,000 to the Plans in 2021 however actual contributions may vary from expected amounts.

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

(in thousands of dollars)

2021	$ 51,007
2022	53,365
2023	55,466
2024	57,470
2025	59,436
2026 – 2028	321,419

Effective May 1, 2020, the Health System terminated a defined benefit plan and settled the accumulated benefit obligation of $18,795,000 by purchasing nonparticipating annuity contracts. The plan assets at fair value were $11,836,000.

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $51,222,000 and $40,537,000 in 2020 and 2019, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by member and plan. No employer contributions were made to any of these plans in 2020 and 2019 respectively.

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

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Service cost	$ 609	$ 384
Interest cost	1,666	1,842
Net prior service income	(5,974)	(5,974)
Net loss amortization	469	10
	$ (3,230)	$ (3,738)

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ 46,671	$ 42,581
Service cost	609	384
Interest cost	1,666	1,842
Benefits paid	(3,422)	(3,149)
Actuarial loss	2,554	5,013
Benefit obligation at end of year	48,078	46,671
Funded status of the plans	$ (48,078)	$ (46,671)
Current portion of liability for postretirement medical and life benefits	$ (3,422)	$ (3,422)
Long term portion of liability for postretirement medical and life benefits	(44,656)	(43,249)
Liability for postretirement medical and life benefits	$ (48,078)	$ (46,671)

As of June 30, 2020 and 2019, the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic postretirement medical and life benefit income and included in the change in net assets without donor restrictions are as follows:

(in thousands of dollars)	2020	2019
Net prior service income	$ (3,582)	$ (9,556)
Net actuarial loss	10,335	8,386
	$ 6,753	$ (1,170)

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2021 for net prior service cost is $5,974,000.

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2021 and thereafter:

(in thousands of dollars)

2021	$	3,422
2022		3,436
2023		3,622
2024		3,642
2025		3,522
2026-2028		16,268

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 2.90% in 2020 and an assumed healthcare cost trend rate of 6.50%, trending down to 5.00% in 2024 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2020 and 2019 by $1,772,000 and $1,601,000 and the net periodic postretirement medical benefit cost for the years then ended by $122,000 and $77,000, respectively. Decreasing the assumed healthcare cost trend rates by one percentage point in each year would decrease the accumulated postretirement medical benefit obligation as of June 30, 2020 and 2019 by $1,603,000 and $1,452,000 and the net periodic postretirement medical benefit cost for the years then ended by $108,000 and $71,000, respectively.

12. Professional and General Liability Insurance Coverage

Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic, along with Dartmouth College, Cheshire Medical Center, The New London Hospital Association, Mt. Ascutney Hospital and Health Center, and the Visiting Nurse and Hospice for VT and NH are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2018 Alice Peck Day Memorial Hospital is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Clinic, and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2020 and 2019, are summarized as follows:

	2020		
(in thousands of dollars)	HAC	RRG	Total
Assets	$ 93,686	$ 1,785	$ 95,471
Shareholders' equity	13,620	50	13,670

	2019		
(in thousands of dollars)	HAC	RRG	Total
Assets	$ 75,867	$ 2,201	$ 78,068
Shareholders' equity	13,620	50	13,670

13. Commitments and Contingencies

Litigation

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

Lines of Credit

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $10,000,000 up to $30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 31, 2021. There was no outstanding balance under the lines of credit as of June 30, 2020 and 2019. Interest expense was approximately $20,000 and $95,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses are presented by functional classification in accordance with the overall service missions of the Health System. Each functional classification displays all expenses related to the underlying operations by natural classification. Salaries, employee benefits, medical supplies and medications, and purchased services and other expenses are generally considered variable and are allocated to the mission that best aligns to the type of service provided. Medicaid enhancement tax is allocated to program services. Interest expense is allocated based on usage of debt-financed space. Depreciation and amortization is allocated based on square footage and specific identification of equipment used by department.

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2020:

	2020			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 981,320	$ 161,704	$ 1,799	$ 1,144,823
Employee benefits	231,361	41,116	395	272,872
Medical supplies and medications	454,143	1,238	-	455,381
Purchased services and other	236,103	120,563	3,830	360,496
Medicaid enhancement tax	76,010	-	-	76,010
Depreciation and amortization	26,110	65,949	105	92,164
Interest	5,918	21,392	12	27,322
Total operating expenses	$ 2,010,965	$ 411,962	$ 6,141	$ 2,429,068

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,239	$ 1,549	$ 22	$ 10,810
Total non-operating income	$ 9,239	$ 1,549	$ 22	$ 10,810

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2019:

	2019			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 922,902	$ 138,123	$ 1,526	$ 1,062,551
Employee benefits	188,634	73,845	333	262,812
Medical supplies and medications	406,782	1,093	-	407,875
Purchased services and other	212,209	108,783	2,443	323,435
Medicaid enhancement tax	70,061	-	-	70,061
Depreciation and amortization	37,528	50,785	101	88,414
Interest	3,360	22,135	19	25,514
Total operating expenses	$ 1,841,476	$ 394,764	$ 4,422	$ 2,240,662

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,651	$ 1,556	$ 14	$ 11,221
Total non-operating income	$ 9,651	$ 1,556	$ 14	$ 11,221

15. Liquidity

The Health System is substantially supported by cash generated from operations. In addition, the Health System holds financial assets for specific purposes which are limited as to use. Thus, certain financial assets reported on the accompanying consolidated balance sheet may not be available for general expenditure within one year of the balance sheet date.

The Health System's financial assets available at June 30, 2020 and 2019 to meet cash needs for general expenditures within one year of June 30, 2020 and 2019, are as follows:

(in thousands of dollars)	2020	2019
Cash and cash equivalents	$ 453,223	$ 143,587
Patient accounts receivable	183,819	221,125
Assets limited as to use	1,134,526	876,249
Other investments for restricted activities	140,580	134,119
Total financial assets	$ 1,912,148	$ 1,375,080
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	54,596	66,082
Investments for restricted activities	140,580	134,119
Bond proceeds held for capital projects	245,484	-
Other investments with liquidity horizons greater than one year	111,408	97,063
Total financial assets available within one year	$ 1,360,080	$ 1,077,816

For the years ended June 30, 2020 and June 30, 2019, the Health System generated positive cash flow from operations of approximately $269,144,000 and $161,145,000, respectively. In addition, the Health System's liquidity management plan includes investing excess daily cash in intermediate or long term investments based on anticipated liquidity needs. The Health System has an available line of credit of up to $30,000,000 which it can draw upon as needed to meet its liquidity needs. See Note 13 for further details on the line of credit.

16. Lease Commitments

In February 2016, the FASB issued ASU 2016-02 (Topic 842) "Leases." Topic 842 supersedes the lease requirements in Accounting Standards Codification Topic 840, "Leases." Under Topic 842, lessees are required to recognize assets and liabilities on the balance sheet for most leases and provide enhanced disclosures. Leases will be classified as either finance or operating. D-HH adopted Topic 842 effective July 1, 2019.

D-HH applied Topic 842 to all leases as of July 1, 2019 with comparative periods continuing to be reported under Topic 840. We have elected the practical expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial direct costs for existing leases. We have also elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

D-HH determines if an arrangement is or contains a lease at inception of the contract. Right-of-use assets represent our right to use the underlying assets for the lease term and our lease liabilities represent our obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. We use the implicit rate noted within the contract. If not readily available, we use our estimated incremental borrowing rate, which is derived using a collateralized borrowing rate for the same currency and term as the associated lease. A right-of-use asset and lease liability is not recognized for leases with an initial term of 12 months or less and we recognize lease expense for these leases on a straight-line basis over the lease term within lease and rental expense.

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of 5 to 10 years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from 2 to 5 years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

On adoption, the Health System recognized lease liabilities and right-of-use assets of $60,269,884, respectively.

The components of lease expense for the year ended June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Operating lease cost	8,992
Variable and short term lease cost (a)	1,497
Total lease and rental expense	10,489
Finance lease cost:	
Depreciation of property under finance lease	2,454
Interest on debt of property under finance lease	524
Total finance lease cost	2,978

(a) Includes equipment, month-to-month and leases with a maturity of less than 12 months.

Supplemental cash flow information related to leases for the year ended June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	8,755
Operating cash flows from finance leases	542
Financing cash flows from finance leases	2,429
	$ 11,726

Supplemental balance sheet information related to leases as of June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Operating Leases	
Right of use assets - operating leases	42,621
Accumulated amortization	(8,425)
Right of use assets - operating leases, net	**34,196**
Current portion of right of use obligations	9,194
Long-term right of use obligations, excluding current portion	25,308
Total operating lease liabilities	**34,502**
Finance Leases	
Right of use assets - finance leases	26,076
Accumulated depreciation	(2,687)
Right of use assets - finance leases, net	**23,389**
Current portion of right of use obligations	2,581
Long-term right of use obligations, excluding current portion	21,148
Total finance lease liabilities	**23,729**
Weighted Average remaining lease term, years	
Operating leases	4.64
Finance leases	19.39
Weighted Average discount rate	
Operating leases	2.24%
Finance leases	2.22%

Included in the $42.6 million of right-of-use assets obtained in exchange for operating lease obligations is $5.6 million of new and modified operating leases entered into during the year ended June 30, 2020. Included in the $26.1 million of right-of-use assets obtained in exchange for finance lease obligations is $2.3 million of new and modified operating leases entered into during the year ended June 30, 2020.

Future maturities of lease liabilities as of June 30, 2020 are as follows:

(in thousands of dollars)	Operating Leases	Finance Leases
Year ending June 30:		
2021	9,852	3,314
2022	8,274	3,003
2023	6,836	2,718
2024	5,650	1,892
2025	3,023	1,109
Thereafter	2,794	17,339
Total lease payments	36,429	29,374
Less: Imputed interest	1,927	5,645
Total lease payments	$ 34,502	$ 23,729

Future minimum rental payments under lease commitments with a term of more than one year as of June 30, 2019, prior to our adoption of ASC 842 are as follows:

(in thousands of dollars)	Capital Leases	Operating Leases
Year ending June 30:		
2020	1,706	11,342
2021	1,467	10,469
2022	1,471	7,488
2023	1,494	6,303
2024	1,230	4,127
Thereafter	10,158	5,752
Total lease payments	$ 17,526	$ 45,481

The Health System's rental expense totaled approximately $12,707,000 for the year ended June 30, 2019.

17. COVID - 19

In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic and the United States federal government declared COVID-19 a national emergency. The Health System quickly developed and implemented an emergency response to the situation to ensure the safety of its patients and staff across the System. A key decision was made to postpone elective and non-urgent care in mid-March. Several factors drove that decision, including efforts to reduce the spread of COVID-19; conservation of personal protective equipment ("PPE"), which was and remains in critically short supply worldwide; and at the urging of the CDC and U.S. Surgeon General who in March urged all hospitals to reduce the number of elective procedures and visits.

On March 27, 2020, the President of the United States signed into law the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") to provide economic assistance to a wide array of industries to ease the financial impact of COVID-19. As part of the CARES Act, the Centers for Medicare and Medicaid Services ("CMS") expanded its Accelerated and Advance Payment Program which allows participants to receive expedited payments during periods of national emergencies.

As of June 30, 2020, the Health System has received approximately $88,877,000 in governmental assistance including funding under the CARES Act. This includes recognition of approximately $88,725,000 of stimulus revenue recorded as a component of other operating revenue in the consolidated statements of operations and changes in net assets as a result of satisfying the conditions of general and targeted grant funding under the Provider Relief Fund established by the CARES Act. The Health System recognized revenue related to the CARES Act provider relief funding based on information contained in laws and regulations, as well as interpretations issued by the HHS, governing the funding that was publicly available as of June 30, 2020. The Health System recorded approximately $239,500,000 attributable to the Medicare Accelerated and Advance Payment Program representing working capital financing to be repaid through the provision of future services. These funds are recorded as a contract liability as a payment received before performing services. This amount is reported as a component of estimated third party settlements in the consolidated balance sheet as of June 30, 2020. Subsequent to June 30, 2020, the Health System received additional stimulus funding attributable to a targeted distribution of approximately $19,700,000 for Safety Net Hospitals and $2,500,000 for a general distribution.

Additionally, the CARES Act provides for payroll tax relief, including employee retention tax credits and the deferral of all employer Social Security tax payments to help employers in the face of economic hardship related to the COVID-19 pandemic. As of June 30, 2020, the Health System deferred approximately $13,727,000 attributable to the employer portion of Social Security taxes and $2,600,000 of employee retention tax credits. D-HH Leadership has also taken advantage of additional Federal and State programs including the Payroll Tax Deferral, Employee Retention Credit, First Responder Support, Front-Line Employees Hazard Pay Grant Program and FEMA funding to help offset some of the incremental costs being incurred to provide comprehensive and safe care during the pandemic.

18. Subsequent Events

The Health System has assessed the impact of subsequent events through November 17, 2020, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

HHS Reporting Requirements for the CARES Act

In September 2020 and October 2020, HHS issued new reporting requirements for the CARES Act provider relief funding. The new requirements first require Hospitals to identify healthcare-related expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source. If those expenses do not exceed the provider relief funding received, Hospitals will need to demonstrate that the remaining provider relief funds were used to compensate for a negative variance in year over year patient service revenue. HHS is entitled to recoup Provider Relief Funding in excess of the sum of expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source and the decline in calendar year over year patient care revenue. Due to these new reporting requirements there is at least a reasonable possibility that amounts recorded under the CARES Act provider relief fund by the Health System may change in future periods.

Medicare and Medicaid Services ("CMS") expanded Accelerated and Advance Payment Program

In October 2020, new regulations were issued to revise the recoupment start date from August 2020 to April 2021.

Note Payable Amendment

In October 2020, the note payable issued to TD Bank in May 2020 was amended. Under the amended terms, the interest on the note payable is fixed at a rate of 2.56%, and matures in 2035. Repayment terms are semi-annual, interest only through July 2024, with annual principal payments to begin August 2024. The obligation can be satisfied at any time beforehand, without penalty.

Consolidating Supplemental Information – Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2020

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	OH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 108,856	$ 217,352	$ 43,940	$ 26,079	$ 22,874	$ 14,377	$ -	$ 433,478	$ 19,745	$ -	$ 453,223
Patient accounts receivable, net	-	146,886	11,413	8,634	10,200	4,367	-	181,500	2,319	-	183,819
Prepaid expenses and other current assets	25,243	179,432	37,538	3,808	6,105	1,715	(82,822)	171,019	(8,870)	(243)	161,906
Total current assets	134,099	543,670	92,891	38,521	39,179	20,459	(82,822)	785,997	13,194	(243)	798,948
Assets limited as to use	344,737	927,207	19,376	13,044	12,768	12,090	(235,568)	1,093,654	40,872	-	1,134,526
Notes receivable, related party	848,250	593	-	1,211	-	-	(848,843)	1,211	(1,211)	-	-
Other investments for restricted activities	-	98,490	6,970	97	3,077	6,266	-	114,900	25,680	-	140,580
Property, plant, and equipment, net	8	466,938	64,803	20,805	43,612	16,823	-	612,989	30,597	-	643,586
Right of use assets	1,542	32,714	1,822	17,574	621	3,221	-	57,494	91	-	57,585
Other assets	2,242	122,481	1,299	14,748	5,482	4,603	(10,971)	139,884	(2,546)	-	137,338
Total assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 747	$ 147	$ 232	$ -	$ 9,371	$ 96	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	1,316	259	631	-	11,716	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	272,764	126,283	39,845	3,087	4,250	3,406	(318,391)	131,244	(1,985)	(243)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,570	3,875	3,582	-	141,151	1,840	-	142,991
Estimated third-party settlements	-	210,144	34,664	25,421	24,667	6,430	-	301,326	1,199	-	302,525
Total current liabilities	273,102	478,419	83,526	34,141	33,198	14,281	(318,391)	598,276	1,209	(243)	599,242
Notes payable, related party	-	814,525	-	-	27,718	6,600	(848,843)	-	-	-	-
Long-term debt, excluding current portion	1,050,694	37,373	23,617	24,312	147	10,595	(10,970)	1,135,768	2,762	-	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,432	16,429	368	2,698	-	46,420	36	-	46,456
Insurance deposits and related liabilities	-	75,697	475	325	388	220	-	77,105	41	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	-	511	-	324,258	(1)	-	324,257
Other liabilities	-	117,631	1,506	384	2,026	-	-	121,547	22,131	-	143,678
Total liabilities	1,324,999	1,849,842	132,396	75,591	63,845	34,905	(1,178,204)	2,303,374	26,178	(243)	2,329,309
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	5,524	242,824	47,729	29,464	36,158	21,247	-	382,946	48,040	40	431,026
Net assets with donor restrictions	355	99,427	7,036	945	4,736	7,310	-	119,809	32,459	(40)	152,228
Total net assets	5,879	342,251	54,765	30,409	40,894	28,557	-	502,755	80,499	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2020

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 108,856	$ 218,295	$ 47,642	$ 22,874	$ 14,568	$ 34,072	$ 6,916	$ -	$ 453,223
Patient accounts receivable, net	-	146,887	11,413	10,200	4,439	8,634	2,246	-	183,819
Prepaid expenses and other current assets	25,243	180,137	27,607	6,105	1,737	2,986	1,156	(83,065)	161,906
Total current assets	134,099	545,319	86,662	39,179	20,744	45,692	10,318	(83,065)	798,948
Assets limited as to use	344,737	946,938	18,001	12,768	13,240	13,044	21,366	(235,568)	1,134,526
Notes receivable, related party	848,250	593	-	-	-	-	-	(848,843)	-
Other investments for restricted activities	-	105,869	25,272	3,077	6,265	97	-	-	140,580
Property, plant, and equipment, net	8	469,613	68,374	43,612	18,432	40,126	3,421	-	643,586
Right of use assets	1,542	32,714	1,822	621	3,220	17,574	92	-	57,585
Other assets	2,242	122,647	7,429	5,482	2,152	8,199	158	(10,971)	137,338
Total assets	$ 1,330,878	$ 2,223,693	$ 207,560	$ 104,739	$ 64,053	$ 124,732	$ 35,355	$ (1,178,447)	$ 2,912,563
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 147	$ 257	$ 747	$ 71	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	259	631	1,316	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	272,762	126,684	35,117	4,251	3,517	3,528	1,791	(318,634)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,875	3,626	3,883	1,483	-	142,991
Estimated third-party settlements	-	210,143	34,664	24,667	6,430	25,421	1,200	-	302,525
Total current liabilities	273,100	478,819	78,798	33,199	14,461	34,895	4,604	(318,634)	599,242
Notes payable, related party	-	814,525	-	27,718	6,600	-	-	(848,843)	-
Long-term debt, excluding current portion	1,050,694	37,373	23,618	147	10,867	24,312	2,489	(10,970)	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,433	368	2,700	16,429	33	-	46,456
Insurance deposits and related liabilities	-	75,697	475	388	222	325	39	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	510	-	-	-	324,257
Other liabilities	-	117,631	1,506	2,026	-	22,515	-	-	143,678
Total liabilities	1,324,997	1,850,242	127,670	63,846	35,360	98,476	7,165	(1,178,447)	2,329,309
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	5,526	266,327	48,549	36,158	21,385	24,881	28,160	40	431,026
Net assets with donor restrictions	355	107,124	31,341	4,735	7,308	1,375	30	(40)	152,228
Total net assets	5,881	373,451	79,890	40,893	28,693	26,256	28,190	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,223,693	$ 207,560	$ 104,739	$ 64,053	$ 124,732	$ 35,355	$ (1,178,447)	$ 2,912,563

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2019

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 42,456	$ 47,465	$ 9,411	$ 7,066	$ 10,462	$ 8,372	$ -	$ 125,232	$ 18,355	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	7,279	8,960	5,010	-	218,067	3,058	-	221,125
Prepaid expenses and other current assets	14,178	139,034	8,563	2,401	5,567	1,423	(74,083)	97,083	1,421	(3,009)	95,495
Total current assets	56,634	367,437	33,854	16,746	24,989	14,805	(74,083)	440,382	22,834	(3,009)	460,207
Assets limited as to use	92,602	688,485	18,759	12,684	12,427	11,619	-	836,576	39,673	-	876,249
Notes receivable, related party	553,484	752	-	1,406	-	-	(554,236)	1,406	(1,406)	-	-
Other investments for restricted activities	-	91,882	6,970	31	2,973	6,323	-	108,179	25,940	-	134,119
Property, plant, and equipment, net	22	432,277	67,147	30,945	41,946	17,797	-	590,134	31,122	-	621,256
Right of use assets	-	-	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,208	1,279	15,019	6,042	4,388	(10,970)	127,484	(3,013)	-	124,471
Total assets	$ 706,260	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,104,161	$ 115,150	$ (3,009)	$ 2,216,302
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 954	$ 547	$ 262	$ -	$ 10,819	$ 95	$ -	$ 10,914
Current portion of right of use obligations	-	-	-	-	-	-	-	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	55,499	99,684	15,620	8,299	3,878	2,776	(74,083)	109,873	6,953	(3,009)	113,817
Accrued compensation and related benefits	-	110,639	5,851	3,694	2,313	4,270	-	126,767	1,641	-	128,408
Estimated third-party settlements	-	26,405	103	1,290	10,851	2,921	-	41,570	-	-	41,570
Total current liabilities	55,499	248,622	22,404	12,237	17,589	10,229	(74,083)	292,497	8,689	(3,009)	298,177
Notes payable, related party	-	526,202	-	-	28,034	-	(554,236)	-	-	-	-
Long-term debt, excluding current portion	643,257	44,820	24,503	35,604	843	11,465	(10,970)	749,322	2,858	-	752,180
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-	-	-
Insurance deposits and related liabilities	-	56,786	440	513	388	240	-	58,367	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	-	4,320	-	281,009	-	-	281,009
Other liabilities	-	98,201	1,104	28	1,585	-	-	100,918	23,218	-	124,136
Total liabilities	698,756	1,241,058	58,713	48,382	48,239	26,254	(639,289)	1,482,113	34,805	(3,009)	1,513,909
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	7,486	356,880	63,051	27,653	35,518	21,242	-	511,830	48,063	40	559,933
Net assets with donor restrictions	18	91,103	6,245	796	4,620	7,436	-	110,218	32,282	(40)	142,460
Total net assets	7,504	447,983	69,296	28,449	40,138	28,678	-	622,048	80,345	-	702,393
Total liabilities and net assets	$ 706,260	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,104,161	$ 115,150	$ (3,009)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2019

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 42,456	$ 48,052	$ 11,952	$ 11,120	$ 8,549	$ 15,772	$ 5,686	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	8,960	5,060	7,280	3,007	-	221,125
Prepaid expenses and other current assets	14,178	139,832	9,460	5,567	1,401	1,678	471	(77,092)	95,495
Total current assets	56,634	368,822	37,292	25,647	15,010	24,730	9,164	(77,092)	460,207
Assets limited as to use	92,602	707,597	17,383	12,427	12,738	12,685	20,817	-	876,249
Notes receivable, related party	553,484	752	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	99,807	24,985	2,973	6,323	31	-	-	134,119
Property, plant, and equipment, net	22	434,953	70,846	42,423	19,435	50,338	3,239	-	621,256
Right of use assets	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,366	7,388	5,476	1,931	8,688	74	(10,970)	124,471
Total assets	$ 706,260	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (642,298)	$ 2,216,302
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 547	$ 288	$ 954	$ 69	$ -	$ 10,914
Current portion of right of use obligations	-	-	-	-	-	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,499	100,441	19,356	3,879	2,856	6,704	2,174	(77,092)	113,817
Accrued compensation and related benefits	-	110,639	5,851	2,313	4,314	4,192	1,099	-	128,408
Estimated third-party settlements	-	26,405	103	10,851	2,921	1,290	-	-	41,570
Total current liabilities	55,499	249,179	26,140	17,590	10,379	13,140	3,342	(77,092)	298,177
Notes payable, related party	-	526,202	-	28,034	-	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	24,503	643	11,763	35,604	2,560	(10,970)	752,180
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-
Insurance deposits and related liabilities	-	56,786	440	388	240	513	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	4,320	-	-	-	281,009
Other liabilities	-	98,201	1,115	1,585	-	23,235	-	-	124,136
Total liabilities	698,756	1,241,615	62,460	48,240	26,702	72,492	5,942	(642,298)	1,513,909
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	7,486	379,498	65,873	36,087	21,300	22,327	27,322	40	559,933
Net assets with donor restrictions	18	99,184	29,561	4,619	7,435	1,653	30	(40)	142,460
Total net assets	7,504	478,682	95,434	40,706	28,735	23,980	27,352	-	702,393
Total liabilities and net assets	$ 706,260	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (642,298)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2020

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,490,516	$ 207,416	$ 65,496	$ 53,943	$ 41,349	$ -	$ 1,858,720	$ 21,305	$ -	$ 1,880,025
Contracted revenue	5,369	114,906	400	-	10	7,427	(54,543)	73,569	498	(39)	74,028
Other operating revenue	26,349	321,028	16,406	7,179	10,185	7,847	(28,972)	360,022	15,128	(528)	374,622
Net assets released from restrictions	409	13,013	1,315	162	160	84	-	15,143	1,117	-	16,260
Total operating revenue and other support	32,127	1,939,463	225,537	72,837	64,298	56,707	(83,515)	2,307,454	38,048	(567)	2,344,935
Operating expenses											
Salaries	-	947,275	115,777	37,596	33,073	27,600	(34,706)	1,126,615	17,007	1,201	1,144,823
Employee benefits	-	227,138	26,979	6,214	6,741	6,344	(4,864)	268,552	4,009	311	272,872
Medications and medical supplies	-	401,165	36,313	8,390	5,140	2,944	-	453,952	1,429	-	455,381
Purchased services and other	13,615	284,714	31,864	11,639	14,311	13,351	(20,942)	348,552	13,943	(1,999)	360,496
Medicaid enhancement tax	-	59,708	8,476	3,226	2,853	1,747	-	76,010	-	-	76,010
Depreciation and amortization	14	71,108	9,351	3,361	3,601	2,475	-	89,910	2,254	-	92,164
Interest	25,780	23,431	953	906	1,097	252	(25,412)	27,007	315	-	27,322
Total operating expenses	39,409	2,014,539	229,713	71,332	66,816	54,713	(85,924)	2,390,598	38,957	(487)	2,429,068
Operating (loss) margin	(7,282)	(75,076)	(4,176)	1,505	(2,518)	1,994	2,409	(83,144)	(909)	(80)	(84,133)
Non-operating gains (losses)											
Investment income (losses), net	4,877	18,522	714	292	359	433	(198)	24,999	2,048	-	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	-	134	-	10,810	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(205)	544	4,317	(2,211)	(3,133)	346	80	(2,707)
Total non-operating gains (losses), net	945	26,238	2,028	87	903	4,884	(2,409)	32,676	2,394	80	35,150
(Deficiency) excess of revenue over expenses	(6,337)	(48,838)	(2,148)	1,592	(1,615)	6,878	-	(50,468)	1,485	-	(48,983)
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	564	179	-	344	300	-	1,387	27	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	-	(7,188)	-	(79,022)	-	-	(79,022)
Net assets transferred to (from) affiliates	4,375	(7,269)	(32)	219	1,911	15	-	(781)	781	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	(2,316)	-	(2,316)
Increase in net assets without donor restrictions	$ (1,962)	$ (114,056)	$ (15,322)	$ 1,811	$ 640	$ 5	$ -	$ (128,884)	$ (23)	$ -	$ (128,907)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2020

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,490,516	$ 207,416	$ 53,943	$ 41,348	$ 65,496	$ 21,306	$ -	$ 1,880,025
Contracted revenue	5,369	115,403	400	10	7,427	-	-	(54,581)	74,028
Other operating revenue	26,349	323,151	16,472	10,185	9,482	16,726	1,757	(29,500)	374,622
Net assets released from restrictions	409	13,660	1,335	160	83	613	-	-	16,260
Total operating revenue and other support	32,127	1,942,730	225,623	64,298	58,340	82,835	23,063	(84,081)	2,344,935
Operating expenses									
Salaries	-	947,275	115,809	33,073	28,477	41,085	12,608	(33,504)	1,144,823
Employee benefits	-	227,138	26,988	6,741	6,517	7,123	2,918	(4,553)	272,872
Medications and medical supplies	-	401,165	36,313	5,140	2,941	8,401	1,421	-	455,381
Purchased services and other	13,615	287,948	32,099	14,311	13,767	14,589	7,108	(22,941)	360,496
Medicaid enhancement tax	-	59,708	8,476	2,853	1,747	3,226	-	-	76,010
Depreciation and amortization	14	71,109	9,480	3,601	2,596	5,004	360	-	92,164
Interest	25,780	23,431	953	1,097	252	1,159	62	(25,412)	27,322
Total operating expenses	39,409	2,017,774	230,118	66,816	56,297	80,587	24,477	(86,410)	2,429,068
Operating (loss) margin	(7,282)	(75,044)	(4,495)	(2,518)	2,043	2,248	(1,414)	2,329	(84,133)
Non-operating gains (losses)									
Investment income (losses), net	4,877	19,361	1,305	359	463	292	588	(198)	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	134	-	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(25)	4,318	(205)	914	(2,131)	(2,707)
Total non-operating gains (losses), net	945	27,077	2,619	334	4,915	87	1,502	(2,329)	35,150
(Deficiency) excess of revenue over expenses	(6,337)	(47,967)	(1,876)	(2,184)	6,958	2,335	88	-	(48,983)
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	591	179	344	300	-	-	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	(7,188)	-	-	-	(79,022)
Net assets transferred to (from) affiliates	4,377	(7,282)	10	1,911	15	219	750	-	-
Other changes in net assets	-	-	(2,316)	-	-	-	-	-	(2,316)
Increase in net assets without donor restrictions	$ (1,960)	$ (113,171)	$ (17,324)	$ 71	$ 85	$ 2,554	$ 838	$ -	$ (128,907)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2019

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,580,552	$ 220,255	$ 69,794	$ 60,166	$ 46,029	$ -	$ 1,976,796	$ 22,527	$ -	$ 1,999,323
Contracted revenue	5,011	109,051	355	-	-	5,902	(46,100)	74,219	790	8	75,017
Other operating revenue	21,128	186,852	3,407	1,748	4,261	2,289	(22,076)	197,609	13,386	(297)	210,698
Net assets released from restrictions	369	11,556	732	137	177	24	-	12,995	1,110	-	14,105
Total operating revenue and other support	26,508	1,888,011	224,749	71,679	64,604	54,244	(68,176)	2,261,619	37,813	(289)	2,299,143
Operating expenses											
Salaries	-	868,311	107,671	37,297	30,549	26,514	(24,682)	1,045,660	15,785	1,106	1,062,551
Employee benefits	-	217,623	25,983	6,454	5,434	7,152	(3,763)	258,883	3,642	287	262,812
Medications and medical supplies	-	354,201	34,331	8,634	6,298	3,032	-	406,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,622)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,061	-	-	70,061
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,360	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,981	533	-	25,514
Total operating expenses	32,057	1,828,123	220,108	74,229	63,107	55,012	(70,471)	2,202,165	38,726	(229)	2,240,662
Operating margin (loss)	(5,549)	59,888	4,641	(2,550)	1,497	(768)	2,295	59,454	(913)	(60)	58,481
Non-operating gains (losses)											
Investment income (losses), net	3,929	32,193	227	469	834	623	(198)	38,077	1,975	-	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	-	186	-	11,221	-	-	11,221
Other (losses) income, net	(3,784)	1,586	(187)	30	(240)	279	(2,097)	(4,413)	791	60	(3,562)
Loss on early extinguishment of debt	-	-	-	(87)	-	-	-	(87)	-	-	(87)
Total non-operating gains (losses), net	145	43,056	1,798	412	594	1,088	(2,295)	44,798	2,766	60	47,624
(Deficiency) excess of revenue over expenses	(5,404)	102,944	6,439	(2,138)	2,091	320	-	104,252	1,853	-	106,105
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	419	565	-	402	318	-	1,704	65	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	-	682	-	(72,043)	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,939	8,760	128	110	-	5,054	(5,054)	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 21,998	$ 1,223	$ 6,622	$ 2,621	$ 1,430	$ -	$ 38,967	$ (3,136)	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2019

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,580,552	$ 220,254	$ 60,166	$ 46,029	$ 69,794	$ 22,528	$ -	$ 1,999,323
Contracted revenue	5,010	109,842	355	-	5,902	-	-	(46,092)	75,017
Other operating revenue	21,128	188,775	3,549	4,260	3,868	10,951	540	(22,373)	210,698
Net assets released from restrictions	371	12,637	732	177	26	162	-	-	14,105
Total operating revenue and other support	26,509	1,891,806	224,890	64,603	55,825	80,907	23,068	(68,465)	2,299,143
Operating expenses									
Salaries	-	868,311	107,706	30,549	27,319	40,731	11,511	(23,576)	1,062,551
Employee benefits	-	217,623	25,993	5,434	7,319	7,218	2,701	(3,476)	262,812
Medications and medical supplies	-	354,201	34,331	6,298	3,035	8,639	1,371	-	407,875
Purchased services and other	11,366	246,101	35,396	13,390	14,371	18,172	7,437	(22,798)	323,435
Medicaid enhancement tax	-	54,954	8,005	2,264	1,776	3,062	-	-	70,061
Depreciation and amortization	14	69,343	8,125	3,920	2,478	4,194	340	-	88,414
Interest	20,678	21,585	1,054	1,119	228	1,637	63	(20,850)	25,514
Total operating expenses	32,058	1,832,118	220,610	62,974	56,526	83,653	23,423	(70,700)	2,240,662
Operating (loss) margin	(5,549)	59,688	4,280	1,629	(701)	(2,746)	(355)	2,235	58,481
Non-operating gains (losses)									
Investment income (losses), net	3,929	33,310	129	785	645	469	983	(198)	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	186	-	-	-	11,221
Other (losses) income, net	(3,784)	1,586	(171)	(240)	288	31	765	(2,037)	(3,562)
Loss on early extinguishment of debt	-	-	-	-	-	(87)	-	-	(87)
Total non-operating gains (losses), net	145	44,173	1,716	545	1,119	413	1,748	(2,235)	47,624
(Deficiency) excess of revenue over expenses	(5,404)	103,861	5,996	2,174	418	(2,333)	1,393	-	106,105
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	484	565	402	318	-	-	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	682	-	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,963	128	118	3,629	45	-	-
Increase (decrease) in net assets without donor restrictions	$ 5,073	$ 22,980	$ 804	$ 2,704	$ 1,536	$ 1,296	$ 1,438	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Note to Supplemental Consolidating Information
June 30, 2020 and 2019

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in net assets without donor restrictions of D-HH and its subsidiaries. All intercompany accounts and transactions between D-HH and its subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

Cheshire Medical Center - 2020 Board of Directors

Susan	Abert *(VICE CHAIR)	Attorney - Norton & Abert PC	Keene NH	03431
Ashok	Bahl	Procurement Director, C&S Wholesale Grocers	Keene NH	03431
Wendy	Fielding	VP Financial Planning Financial Services - Dartmouth Hitchcock	Lebanon NH	03756
Mark	Gavin *(TREASURER)	Chief Financial Officer - SoClean	Peterborough NH	03458
H. Roger	Hansen	Retired physician - Cheshire Medical Center	Keene NH	03431
Nathalie	Houder *(CHAIR)	Chief Financial Officer, Auto Europe	Portland, ME	04101
Michael	Kapiloff	Owner/Agent - Kapiloff Insurance Agency	Keene NH	03431
Robert	Mitchell	Retired, FDIC Bank Examiner	Swanzey, NH	03446
Geof	Molina	Retired, Vice President, Internal Audit, Main Street America Group	Keene NH	03431
Maria	Padin, MD	Chief Medical Officer - Dartmouth Hitchcock	Lebanon NH	03756
Steve	Paris, MD *(AT LARGE)	Medical Director - Dartmouth Hitchcock	Manchester NH	03104
Katherine	Snow *(SECRETARY)	Retired President, Monadnock United Way	Keene NH	03431
Gregg	Tewksbury	President, Savings Bank of Walpole	Keene NH	03431
Andy	Tremblay, MD	Chair, Dept. of Primary Care Services - Dartmouth Hitchcock	Keene NH	03431
Ex Officio				
Don	Caruso, MD	CEO/Pres/CMO - Dartmouth Hitchcock	Keene NH	03431
Michale	Ormont, MD	Physician & Medical Staff Pres - Dartmouth Hitchcock	Keene NH	03431
Cherie	Holmes, MD	Medical Director - Dartmouth Hitchcock	Keene NH	03431

Shawn V LaFrance

Professional Experience

CHESHIRE MEDICAL CENTER/DARTMOUTH-HITCHCOCK, Keene, NH
Vice President of Population Health and Health System Integration, 2017-current
Advance the vision and mission of Cheshire Medical Center by directing and coordinating population health interventions and integrating clinical areas with community strategies to deliver value based care Provide leadership for the Healthy Monadnock initiative and for public health activities in the region Manage staff in the Center for Population Health Member of the Senior Operations Team Serve as principal liaison to Dartmouth Hitchcock Health for all matters related to population health

FOUNDATION FOR HEALTHY COMMUNITIES, Concord, NH
Executive Director, 2004- February 2017
Vice President for Planning and Development, 1998-2004
Provide leadership in the design and management of statewide initiatives through innovative public and private sector partnerships to improve health and the delivery of health care services in New Hampshire Manage professional staff and annual budget of $2+ million

THE COMMONWEALTH FUND, New York, NY
Program Officer, 1994-1997
Managed grant-making portfolio of nationwide projects focused on child health, youth development and local public-private partnerships for leading foundation in health care philanthropy Designed and monitored program outcomes for $3 5 million in annual grant expenditures Accomplishments include organized key start-up activities for a national initiative, in partnership with conversion and community foundations, to improve the delivery of pediatric care with a focus on child development and family support Re-structured youth projects to strengthen career-to-school emphasis with mentoring, and initiated new local focus on promoting public-private partnerships Advised applicants on project development, budgets, evaluation plans, and crafting communications strategies for projects Initiated new procedures to effectively plan and prioritize communication of results from the national program

NEW YORK CITY DEPARTMENT OF HEALTH, New York, NY
Special Assistant to Commissioner, (Margaret A Hamburg, MD) 1992-1994
Assisted Commissioner of the largest local health department in the US on wide range of internal and external policy issues Accomplishments include managed recruitment and operations for 130+ provider sites to reach at-risk children in the largest immunization campaign in the city's history; convened multi-sector lead poisoning task force to revise prevention strategies, and initiated a review of managed care options and health education services for the Department of Health

Education

Columbia University, New York, NY
Master of Public Health - 1985 M S , Urban Planning- 1985
Master's Thesis Hospitals and Urban Neighborhoods Bases for Joint Planning and Community Development (Research Bibliography published by the Council for Planning Librarians, Chicago, IL, October 1985)

University of New Hampshire, Durham, NH
B S , Health Administration and Planning - 1979

Awards

Innovators Award, 2017, Foundation for Healthy Communities
Byock & Corbeil Award, 2017, NH Hospice and Palliative Care Organization
Well Done Award, 2017, Capital Area Wellness Coalition
Public Citizen of the Year, 2011, NH Pediatric Society
Chapter Award, 2006, Northern New England Association of Healthcare Executives
Healthier Communities Fellowship, Health Forum, Class of 2003
Leadership New Hampshire, Class of2000
Hospice Hero Award, 1999, NH Hospice and Palliative Care Organization
Barney Rabinow Award, 1986, NYC Department of City Planning
Foster McGaw Scholar, 1985, Columbia University, School of Public Health

Nelson Hayden MA, MBA, MSF

[redacted]

Objective

I would like to find a position where I can combine the knowledge and experience I have in the counseling and substance use disorder field with my strong business acumen and administrative experience I have held leadership positions in a wide array of situations including hospitality, clinical practice, and non-profit Boards of Directors I seek an organization that values leadership and hard work where my talents will be used and valued

Professional Experience

Director/Clinician – Doorway at Cheshire Medical Center – Keene, NH February 2019 – Present

- The Doorway at Cheshire Medical Center is one of nine Doorways that make up regional access points as part of a $45 Million State Opioid Response to address the substance use disorder crisis in New Hampshire. In this position I have created a new department as part of the Center for Population Health including staffing, budgeting and creating systems for measurement of our objectives
- As part of my position as Director of the Doorway I have led a diverse group including physicians, nurses, nurse practitioners, behavioral health clinicians and community partners to develop a Medically Assisted Treatment plan for both our inpatient population and our Emergency Department -This has led to better patient care, improved access to substance use treatment, and better experiences for staff and patients alike
- We are not technically a treatment program but rather a facilitating organization which helps individuals seeking treatment for their substance use disorder with appropriate ASAM levels of care We assess, consent, and refer clients/patients to various levels of care and provide interim therapy as well as case management while they are waiting for placement

Counseling Intern/Senior Counselor – Dublin Phoenix House – Dublin, NH October 2017 – February 2019

- The Dublin Phoenix House is a 49 Bed coeducational Residential Treatment Home for people with Substance Use Disorders This nonprofit facility believes in the understanding that addiction is a chronic disease not a moral failing. Individuals suffering from substance use disorders deserve and require evidence-based treatment in settings that offer privacy and dignity.
- In this second-year internship, my work focused upon two major areas: 1) developing treatment plans and transitional support for a caseload of 6-10 individual clients and 2) facilitating groups for males and females of up to 30 members and educating group participants in areas such as Helping Men Recover, 12-Step Introduction, Seeking Safety and psychoeducation surrounding addiction and recovery My success in the internship led to employment as a Senior Counselor
- My caseload consists of up to ten clients and developing self-directed treatment plans, mental health evaluation, counseling these clients in individual, family, and group settings In addition to the traditional counseling performed for the substance use population, I perform a great deal of case management including assisting with housing, co-managing treatment and aftercare with various social and corrections departments, improving bio-psycho-social health and creating transition plans for the same and evaluating financial and vocational concerns and creating improvement plans

Counseling Intern – Keene State College – Keene, NH August 2016 – May 2017

- The Keene State College Counseling Center is a highly sought-after internship for Antioch University Clinical Mental Health Counseling Students I was fortunate enough to be able to participate in this program in my first year of internship due in part to the extensive organizational development in the Substance Use arena. I was the initial intern for a new Keene State College Counseling Internship focusing on Alcohol and Other Drugs and working under Michelle M Morrow, Ph.D who was the Coordinator of AOD Prevention, Treatment, and Education Services
- In this specialized internship, my work focused upon two major areas: 1) providing interventions (both individual and small group interventions) and 2) helping to develop and deliver outreach and prevention efforts to address alcohol and other drug misuse on campus We performed weekly outreach in the residence halls, met with each athletic team, and performed educational outreach to all incoming freshmen
- As an intern, I was able to co-facilitate a general process group with a senior staff member Additionally, my work included co-facilitating a bi-monthly Alcohol Education Class that included bystander intervention components
- My caseload included conducting BASICS and CASICS (*Brief Alcohol Screening and Intervention for College Students/Cannabis Screening and Intervention for College Students).* BASICS and CASICS are empirically supported treatments that include the student completing an online feedback profile and attending 1 to 2 sessions that emphasize the examination of their own use patterns and behavior within a Motivational Interviewing framework. The aim of BASICS/CASICS is to reduce risky behaviors and the harmful consequences of use by increasing awareness and increasing the use of protective behaviors Additionally, I saw students through a general caseload, where I focused primarily on CBT and Motivational Interviewing to help the students best adjust and perform in the higher education setting

Administrator – Sheth-Horsley Eye Center – Stoneham, MA June 2010 – October 2013

- In this position, I was able to navigate the change in ownership of this longstanding practice, we grew the practice significantly in a short amount of time using premium cataract surgery and refractive surgery I brought a culture of patient satisfaction to the reception and clinical staffs as well as to the doctor, which helped to increase patient visits We worked diligently with the referral community to exceed HEDIS standards and promote communication
- We were able to implement systems where practitioners worked to the maximum of their licensure and ability thereby increasing overall efficiencies in the practice
- I was able to evaluate the billing and collections for the practice and collaborate to improve processes to increase the average daily collections by 50% and reduce the number of days sales were outstanding from 48 days to 39 days

Executive Director – Tallman Eye Associates – Lawrence, MA February 2006 through March 2010

- As Executive Director for this 18-doctor private practice I helped to increase revenues by 43% in the clinic and 45% in the optical dispensaries over four years Total revenues exceeded $13 Million
- Our team was able to expand the capacity of the organization through adjustments to the physical plant, provider relations, schedule engineering, and human resources development
- I was able to lead the transition of this large group from restrictive systems to integrated processes through the use of IT The use of technology improved transparency, efficiency, as well as communication and revenues

Education

Antioch University – MA CMHC Program Substance Abuse Counseling Focus June 2015– May 2018

I recently completed a Masters in Clinical Mental Health Counseling with a concentration in Substance Abuse Counseling at Antioch University I completed coursework in Social Cultural Diversity, Group Approaches to Counseling, Ethics, Fundamental Therapeutic Interactions, Counseling Theories, Human Development, and Career & Lifestyle Counseling in my first year. In my second year, I completed coursework in Human Sexuality & Sex Therapy, Psychopharmacology, Psychopathology, Family Counseling Approaches to Addiction, and Integrated Approaches to Addiction Counseling, Crisis and Trauma Informed Therapy, Research and Evaluation in Counseling and Therapy, and Issues in Addiction Recovery. I transferred to Antioch as it offers a classroom aspect to the program and can lead to licensure in the State of New Hampshire

University of South Dakota – MS Addiction Studies January 2013 – August 2013

I enrolled as a degree-seeking student at the University of South Dakota, seeking a Masters in Addiction Studies I completed my first two terms with a 4 0 Grade Point Average The coursework included pharmacology, alcohol and drug counseling theories, addiction studies research, and addressing families and drug and alcohol issues.

Northeastern University – MBA/MSF Program January 2010 – August 2012

I completed my MBA program at Northeastern University and took an extra semester to earn a Master of Science in Finance as well I was fortunate enough to walk through Commencement on May 4, 2012 and realize the fruits of this two and a half year effort. The curriculum included coursework in Organizations in the New Economy, Healthcare Finance, Strategic Decisions in Healthcare, Financial Strategy, Financial Accounting and Management Accounting

State University of New York – BS Business Management/Health Services 2006 - 2009

I spent three years completing my undergraduate degree while altering my focus from liberal arts focus to a business management degree with a concentration in health care management

University of Southern California – English Literature 1984 - 1989

Spent five years working towards a BA Degree in English Literature. Rowed for the University of Southern California Crew Team in 1984 and 1985. Vice President of the Phi Kappa Tau Fraternity in 1987, President in 1989.

Organizational Involvement

Recovery Task Force August 2015 – May 2018

I currently sit on this committee, which is part of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment The work done by this task force includes standards for NH Recovery Housing, as well as helping with the Recovery Aspect of the State Plan The mission of the recovery task force is to promote effective community based Recovery Support Services by recommending to the Governor's Commission policies, practices and funding to address unmet needs in the continuum of care for SUD.

Monadnock Alcohol & Drug Abuse Coalition April 2015 – December 2016

I recently concluded volunteering with this Prevention Coalition in Keene, NH The Monadnock Alcohol and Drug Abuse Coalition works to reduce alcohol and drug use and misuse in Cheshire County I contributed to the organization through strengthening the bond along the continuum of care. I have done this through participation in Recovery Coach Training, leading the Compliance Check initiative for local retailers I have also carried

MADAC's message to other agencies including Monadnock Family Services, Acting Out, and the Keene Serenity Center I have trained over 80 Recovery Coaches in Keene through three-week long training sessions

Board Member/ Treasurer New Hampshire Providers Association July 2015 – Present

The mission of the NH Providers Association is to represent its members in advancing substance use prevention, treatment and recovery through public policy, leadership, professional development, and quality member services I have been a Board Member, their VP of Recovery, and a member of the Finance Committee for this organization and I am very excited about the opportunity to serve this organization and help advocate for providers of drug and alcohol treatment in the State of New Hampshire

Board Member/Treasurer Monadnock Restorative Community July 2015 – December 2016

Monadnock Restorative Community promotes recovery and successful re-integration of recently incarcerated women with an addiction into the larger community through an outpatient setting designed to achieve health and wholeness of mind, body and spirit. This organization has been active in the use of Recovery Coaches and Community mentors in order to assist these women. Much of my contribution is my business acumen as well as my experiences with Recovery Coaching and business planning.

Board Member/Treasurer Keene Serenity Center January 2016 – Present

The Serenity Center is a membership organization and a separate entity that is neither affiliated with nor financed by any recovery program or other organization We recognize that there are many pathways to successful recovery from addictions, and we welcome people on all paths to recovery and their families Our center provides a safe haven to initiate and / or maintain long-term recovery through peer-to-peer support meetings and fellowship At present, we have over 20 meetings serving more than 300 people each week I am most proud that this organization was chosen as one of five Community Recovery Organizations to work with Harbor Homes and the Bureau of Drug and Alcohol Services to promote peer-to-peer recovery

References

References are available upon request

Laurie Butz-Meyerrose

[redacted]

Objective To obtain a job in the field of Mental Health and Substance Abuse Counseling

Experience

Clinician

The Doorway @ Cheshire Medical
Keene, New Hampshire

March 25, 2019 – Present

Assessments and referrals for substance abuse treatment Coordinate treatment for and aftercare in the community Meet with patients, perform assessments and make referrals dependent on level of care Assist in coordinating follow up care that includes housing, legal issues, ongoing MAT, mental health, physical health, and insurance

Senior Counselor

Sobriety Centers of New Hampshire – Antrim House
Antrim, NH

January 2016 – current

Assessments, individual and group counseling Create, implement and review treatment plans Coordinate discharge and follow up care in the community Vast experience working with Medicaid
Outpatient clinical with former clients, establishing bridge program back into the community

Senior Counselor

Phoenix House, Dublin, New Hampshire

January 2015 –Current

Intakes and Assessments

Individual and Group Counseling

Create, implement and Review Treatment Plans

Coordinate discharge, working closely with transitional living, community mental health, department of corrections, DCYF

Case Manager

Crotched Mountain Rehabilitation Hospital, Greenfield, New Hampshire

August 2010 – January 2015

Discharge Planning

Coordination of Insurance Updates

Coordination of services and transitioning of patients into the community

Data Entry

TD Bank, Keene, New Hampshire

October 2009 – May 2010

Temporary Assignment, Data Entry

Case Manager
AIDS Services for the Monadnock Region, Gilsum, New Hampshire
June 2007 – July 2009

Responsible for 20 – 25 HIV/HepC clients

Care Program Applications, Application for community benefits

Meetings at the State for continued funding processes

Education

MS Clinical Mental Health Counseling
Walden University, Minneapolis, MN
November 2014

Chi Sigma Iota Honor Society/Concentration in Forensic Counseling

Golden Key International Honor Society

BA Psychology

Ashford University, Clinton, IA

May 2010

Magna Cum Laude

License **LCHMC, MLADC, ACS**

Laune K Bulz-Meyerrose
1182 Nelson Road, Nelson NH 03457 603-852-5289 laune81958@yahoo com

HEATHER TREMPE

Masters level Mental Health Clinician

[redacted]

Authorized to work in the US for any employer

WORK EXPERIENCE

Clinician

Cheshire Medical Center - Keene, NH
October 2019 to Present

Assistant Director/Trauma Therapist

Neurodevelopmental Therapy Services, Inc - Manchester, NH
April 2019 to July 2019

- 60 day residential facility
- 1:1 therapy with children twice a week.
- daily meditation groups
- daily motivational groups

Clinician III

COMMUNITY HEALTHLINK - Leominster, MA
January 2019 to April 2019

- Weekly In home therapy with families and children
- Weekly family therapy without child present to assist with strategies and parent resources.

Supervisor III

Department of Health and Human Services - Manchester, NH
July 2014 to December 2018

- Trains new employees on policies and procedures
- Achieve excellent customer service
- Assists the community with eligibility for food stamps, medicaid, and cash.

Preschool Teacher

The World of Discovery - Londonderry, NH
December 2009 to July 2014

- Create lesson plans encompassing math, reading, writing, art, and science
- managed a classroom of 14-16 3-4 year olds
- Did bi yearly progress reports and family meetings
- Completed evaluations

EDUCATION

Master's in Clinical mental health

Southern New Hampshire University - Manchester, NH
January 2016 to December 2018

Bachelor's in Psychology

HESSER COLLEGE - Manchester, NH
2012 to 2015

Early Childhood Education

HESSER COLLEGE - Manchester, NH
August 2006 to May 2008

Early Childhood Education Certification/General Studies

SEACOAST SCHOOL OF TECHNOLOGY - Exeter, NH
September 2004 to June 2006

SKILLS

- **Counseling**
- **Therapy**
- **Documentation**
- **Mental Health**
- **Case Management**
- **Microsoft Office**
- **problem solving**
- **Management**

CERTIFICATIONS AND LICENSES

TF-CBT

January 2016 to Present

Completed and 8 hour training on trauma focused cognitive behavior therapy.

Trust-Based Relational Intervention(TBRI)

April 2019 to Present

CPR/AED/First Aid

April 2019 to April 2021

Medication Administration

April 2019 to Present

Non-abusive psychological and physical intervention (NAPPI)

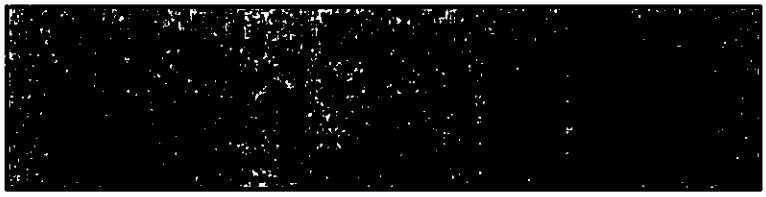
April 2019 to Present

ADDITIONAL INFORMATION

- First Aid and CPR certified

- Has over ten years working with children and assisting with their development
- Demonstrates resourceful and positive outlook for the best answer to each client's needs and wants.
- Able to work efficiently and stay calm with clients and assist with looking for resources in their community
- Punctual and motivated

David H. Burrows



Objective

Contribute to the success of an enterprise involved in compassionate solutions to compelling challenges

Ability Summary

Dedicated, driven, with wide range of training and experience in many areas of recovery from substance use disorder and behavioral health.

Occupational Licenses & Certificates

Certification Title	Issuing Organization	Completion Date
Recovery Coach Academy	CCAR	01/2016
Ethical Considerations of Recovery Coaching	CCAR	01/2016
Suicide Postvention	Southern New Hampshire Area Health Education Center	06/2016
Roles for Peers Providing Recovery Support	NH Center for Excellence	01/2017
Telephone Recovery Support	NH Center for Excellence	03/2017
Prevention Ethics	NH Training Institute on Addictive Disorders	04/2017
Supervising a peer recovery workforce	NH Training Institute on Addictive Disorders	04/2017
Motivational Interviewing Basic	NH Training Institute on Addictive Disorders	06/2017
Creative Outreach to Increase Recruitment for PRSS	NH Center for Excellence	12/2017
Recovery Coaching in the Emergency Department	CCAR	1/2018
Implementing Recovery Coaching in the ED	JSI Research & Training Institute, Inc	1/2019
Standards for Recovery Housing and Building this Capacity for New Hampshire	JSI Research & Training Institute, Inc	4/2019
Understanding and Using the ASAM Criteria and Engaging People into Collaborative Addiction Treatment		7/2019

Employment History

Certified Recovery Support Worker
05/19 - present — Cheshire Medical Center — 580 Court Street, Keene, NH 03431

Community Volunteer
03/2016 – present — Be the Change Behavioral Health Task Force

Be the Change is the Eastern Monadnock Region's Behavioral Health Task Force. Our mission is to provide education and resources to our community about Substance Misuse and Mental Health. Be the Change began when Monadnock Community Hospital's 2012 Community Health Needs Assessment identified that there was a need for more education in our community regarding behavioral health, a term that encompasses both mental health and substance misuse, and awareness of the resources we have in both our region and state.

Vision/Controls Engineer

05/2009 - 05/2015 — Crane Security Technologies (Formerly Technical Graphics Inc.) — Suite 100 1 Cellu Dr., Nashua, NH

Main duties were integrating, documenting, commissioning and maintaining machine vision and control systems within the Currency (U.S. Government Products) production areas. These systems include real-time inspection systems and related closed-loop control systems.

- Coordinated team efforts with internal support groups, production personnel, customers, and outside vendors.
- Assisted in all aspects of installation and improvement projects and sub-projects within the

manufacturing areas relating to automated control systems and machine vision disciplines.

- Directed technicians and other support personnel in all phases of projects. Interfaced with other support groups during appropriate phases of the project to ensure effective integration with existing processes and/or other improvements and installations.
- Planned and implemented data collection network to provide real time process monitoring utilizing GE Proficy software suite
- Installed programmed and updated Rockwell and Rexroth based PLC control systems involved in motion control, waste water and chemical supply systems
- Responsible for troubleshooting inspection and machine vision systems maintained by Engineering/Maintenance and trained and directed technicians in those efforts. Assisted plant leadership in diagnosing and solving manufacturing and converting inspection problems. Optimized machine vision systems and strategies.
- Identified, investigated and developed process improvements and optimization. Assisted in team approaches with Manufacturing, Quality and Continuous Improvement, R&D and Engineering to develop optimal strategies for improved yields, efficiencies and quality.
- Trained Technicians and user community on specific systems and installed equipment. Developed procedures and defined preventative maintenance programs for new equipment.

Device Lead Third Shift

03/2000 to 06/2001 Teleflex Inc. 50 Plantation Dr., Jaffrey, NH

Supervised employees in production of medical device assemblies.

- Submitted performance reviews
- Performed quality control testing
- Supported manufacturing operation in a variety of roles including injection molding machine set up

Supervised cell based production operations involving extruded tubing and plastic injection molding, along with heat forming and deburring steps. Responsible for sign off of initial setup of equipment to product specifications and performing quality tests using Instron strain gauge, optical comparator, Go/No-go gauges, calipers and ruled scale. Setup and monitored Arburg molding machine along with various equipment used in heat forming operation. Maintained training, attendance and performance records used in employee evaluation and created performance reviews.

Technical / Training Coordinator

04/1999 – 05/2009 (Consulted as Parhelion PC 3/2000-06/2001) Technical Graphics Inc. 50 Meadowbrook Dr., Milford, NH

Performed training and operation of equipment producing high quality micro printed film.
Involved in transition from manual control of process to more automated systems. Installed and maintained SCADA network used in maintaining process control parameters and recording values for quality assurance and production metrics. Responsible for operation and repair of computerized optical inspection equipment using high speed high resolution cameras and proprietary template matching algorithms.

Shift Supervisor

05/1996 – 04/1999 Technical Graphics Inc. 50 Meadowbrook Dr., Milford, NH

Primarily coordinated various operations/personnel on night shift.

- Performed maintenance and support functions as needed due to absence of maintenance or engineering staff on night shift
- Responsible for sign off of initial setup of equipment to product specifications
- Trained personnel in all areas of production and finishing of various security products
- Designed graphics using Adobe Illustrator for polymer printing plates
- Operated platemaking equipment and mounted flexographic printing plates
- Operated and maintained code for waste water treatment system

Equipment setup and operation included printing press, micro slitter/ spool winder, lathe, milling machine, drill press, powered hand tools, multi-meters, oscilloscopes, along with metrology instruments such as Instron strain gauge, COF / Peel Tester, calipers, densitometers, spectrophotometer, optical comparators, scaled reticle loupes.

Flexographic Press Operator

05/1995 – 04/1996 Technical Graphics Inc. 50 Meadowbrook Dr., Milford, NH

Operation of custom flexographic printing press producing security strip substrate for currencies.
Learned unique process involving chemical etching of web substrate relying on solutions tightly controlled for pH, specific density, viscosity. Manual testing involved hygrometers, pH meters, litmus paper, viscosity cups, densitometers, spectrophotometer, optical comparators, scaled reticle loupes.

Webtron Press Operator

03/1994 – 05/1995 D.D. Bean and Sons. 207 Peterborough St., Jaffrey, NH

Operation of 8 color flexographic printing press.
Produced high quality four process color printed material for use in large promotional campaigns. Previous printing experience proved instrumental in contributing to the successful operation of a newly installed advanced Webtron printing press. Operated flexographic polymer printing plate maker and mounted 4 color process printing plates.

Assistant Store Manager

10/1993 – 03/1994 Chill Out Convenience West Peterborough, NH

Established and assessed key procedures during initial start-up of retail store.
Setup inventory control and POS computer systems for operation of small convenience store
Operated register and stocked shelves during startup

Lead-Pressman 3rd Shift

10/1985 to 10/1993 Label Art Inc. 1 Riverside Way, Wilton, NH

Responsible for supervision of third shift operations manufacturing high quality printed labels.
Duties involved reading job jackets and signing off on jobs setup by co-workers. Performed quality checks

throughout the shift using densitometers, spectrophotometer, visual comparison to customer proof, testing of die cut quality, and measurement of dimensional characteristics. Other duties involved mounting printing plates on cylinders, and mixing batches of color matched printing ink using Pantone color formulations.

Maintenance Mechanic

06/1980 to 03/1984 — Crotched Mountain Rehabilitation Center — 1 Verney Dr., Greenfield, NH

- **General maintenance and repair of a fleet of vans, trucks, and cars**
- **Assisted electricians, plumbers, and carpenters**
- **Supervised 2nd shift cleaning crew**

Operations involved performing preventive maintenance i.e. oil change, brake inspection and repair, engine tune up (sparkplug, ignition wires, adjustment of timing, etc.). Operated various powered hand tools (impact wrenches, drills, saws, floor buffers, floor scrubbers, etc.).

Education

Completion Date	Issuing Institution	Location	Qualification	Course of Study
05/2005	Keene State College	Keene, NH	2 Years of College	Computer Science
06/1993	NRI Schools	Washington, DC		Microcomputers and Microprocessors

Training

SLC 500 and RSLogix 500 Maintenance and Troubleshooting
RSLogix 5000 Level 1: ControlLogix Fundamentals and Troubleshooting
RSLogix 5000 Level 2: Basic Ladder Logic Programming
RSLogix 5000 Level 3: Project Development
FactoryTalk View ME and PanelView Plus Programming
DeviceNet and RSNetWorx Configuration and Troubleshooting

Detailed References

LeeAnn Clark Moore
Monadnock Community Hospital
Philanthropy & Community Relations
603-924-1700

Thomas Bruneau, Engineering
Crane Security Technologies
1 Cellu Dr., Nashua, NH 03063
603-881-1890

Ray Fangmeyer, General Manager
W S Packaging
1 Riverside Way Wilton, NH 03086
1-800-258-1050

John Parisi
Director Plant Operations
Crotched Mountain Rehabilitation Center
One Verney Drive
Greenfield, NH 03047
603-547-3311 ext. (2120)

JUDY GALLAGHER, MA, M-LADC

EDUCATION AND LICENSURE

MLADC: Master Licensed Alcohol and Drug Counselor - State of New Hampshire — 9/15-Pres.
M.A. Counseling Psychology: Antioch New England, Keene, NH — 1/98-11/00
B.A. Psychology: University of Texas at Dallas, Richardson, TX — 8/94 -8/96

PROFESSIONAL PROFILE

- Qualified in counseling clients diagnosed with severe and persistent mental illness and substance use disorders.
- Adept at client assessments, intakes, treatment and individual service plans, and referrals.
- Training in and implementation of Strength Based Counseling, Motivational Interviewing, Precursors to Change Model, MRT (Moral Reconation Therapy), CBT (Cognitive Behavioral Therapy), Emerge curriculum training (group counseling skills working with domestic violence abusers), DBT (Dialectical Behavioral Therapy), and Mindfulness Based Relapse Prevention.
- Open and effective interpersonal communication skills.
- Excellent computer and organizational skills, file keeping, and assessment writing.
- Clinical Supervision experience and continuing education certificate from Antioch University New England.

PROFESSIONAL EXPERIENCE

*Cheshire County Behavioral Health Court (*Alternative Sentencing, Mental Health Court and Drug Court Programs*)* — Keene, NH

CLINICAL CASE MANAGER: — 06/11-Pres.

- Assess individuals facing criminal charges for substance use disorders and mental illness utilizing the Bio-Psycho-Social interview, Global Appraisal of Individual Needs (GAIN), and/or the Ohio Risk Assessment System (ORAS) tools.
- Develop comprehensive individualized service plans and refer participants to needed community resources.
- Conduct weekly case management meetings, provide brief supportive counseling and crisis intervention, facilitated a relapse prevention group, regularly review progress of the individualized service plan.
- Assist clients with insurance, SSI/SSDI, food stamps and housing applications.
- Maintain ongoing communication and collaboration with community mental health agencies, contracted treatment providers, department of children, youth and family services (DCYF) house of corrections, judicial services and probation and parole.
- Provide updates and clinical summaries to the court with the client present, to inform of their level of progress and ongoing needs.
- Work with and actively involve client's family members, significant others and other support persons in order to increase success in recovery from substance use and mental illness.
- Provide random urinalysis and breathalyzer monitoring.
- Active member and participant in the following: Mental Health Court monthly meetings, Cheshire County Domestic Violence Council (CCDVC) and Offender Rehabilitation Support Team (OREST).
- Provide supervision for Master and Bachelor level interns.
- Planned, developed and fully implemented in 2012-2013, as part of an interdisciplinary team, a Drug Court Program in the Superior Court of Cheshire County.

Serenity Center — Keene, NH

MLADC SUPERVISOR – CONTRACTED POSITION: — 10/17-3/18

- Provided individual and group supervision to recovery coaches working toward their CRSW.

Monadnock Family Services – Emerald House – (Adult Transition Residence) — Keene, NH

09/14-12/17
RESIDENTIAL EDUCATOR – PART TIME/PER DIEM 05/12-05/13
06/00-11/03

Provided supportive supervision and maintain structure of a therapeutic milieu for residents recovering from severe and persistent mental illness, recently discharged from the state hospital and working toward transition into the community
Educated and supported residents in independent living skills
Monitored medication distribution, provide vocational and social skills education, facilitate community integration, and support client management of psychiatric symptoms and overall physical and mental well-being.
Participated in crisis care for residents
Worked as a team member to promote open communication and exceptional client care.
Completed documentation and progress notes in EMR system

State of Vermont (Department of Aging and Independent Living)

Springfield, VT
VOCATIONAL REHABILITATION COUNSELOR 01/11-04/11

- Provided assessment, guidance counseling, and case management to adults with physical, psychiatric, and/or cognitive disabilities including substance abuse and dependence to successfully obtain and maintain employment.
Collaborated with community providers and attended consults to better serve clients
Maintained appropriate documentation and case files
- Referred clients for vocational, medical, substance abuse and mental health services
Attended bi-weekly treatment team meetings.

Washington County Community Corrections Center (Alternative Sentencing Program)

Hillsboro, OR
RESIDENTIAL CASE MANAGER / TREATMENT DORM COUNSELOR 07/04-09/10

Provided addiction treatment, mental health counseling, case management, crisis intervention, education, vocational support/counseling, and program supervision for adults in work release custody who were transitioning into the community and/or participating in the 90-day residential alcohol and drug treatment program.
Conducted intake interviews, mental health and addiction assessments and referred clients to the on-site psychiatrist for medication needs
Created and implemented individualized case plans based on diagnosis and needs assessments
Facilitated psycho-educational groups: Mindfulness Based Relapse Prevention, Matrix Addiction Education, Stages of Change, Coping Skills, Staying Quit.
Interviewed clients at the Washington County Jail for program appropriateness and readiness based on the American Society of Addiction Medicine's (ASAM) criteria and the Level of Service Inventory (LSI)
- Assessed and appropriately assigned client cases to co-counselors and treatment providers
Worked with employers and the on-site job specialist to assist clients with job search activity and retention
Participated in transition meetings with client, recovery mentor, probation officer, aftercare provider, and other support personnel
Referred clients to appropriate agencies for advancement including. housing, mental health, Veteran's services, GED, college education, parenting support and education.
Attended family planning meetings with client, their family, and Department of Human Services (DHS) case workers in order to support and strengthen client's ability toward gaining independence with their children
Wrote psychosocial assessments, individualized treatment plans, treatment summaries, disciplinary, and reports for the Washington County Jail

Phoenix House – (Outpatient and Residential Addiction Services)

Keene, NH
07/01-07/03

CLINICIAN (Outpatient Services–Cheshire Academy Alternative Sentencing Program):
DUAL DIAGNOSIS CLINICIAN (Residential Services).

Provided individual counseling and case management for adults diagnosed with co-occurring disorders
Worked 20 hours in the residential substance abuse recovery program and 20 hours in the outpatient

Cheshire Academy Alternative Sentencing Program
Facilitated psychotherapy and psycho-educational groups including Women in Recovery, Alcohol and Drug Education, Motivation, Relapse Prevention, Relationships, and Skills Group
- Performed client screening, interviews, substance abuse and mental health assessments

Completed paperwork including progress notes, client recommendations and evaluations for the courts
Supervised and implemented community service projects
Provided supervision for master's level counseling and dance movement therapy interns
Created and implemented individualized treatment plans and recommendations for aftercare.
Maintained a positive working relationship with community agencies
Participated in daily treatment team meetings and weekly group supervision
- Functioned as part of an interdisciplinary team

Maintained regular training for continued professional growth.

Riverbend Community Mental Health – (Community Support Program) Concord, NH
08/00-07/01

OUTPATIENT CLINICIAN.

Provided brief and long-term individual therapy to a diverse adult client population Many had co-occurring disorders, and all met the criteria for severe and persistent mental illness.
Facilitated substance abuse, psycho educational, acute stabilization, and mindfulness groups
- Conducted crisis assessments for hospitalization and crisis coverage for co-workers

Evaluated potential clients and determined eligibility based upon therapeutic needs and functional impairments
- Communicated and functioned as part of an interdisciplinary team to effectively treat each client's individual needs.
- Attended DBT training and served as a primary individual DBT therapist for several clients
- Maintained and organized client records in accordance with program policies

Phoenix House Keene, NH
9/99-5/00

COUNSELING INTERN

Provided individual counseling to a diverse adult client population most of them were participating in the Cheshire Academy Alternative Sentencing Program.
- Facilitated and Co-led psycho educational, substance abuse, and psychotherapy groups

Provided case management for one client to assess and encourage progress within the Cheshire Academy court mandated program
- Administered and wrote substance abuse evaluations for clients and the courts which consisted of alcohol and drug screening, bio-psycho-social surveys, client intake assessments, and psychological testing.

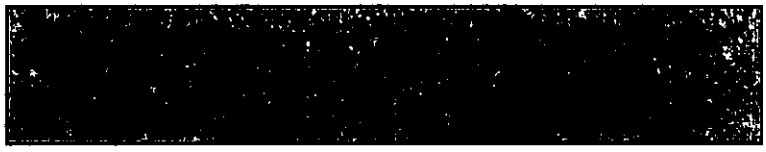
Henry Heywood Hospital – (Mental Health Unit) Gardner, MA
9/98-5/99

COUNSELING INTERN.

- Provided brief individual counseling and support to a diverse adult inpatient client population

Facilitated and co-led psychotherapy, support, and dual diagnosis groups
Conducted and wrote intake interviews, cognitive and psychological assessments, and emergency room evaluations to determine if a client required inpatient services
Assisted with case management, discharge treatment planning, and referrals
Presented client progress to the attending psychiatrist during daily rounds

Tracy Grissom, MA, LCMHC, NCC



EXPERIENCE

Phoenix House, Keene - *New Hampshire Director of Access and Clinical Manager of Keene Residential Program*

JUNE 2017 - PRESENT

- Build and foster relationships with stakeholders
- Uphold clinical framework of residential program
- Communicate the need for treatment by requesting pre-authorizations and concurrent reviews to insurance providers consistent with the ASAM criteria
- Provide administrative and clinical supervision to clinical and non-clinical staff

Meadowview Recovery Residence, Brattleboro, VT - *Program Care Coordinator*

JUNE 2016 - JUNE 2017

- Provided clinical framework and group supervision for staff
- Cultivated and maintained relationships with referral sources
- Coordinated all intakes, discharges, and referrals for program in collaboration with VT Dept of Mental Health and team members
- Assisted in collecting essential data for reporting to the state and agency

Health Care and Rehabilitation Services, Hartford, VT - *Clinician I*

JANUARY 2015 - JUNE 2016

- Completed clinical assessments and formulated diagnosis in accordance with DSM-5
- Maintained accurate and timely clinical documentation in Electronic Medical Record
- Assisted individuals in identifying and prioritizing treatment goals
- Designed client centered treatment plans with specific goals allowing for measurable progress and completion of treatment

Health Care and Rehabilitation Services, Brattleboro, VT - *Case Manager I*

SEPTEMBER 2013 - JANUARY 2015

- Referred individuals to community resources based on presenting need and scheduled required evaluations and assessments
- Promoted independence through skill acquisition in activities of daily living
- Modeled appropriate and healthy boundaries
- Conducted mental health screenings and sub assessments in a timely manner

Education

Antioch University New England, *Master of Arts* in Dance/Movement Therapy and Counseling, MAY 2013

Erica Snyder CRSW

[redacted]

[redacted]

[redacted]

EXPERIENCE

The Grapevine Resource Center- Parent Educator/ Home Visitor
October-2020-present

Provide parent educational groups for family resource centers in person and through zoom. Provide supportive case management in home to families with children.

Sobriety Centers of NH- Residential Program Manager
January 2018-2020

Duties including supervising peer support workers, scheduling group activities. Auditing medication administration records and reporting to the doctor and director. Performing supportive case management to clients with a strong knowledge of DHHS and the recovery community. Maintaining staff professional development and ensuring supervision hours are met. Crossed trained in all Outpatient clinic responsibilities such as Urine Analysis procedures, scheduling and prescription management.

Crotched Mountain — Paraprofessional

February 2010 - 2016

Assisting in school and home activities. Transporting clients to appointments and community events. Skilled in de escalation techniques such as MANDT and gentle teaching.

The GrapeVine — After School Club Assistant

September 2014- June 2016

Over seeing elementary school children during after school hours until parents pick up. Playing structured games and helping with homework.

EDUCATION

High school Diploma

Conval Regional High school
June 2009

CPR certified- present
CRSW-present
Supervising CRSW- present

Dawn L Harland, MD, FACP, FASAM

CV Updated: 01/2020

Education/Post Graduate Training:

University: San Jose State University, San Jose, CA
Degree: BA, 1977-1980
Stanford University, Palo Alto, CA
Fall terms, 1976, 1978

Med School: University of Colorado, Health Sciences Center, Denver, CO
Degree: MD, 1992-1996

Residency: Internal Medicine
Dartmouth Hitchcock Medical Center, Lebanon, NH
Internship and residency, 1996-1999

Fellowship: Cardiology
Dartmouth Hitchcock Medical Center, Lebanon, NH
1999-2000 (partial completion of program)

Subspecialty: Addiction Medicine
10/2015

Licensure and Certification:

Medical License, NH Board of Medicine:
#NH11060, expires 6/30/20

Board Certified, Addiction Medicine:
American Board of Preventive Medicine, #61-1430; 2018

Board Certified, Internal Medicine:
American Board of Internal Medicine, # 192453; 2005, 2015

Diplomate, American Board of Addiction Medicine, #634405; Dec 2015

Licensure and Certification, continued:

DEA, #BH6949551, exp 10/31/21; DATA 2000 waiver 2014: # XH6949551; 275 cap

NPI # 1487742797

BLS, expires 10/2021

Academic Appointments:

Geisel School of Medicine at Dartmouth

2010 - 2015	Assistant Professor of Medicine and Pediatrics
2003 - 2010	Assistant Professor of Medicine
2000 - 2003	Instructor in Medicine and Pediatrics
1999 - 2000	Instructor in Cardiology

Hospital Appointments:

2000 - 2017	Mary Hitchcock Memorial Hospital Dartmouth Hitchcock Medical Center (DHMC) Active Clinical Professional Staff, Assistant Professor Department: Medicine
2001 - 2003	Department of Veterans Affairs Medical Staff with Clinical Privileges White River Junction, VT

Administrative Leadership Positions:

2017 - 2020	Medical Director, Sobriety Centers of NH (SCNH)- Antrim House
2017 - 2018	Medical Director for New England, Groups- Recover Together
2003 - 2011	Assoc Director for Clinical Affairs, Dartmouth College Health Svc
2002 - 2003	Acting Assoc Director for Clinical Affairs, Dartmouth College
2009 - 2011	Physician Director for CME, Regularly Scheduled Series conferences held at the Dartmouth College Health Service
2002 - 2011	Pharmacy and Therapeutics Committee, Co-Chair
2002 - 2011	OSHA - responsible for blood borne pathogen exposure control plan, policy development, implementation and staff education

Current position:

2017 - 2020	SCNH-Antrim House - Medical Director, Residential Treatment and Out-Patient Clinic - Serve as Medical Director, see residential patients weekly, manage all new admissions, prescribe MAT (buprenorphine, naltrexone/ Vivitrol, Sublocade, acamprosate) and necessary meds for comfort and dual diagnoses/primary care needs.

Committees, Innovations, Special Projects:

2017 - 2018	Medical Director for New England, Groups- Recover Together; Developed a program for monthly provider calls, including physicians in NH and ME, to discuss cases, polices, concerns in treatment of opioid use disorder. Co-developed a Peer Review process for 60-70 physicians in NH and Maine, Groups-Recover Together
Sept 2017	Washington DC – On the Hill – Spoke with US Senators and Congressmen, and their aids, about pending legislation - related to healthcare and treatment of opioid use disorder
2010 - 2011	Mental health in primary care at Dartmouth College Health Service – sharing selective mental health records in the EMR
2010 - 2011	Concussion evaluation template development - collaborative effort with Dartmouth College athletic trainers and primary care
2010 - 2011	Implementing PHQ-9 Depression screening at Dartmouth College Health Service
2006 - 2011	Anti-Coagulation Clinic - physician coordinator at Dartmouth College Health Service
2006 - 2011	Travel Clinic – Dartmouth College Health Service, director/ program development
2006 - 2011	Allergy Clinic – Dartmouth College Health Service, director/ desensitization program development
2006 - 2011	Immunization - physician consultant for annual updates
2008 - 2010	Research study co-investigator - "T-Spot Specificity Study in Students at Low Risk for LTBI at a College Health Service"
2006 - 2010	Electronic medical record committee - template design, training, physician liaison for clinicians, business office and pharmacy
2005 - 2010	Collaborative projects with infectious disease faculty at DHMC and Public Health - HPV vaccine trials, meningitis vaccine study, TB studies
2005 - 2010	Search committees for a variety of positions - physician, physician assistant, nurse practitioner, director of disability services, director of Native American studies, athletic trainer
2002 - 2005	Quality improvement committee

Teaching of Dartmouth College Undergraduate Students:

2007	Taught 20 Dartmouth College students in Namibia and So. Africa as part of an Environmental Studies Foreign Study Program.
2003 - 2011	Travel Preventive Medicine - educated groups of students on medical topics prior to foreign travel

Formal Teaching of Residents and Medical Students:

2006 - 2010	Adolescent Health, Eating Disorders - Primary Care Resident sessions - invited to discuss topics annually
2000 - 2002	On Doctoring Program - preceptor for a medical student
2000 - 2002	Cardiac Physical Exam - first year medical students

Clinical Supervisory and Training Responsibilities:

2013 - 2017	Attending Physician - General Internal Medicine, DHMC Direct supervision of Internal Medicine resident physicians
2012	Attending Physician - General Internal Medicine, DHMC Direct supervision of medical student and physician assistant student
2000 - 2011	Attending Physician - Dartmouth College Health Service Direct supervision of Internal Medicine and Pediatric residents. Implemented daily "chart review" sessions for case presentations and informal teaching
2002 - 2011	Clinical Director - Dartmouth College Health Service Direct supervision of clinical staff – physicians, nurse practitioners, PA's, nurses, medical assistants and support staff

Formal Teaching of Peers:

2016	Associate providers, DHMC - Opioid Dependence
2015	Internal Medicine faculty - Buprenorphine for Opioid Dependence
2014	Internal Medicine faculty - The Opioid Crisis
2011	Internal Medicine faculty- Eating Disorders in Primary Care
2010	Depression and Anxiety in Primary Care - including introduction of PHQ-9 survey tool, Health Service staff
2010	Dengue Fever - Case presentation to Infectious Disease staff, DHMC

Formal Teaching of Peers, continued:

2010	Reef Fish and Potential Neurotoxicity - Case presentation to Infectious Disease staff, DHMC
2008	Acute Pulmonary Tuberculosis - Case presentation and discussion
2008	Polio and Rabies – Health Service talk
2006	Atypical Pneumonias – Health Service talk
2004	HIV Seroconversion - Case presentation with staff
2004	Community Acquired Pneumonia – Health Service talk
2003	Antibiotics and Antibiotic Resistance – Health Service talk
2001	Cardiac Auscultation – Health Service talk

Regional Teaching and Presentations:

2008	"The Hook Up Culture"; NE College Health Assoc, Annual Meeting, Mystic, CT
2006	"Pneumonia in the College-Aged Student"; NE College Health Assoc, Annual Meeting, Portland, ME

Clinical Activities:

2017 - 2020	Physician - Residential Treatment – MAT, Mental Health, Sobriety Centers of NH - Antrim House, Antrim, NH
2017 - 2020	Outpatient Clinic Physician – MAT, Mental Health, Sobriety Centers of NH - Antrim House, Antrim, NH
2015 - 2018	Clinic Physician - Addiction, Groups- Recover Together, Keene, NH
2015 - 2017	Clinic Physician - Addiction, ROAD to a Better Life, Lebanon, NH
2015 - 2017	Physician - Resident Supervision, GIM, DHMC, Lebanon,
2011 - 2015	Primary Care Physician - General Internal Medicine, DHMC
2000 - 2011	Primary Care Physician - College Health, Outpatient clinic
2000 - 2011	Inpatient Care Physician - College Health, Infirmary

Professional Affiliations:

2006 – 2020	**Fellow (FACP)** in the American College of Physicians
2015 - 2020	**Fellow (FASAM)** in the American Society of Addiction Medicine
2015 - 2020	**Diplomate (DABAM)** in the American Board of Addiction Medicine
2002 - 2018	Dartmouth Hitchcock Clinic; Senior Member
1997 - 2003	American College of Physicians
2003 - 2011	New England College Health Association, Board Member, 2010 - 2011

Professional Affiliations, continued:

1998 - 2019 NH Medical Society
1992 - 1996 Colorado Medical Society

Awards and Honors:

2005	Affiliate New Professional Award American College Health Association New England College Health Association
1996	Glaser Research Award University of Colorado, School of Medicine
1996	Adler Scholar Award University of Colorado, School of Medicine
1994	Scholarship for Merit, for Excellence in Community Service University of Colorado, School of Medicine
1990 - 1992	Dean's Honor Roll - University of Colorado, Denver, CO
1990 - 1992	National Dean's List - University of Colorado, Denver, CO
1982 - 1983	Dean's Honor Roll - University of Nevada, Reno, NV
1977 - 1980	Dean's Honor Roll - San Jose State University, SJ, CA
1980	BA, with Honors and Great Distinction San Jose State University, San Jose, CA
1976	Valedictorian - Camden High School, San Jose, California

Major Interests:

Opioid, alcohol and stimulant dependence, other substance use disorders, mental illness, trauma, prevention, behavioral health, meditation, healthy lifestyles.

Major Research Experience:

2008 Clinical Research involving Dartmouth College Health Service, Infectious Disease, DHMC, and State of NH.
Evaluation of IGRA specificity in college students at low risk for TB.
Published as co-author in Journal of American College Health

1995 Clinical and basic science research in medical oncology, University of Colorado, Health Sciences Center, Denver, Colorado
Investigation of the molecular mechanism for the occurrence of aggressive carcinoma in burn scars
Published as first author in Journal of Trauma

1995 Walter and Eliza Hall Institute, Melbourne, Australia
Analysis of the molecular structure of the signaling domain of G-CSF receptor in human acute myeloid leukemia
Primary Investigator

Bibliography:

Talbot EA, Harland D, Wieland-Alter W, Burrer S, Adams LV: Specificity of the tuberculin skin test and the T-SPOT.TB assay among students in a low - tuberculosis incidence setting. J Am Coll Health 60(1): 94, 2012.

Harland DL, Robinson WA, Franklin WA: Deletion of the P53 gene in a patient with aggressive burn scar carcinoma. J Trauma 42(1); 104,1997.

Tara S. Abbott

[redacted]

RN

Objective

Seeking an opportunity to obtain a position to apply my education and experience with continued opportunity for growth and knowledge.

Education

Fitchburg State University — **2020-Current**

RN-BSN Program

Mount Wachusett Community College — **2017-2018**

LPN-RN Bridge Program Associates Degree

River Valley Community College-Keene, NH — **2013-2016**

Classes toward completing requirements for Registered Nursing Program

St. Joseph School of Nursing-Nashua, NH — **2010-2011**

Completed LPN Program – Diploma.

Served as class Vice President.

Received Most Dependable Award for class of 2011

Southern New Hampshire University-Manchester, NH — **1998-2000**

Classes working toward a Business Administration Degree

Pinkerton Academy- Derry, NH — **1987-1992**

High School Diploma.

Experience

Cheshire Medical Center-Keene, NH **2019-Current**

Progressive Care Unit RN- Implement total nursing care through the nursing process while communicating effectively with family members and patients. Evaluate and monitor patient response to treatment and progress toward goals. Act as patient advocate; interact in a timely manner between multidisciplinary staff to minimize delays and optimize patient care and efficiency. Administer and execute therapeutic physician and nurse initiated interventions. Worked collaboratively with physicians to discuss and identify patient treatment needs. Modify and individualize care according to patient and family culture, demographics, history and needs.

Cheshire County Department of Corrections-Keene, NH **2011-2019**

Medical Services Coordinator- Department Director – since 2015. Provide nursing services, treatments and preventative procedures appropriate for emergency, acute and chronic care. Responsible for planning, organizing and directing the administration of all medical services. Implemented methods and systems to ensure inmate care and documentation reflect an accurate and complete process with the standard of care. Serve on the Medication Assisted Treatment (MAT) committee for substance abuse ensuring continuity of care in recovery while supporting harm reduction. Responsible for the administration and evaluation of nursing practice and the environment of care including staffing, discharge, scheduling, supervision, evaluation, consultation and education of the nursing staff. Verify, oversee and monitor nursing staff for current nursing license, certifications and CEUs to comply with the NH board of nursing. Oversee Medical Services Administrative Assistant and assign responsibilities. Assess, monitor and coordinate patient health care needs, establish medication administration, safety and control in conjunction with consulting pharmacist and medical staff. Collaboration with facility MD, PA-C, Mental Health, LADCs, case management, DOC administration, community health care providers and US Marshal Services to provide appropriate medical care as needed. Develop and review all medical services policies and procedures.

Aware Recovery Care In-Home Addiction Treatment-Bedford, NH **2/2019-11/2019**

Care Coordinator- Responsible for admission, care management and discharge of a caseload of clients receiving recovery services in the home. Assessment and development of an appropriate treatment plan to meet individual client needs and goals. Regular evaluation of client progress, including crisis intervention as appropriate. Submit timely clinical documentation. Collaboration and coordination of services with the client, family and all providers involved in the treatment plan. Supervision and delegation of the services rendered to the client by the Certified Recovery Advisors (CRA) in accordance with organization policies. Identify client and family needs for services or other community resources and referrals.

Volunteer Work

PCU Practice Council – Cheshire Medical Center, Keene NH	2020-Current
Monadnock Regional Special Olympics	2008- Current
Gym Rats Basketball Association	2017- Current
Serenity Center Keene, NH	2018-2019
Keene Knights Football Association	2014-2016

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Nelson Hayden, LADC	Project Director	$87,505.00	100%	$87,505.00
Laurie Butz-Meyerrose, MLADC	Clinician	$70,699.20	100%	$70,699.20
Heather Trempe, MA	Clinician	$62,920.00	100%	$62,920.00
David Burrows	Peer Recovery Support	$25,708.00	100%	$25,708.00
Erica Snyder	CRSW	$27,456.00	100%	$27,456.00
Vacant	Administrative Asst.	$41,600.00	100%	$41,600.00
Judy Gallagher, MLADC	Clinical Supervisor	$8,736.00	100%	$8,736.00
Dawn Harland, MD	Medical Doctor	$104,000.00	100%	104,000.00
Tara Abbott, RN	Nurse/Care Manager	$63,211.00	100%	$63,211.00
Tracy Grissom	Behavioral Health Clinician	$70,000.00	100%	$70,000.00

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 3rd Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #3") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Wentworth-Douglass Hospital, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 789 Central Ave, Dover, NH 03820.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 31, 2018 (Item #17A), as amended on September 18, 2019, (Item #20), and on June 24, 2020, (Item #31) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Paragraph 3. Renewal, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement and increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $4,109,399.

3. Modify Exhibit A Amendment #1, Scope of Services, by replacing in its entirety with Exhibit A Amendment #3, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.
4. Modify Exhibit B, Methods and Conditions Precedent to Payment, by replacing in its entirety with Exhibit B Amendment #3, Methods and Conditions Precedent to Payment, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein.
5. Modify Exhibit B-1, Budget by reducing the total budget amount by $184,962, which is identified as unspent funding that is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020), as specified, in part, in Exhibit B-4 Amendment #3 NCE.
6. Add Exhibit B-4 Amendment #3 NCE, which is attached hereto and incorporated by reference herein
7. Add Exhibit B-5 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.
8. Add Exhibit B-6 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.
9. Add Exhibit B-7 Amendment #3 GovComm, which is attached hereto and incorporated by reference herein.

10. Add Exhibit B-8 Amendment #3 SOR II, which is attached hereto and incorporated by reference herein.

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective retroactive to September 29, 2020, upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/5/2021
Date

DocuSigned by:
Katja Fox
ED0005B04C83442...
Name: Katja Fox
Title: Director

Wentworth-Douglas Hospital

1/5/2021
Date

DocuSigned by:
Jeffrey Hughes
C0B3EF4C09C8473...
Name: Jeffrey Hughes
Title: Interim President & CEO

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

1/15/2021
Date

DocuSigned by:
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

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

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

1.3. All Exhibits B Amendment #3 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Dover Region with access to referrals to SUD treatment and recovery support services and other health and social services.

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

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

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

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

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

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

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

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

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

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

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

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

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

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

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

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

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

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

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

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

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff; capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

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

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

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

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

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

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

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

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

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

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

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

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

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

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

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

3.1.10.5.4.1.1. A Doorway client;

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

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

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

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

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

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

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service

provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

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

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the Contractor shall proceed in alignment with best practices for the prevention of suicide.

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

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

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

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

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

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

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

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

3.1.11.8.3. Upon discharge from the initially referred service.

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

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

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare,

and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

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

3.3. The Contractor shall provide services in accordance with:

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

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

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

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

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

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

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

4. Subcontracting for the Doorways

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

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

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

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

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

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

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

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

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

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

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

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

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

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

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

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

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

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

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

5.7.4.1. The contract requirements.

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

5.8. The Contractor shall provide staff, subcontractors, or end users as defined in Exhibit K with periodic training in practices and procedures to ensure compliance with information

security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (7) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

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

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

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

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

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

7. Health Insurance Portability and Accountability Act and Confidentiality:

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

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

8. Reporting Requirements.

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

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

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

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

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

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

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s)

must collect and share data with the Department in a format specified by the Department.

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

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

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

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

11.4. The Contractor and referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal

management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

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

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

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

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

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

13. Termination Report/Transition Plan

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

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

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

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

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

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

14. Credits and Copyright Ownership

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

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

15. Operation of Facilities: Compliance with Laws and Regulations

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

16. Equal Employment Opportunity Plan (EEOP)

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

17. Equipment Purchases

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

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

18. Compliance with Federal and State Laws

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

18.2. Time and Manner of Determination.

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

18.3. Documentation

18.3.1. In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The

Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

18.4. Fair Hearings

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

EXHIBIT B Amendment #3

Methods and Conditions Precedent to Payment

1. This Agreement is funded as follows:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI083326.
   1.2. 2.72% Other Funds from Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment Funds. .
2. Governor Commission Funds
   2.1. The Contractor shall utilze funds in Exhibit B-5 Amendment #3 GovComm and Exhibit B-7 Amendment #3 GovComm for the purpose of providing services and supports to clients whose needs to not make them eliglbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit B-1, Budget Sheet, Overnight and Weekend Clinical Telephone Services through Exhibit B-11 Amendment #4 GovComm.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or or payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

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

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

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

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

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

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

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported, including but not limited to:

6.1.3.1. Unallowable expenses that include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

6.1.3.1.7. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference

grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

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

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

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

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

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

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

11. 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.

12. The Contractor must provide the services in Exhibit A, Amendment #3, Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A, Amendment #3, Scope of Services, including failure to submit required monthly and/or quarterly reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

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

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

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

Contractor Name: Wentworth-Douglass Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-08

Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 122,520	$ 12,252	$ 134,772	$ -	$ -	$ -	$ 122,520	$ 12,252	$ 134,772
2. Employee Benefits	$ 36,753	$ 3,675	$ 40,429	$ -	$ -	$ -	$ 36,753	$ 3,675	$ 40,429
3. Consultants	$ 300	$ 30	$ 330	$ -	$ -	$ -	$ 300	$ 30	$ 330
4. Equipment:	$ 6,000	$ 600	$ 6,600	$ -	$ -	$ -	$ 6,000	$ 600	$ 6,600
5. Supplies:	$ 1,600	$ 160	$ 1,760	$ -	$ -	$ -	$ 1,600	$ 160	$ 1,760
6. Travel	$ 500	$ 50	$ 550	$ -	$ -	$ -	$ 500	$ 50	$ 550
7. Occupancy	$ 300	$ 30	$ 330	$ -	$ -	$ -	$ 300	$ 30	$ 330
8. Current Expenses	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 50	$ 5	$ 55	$ -	$ -	$ -	$ 50	$ 5	$ 55
11. Staff Education and Training	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Naloxone	$ 78,495	$ 7,850	$ 86,345	$ -	$ -	$ -	$ 78,495	$ 7,850	$ 86,345
Flex Funds	$ 9,000	$ 900	$ 9,900	$ -	$ -	$ -	$ 9,000	$ 900	$ 9,900
Shelter/Respite Vouchers Funds	$ 15,200	$ 1,520	$ 16,720	$ -	$ -	$ -	$ 15,200	$ 1,520	$ 16,720
TOTAL	$ 271,818	$ 27,182	$ 299,000	$ -	$ -	$ -	$ 271,818	$ 27,182	$ 299,000
Indirect As A Percent of Direct		10.0%							

DS
Contractor Initials JBH
Date 1/5/2021

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

Contractor Name: Wentworth-Douglass Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-08

Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
2. Employee Benefits	$ 300	$ 30	$ 330	$ -	$ -	$ -	$ 300	$ 30	$ 330
3. Consultants	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
4. Equipment:	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
5. Supplies:	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
6. Travel	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
7. Occupancy	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
8. Current Expenses	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
11. Staff Education and Training	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
12. Subcontracts/Agreements	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Naloxone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex Funds	$ 65,000	$ 6,500	$ 71,500	$ -	$ -	$ -	$ 65,000	$ 6,500	$ 71,500
Shelter/Respite Vouchers Funds	$ 61,574	$ 6,157	$ 67,731	$ -	$ -	$ -	$ 61,574	$ 6,157	$ 67,731
TOTAL	$ 128,774	$ 12,877	$ 141,651	$ -	$ -	$ -	$ 128,774	$ 12,877	$ 141,651
Indirect As A Percent of Direct		10.0%							

Contractor Initials: JBH (DS)

Date: 1/5/2021

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

Contractor Name: Wentworth-Douglass Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-08

Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 275,571	$ 27,557	$ 303,128	$ -	$ -	$ -	$ 275,571	$ 27,557	$ 303,128
2. Employee Benefits	$ 82,672	$ 8,267	$ 90,939	$ -	$ -	$ -	$ 82,672	$ 8,267	$ 90,939
3. Consultants	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
4. Equipment:	$ 3,000	$ 300	$ 3,300	$ -	$ -	$ -	$ 3,000	$ 300	$ 3,300
5. Supplies:	$ 5,000	$ 500	$ 5,500	$ -	$ -	$ -	$ 5,000	$ 500	$ 5,500
6. Travel	$ 750	$ 75	$ 825	$ -	$ -	$ -	$ 750	$ 75	$ 825
7. Occupancy	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
8. Current Expenses	$ 200	$ 20	$ 220	$ -	$ -	$ -	$ 200	$ 20	$ 220
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
11. Staff Education and Training	$ 2,216	$ 222	$ 2,438	$ -	$ -	$ -	$ 2,216	$ 222	$ 2,438
12. Subcontracts/Agreements	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Naloxone	$ 200,000	$ 20,000	$ 220,000	$ -	$ -	$ -	$ 200,000	$ 20,000	$ 220,000
Flex Funds	$ 18,000	$ 1,800	$ 19,800	$ -	$ -	$ -	$ 18,000	$ 1,800	$ 19,800
Shelter/Respite Vouchers Funds	$ 38,000	$ 3,800	$ 41,800	$ -	$ -	$ -	$ 38,000	$ 3,800	$ 41,800
TOTAL	$ 628,509	$ 62,851	$ 691,368	$ -	$ -	$ -	$ 628,509	$ 62,851	$ 691,368
Indirect As A Percent of Direct		10.0%							

Contractor Initials: JBH (DS)

Date: 1/5/2021

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

Contractor Name: Wentworth-Douglass Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-08

Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
2. Employee Benefits	$ 300	$ 30	$ 330	$ -	$ -	$ -	$ 300	$ 30	$ 330
3. Consultants	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
4. Equipment:	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
5. Supplies:	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
6. Travel	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
7. Occupancy	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
8. Current Expenses	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
11. Staff Education and Training	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
12. Subcontracts/Agreements	$ 100	$ 10	$ 110	$ -	$ -	$ -	$ 100	$ 10	$ 110
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Naloxone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Flex Funds	$ 20,000	$ 2,000	$ 22,000	$ -	$ -	$ -	$ 20,000	$ 2,000	$ 22,000
Shelter/Respite Vouchers Funds	$ 20,725	$ 2,073	$ 22,798	$ -	$ -	$ -	$ 20,725	$ 2,073	$ 22,798
TOTAL	$ 42,925	$ 4,293	$ 47,218	$ -	$ -	$ -	$ 42,925	$ 4,293	$ 47,218
Indirect As A Percent of Direct		10.0%							

DS
Contractor Initials JBH
Date 1/5/2021

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

Contractor Name: Wentworth-Douglass Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services
SS-2019-BDAS-05-ACCES-08

Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 140,786	$ 14,079	$ 154,865	$ -	$ -	$ -	$ 140,786	$ 14,079	$ 154,865
2. Employee Benefits	$ 42,236	$ 4,224	$ 46,459	$ -	$ -	$ -	$ 42,236	$ 4,224	$ 46,459
3. Consultants	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
4. Equipment:	$ 4,000	$ 400	$ 4,400	$ -	$ -	$ -	$ 4,000	$ 400	$ 4,400
5. Supplies:	$ 2,500	$ 250	$ 2,750	$ -	$ -	$ -	$ 2,500	$ 250	$ 2,750
6. Travel	$ 600	$ 60	$ 660	$ -	$ -	$ -	$ 600	$ 60	$ 660
7. Occupancy	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
8. Current Expenses	$ 400	$ 40	$ 440	$ -	$ -	$ -	$ 400	$ 40	$ 440
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 133	$ 13	$ 146	$ -	$ -	$ -	$ 133	$ 13	$ 146
11. Staff Education and Training	$ 800	$ 80	$ 880	$ -	$ -	$ -	$ 800	$ 80	$ 880
12. Subcontracts/Agreements	$ 1,000	$ 100	$ 1,100	$ -	$ -	$ -	$ 1,000	$ 100	$ 1,100
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Naloxone	$ 90,000	$ 9,000	$ 99,000	$ -	$ -	$ -	$ 90,000	$ 9,000	$ 99,000
Flex Funds	$ 10,000	$ 1,000	$ 11,000	$ -	$ -	$ -	$ 10,000	$ 1,000	$ 11,000
Shelter/Respite Vouchers Funds	$ 19,800	$ 1,980	$ 21,780	$ -	$ -	$ -	$ 19,800	$ 1,980	$ 21,780
TOTAL	$ 314,255	$ 31,425	$ 345,680	$ -	$ -	$ -	$ 314,255	$ 31,425	$ 345,680
Indirect As A Percent of Direct		10.0%							

Contractor Initials: DS JBH

Date: 1/5/2021

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 WENTWORTH-DOUGLASS HOSPITAL is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on February 09, 1905. 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: **68727**

Certificate Number: **0004925098**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 3rd day of June A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Carol Bailey, hereby certify that:

1. I am a duly elected Officer of Wentworth-Douglass Hospital

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 October 5, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Jeffrey Hughes, Interim President & CEO, is duly authorized on behalf of Wentworth-Douglass Hospital to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 12/23/2020

Carol N Bailey

Signature of Elected Officer
Name: Carol Bailey
Title: Board Chairman

CONTROLLED RISK INSURANCE COMPANY OF VERMONT INC. (A Risk Retention Group)
Burlington, Vermont

Evidence of Insurance

WENTWORTH-DOUGLASS HOSPITAL
789 CENTRAL AVENUE
DOVER, NH 03820

Named Insured: THE MASSACHUSETTS GENERAL HOSPITAL **Date:** 11/23/2020

Coverage	**Limits of Liability:**	
Medical Professional Liability:	$5,000,000.00	each "Claim"
	$10,000,000.00	annual aggregate each insured person for all claims made and reported during the "Policy Period".
General Liability:	$5,000,000.00	each "Claim"
Policy Number:	MGH-CRICO-C-GLPL-1626-2021	
Policy Period:	01/01/2021 to 12/31/2021	

Special Provisions:

The insured named above is insured under the policy referenced. Coverage is subject to all the terms, conditions and exclusions of the CRICO policy.

Should the above described policy be canceled before the expiration date thereof, the "Company" will endeavor to mail 30 days written notice to the certificate holder, but failure to mail such notice shall impose no obligation or liability of any kind upon the "Company" or the Risk Management Foundation.

This Evidence of Insurance does not extend any rights to persons or entities who are not "Insured's" under the policy and neither affirmatively nor negatively amends, extends or alters the coverage afforded by the policy. It is furnished as a matter of information only, and is issued with the understanding that the rights and liabilities of the parties will be governed by the original policy.

* CLAIMS MADE AND REPORTED POLICY: This is a claims made and reported policy. Please review the policy carefully.

NOTICE

"The policy pursuant to which this Evidence of Insurance is provided is issued by the "Insured's" risk retention group. The "Insured's" risk retention group may not be subject to all the insurance laws and regulations of your State. State insurance insolvency funds are not available for the "Insured's" risk retention group."

Terms appearing in quotation marks in the Evidence of Insurance shall have the same meaning as the definition of that term in the policy.

Controlled Risk Insurance Company of Vermont, Inc.
(A Risk Retention Group)

Duly Authorized Representative

Rev. 10-2019

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/06/2021

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

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must 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	CONTACT NAME: Willis Towers Watson Certificate Center
Willis Towers Watson Northeast, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	PHONE (A/C, No, Ext): 1-877-945-7378 FAX (A/C, No): 1-888-467-2378 E-MAIL ADDRESS: certificates@willis.com

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

INSURED
Wentworth-Douglass Hospital
789 Central Avenue
Dover, NH 03820

COVERAGES **CERTIFICATE NUMBER:** W19781922 **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A						E.L. EACH ACCIDENT	$
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Employers Liability			AGC4064334	01/01/2021	01/01/2022	Per Occurrence	$1,000,000
	Employers Liability						Aggregate	$1,000,000
	Self Insured Retention						Per Occurrence	$650,000

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

CERTIFICATE HOLDER

NH Department of Health and Human Services
40 Terrell Park Dr
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

WENTWORTH-DOUGLASS HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL SUBSIDIARY

Wentworth-Douglass Hospital
Mission Statement

We partner with individuals and families to attain their highest level of health.

Amended	Ratified
May 4, 1998	April 5, 2003
February 7, 2000	April 5, 2004
May 6, 2002	April 8, 2006
April 2, 2005	April 2, 2007
April 4, 2011	April 7, 2008
January 9, 2017	February 2, 2009
	April 5, 2010
	February 6, 2012
	February 4, 2013
	April 7, 2014
	April 6, 2015
	April 4, 2016
	August 6, 2018
	August 5, 2019

Wentworth-Douglass Hospital
Vision Statement

Wentworth-Douglass Hospital will be the regional hub for health care services on the Seacoast of New Hampshire and York County, Maine. We will be recognized for the breadth of clinical services provided, the quality of clinical outcomes, and the value of health care services delivered.

Amended	Ratified
April 5, 1999	April 5, 2004
June 3, 2002	April 2, 2007
September 12, 2005	April 7, 2008
April 5, 2010	February 2, 2009
February 6, 2012	April 4, 2011
October 6, 2012	February 4, 2013
April 6, 2015	April 7, 2014
January 9, 2017	April 4, 2016
	August 6, 2018
	August 5, 2019

Partners HealthCare System, Inc. and Affiliates

Consolidated Financial Statements
(With Consolidating Financial Information)
September 30, 2019 and 2018

Partners HealthCare System, Inc. and Affiliates
Index
September 30, 2019 and 2018

Report of Independent Auditors

To the Board of Directors of
Partners HealthCare System, Inc.

We have audited the accompanying consolidated financial statements of Partners HealthCare System, Inc. and its affiliates (Partners HealthCare), which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, of changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Partners HealthCare System, Inc. and its affiliates as of September 30, 2019 and 2018, and the results of their operations, changes in net assets and their 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 consolidated financial statements, Partners HealthCare System, Inc. changed the manner in which it presents net assets and reports certain aspects of its financial statements as a not-for-profit entity, and the manner in which it presents the recognition of and measurement of financial assets in 2019. Our opinion is not modified with respect to this matter.

PricewaterhouseCoopers LLP

Boston, Massachusetts
December 6, 2019

Partners HealthCare System, Inc. and Affiliates
Consolidated Balance Sheets
September 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Assets		
Current assets		
Cash and equivalents	$ 283,807	$ 398,413
Investments	2,791,502	1,942,117
Current portion of investments limited as to use	2,235,171	1,465,354
Patient accounts receivable, net	1,129,594	1,078,086
Research grants receivable	136,557	154,449
Other current assets	556,954	517,812
Receivable for settlements with third-party payers	116,791	115,561
Total current assets	7,250,376	5,671,792
Investments limited as to use, less current portion	4,498,716	3,716,162
Long-term investments	1,997,617	1,628,972
Net pledges and contributions receivable, less current portion	284,924	246,951
Property and equipment, net	6,557,206	6,401,710
Other assets	643,534	637,944
Total assets	$ 21,232,373	$ 18,303,531
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term obligations	$ 455,165	$ 459,390
Accounts payable and accrued expenses	790,820	696,890
Accrued medical claims and related expenses	57,550	64,398
Accrued employee compensation and benefits	932,870	854,375
Accrual for settlements with third-party payers	75,287	68,711
Unexpended funds on research grants	262,017	284,178
Total current liabilities	2,573,709	2,427,942
Accrued professional liability	542,136	512,516
Accrued employee benefits	2,410,974	958,275
Interest rate swaps liability	510,579	254,295
Accrued other	187,060	231,954
Long-term obligations, less current portion	5,260,196	4,945,968
Total liabilities	11,484,654	9,330,950
Commitments and contingencies		
Net assets		
Unrestricted	7,358,335	7,073,335
Donor restricted	2,389,384	1,899,246
Total net assets	9,747,719	8,972,581
Total liabilities and net assets	$ 21,232,373	$ 18,303,531

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

Partners HealthCare System, Inc. and Affiliates
Consolidated Statements of Operations
Years Ended September 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Operating revenues		
Net patient service revenue	$ 10,145,150	$ 9,239,118
Premium revenue	791,356	1,420,489
Direct academic and research revenue	1,594,085	1,485,467
Indirect academic and research revenue	463,247	420,559
Other revenue	957,499	741,636
Total operating revenues	13,951,337	13,307,269
Operating expenses		
Employee compensation and benefit expenses	7,110,009	6,635,581
Supplies and other expenses	3,339,331	3,027,832
Medical claims and related expenses	556,110	993,870
Direct academic and research expenses	1,594,085	1,485,467
Depreciation and amortization expenses	686,374	674,030
Interest expense	180,922	180,590
Total operating expenses	13,466,831	12,997,370
Income from operations	484,506	309,899
Nonoperating gains (expenses)		
Income from investments	182,829	198,118
Change in fair value of interest rate swaps	(271,527)	131,182
Other nonoperating income (expenses)	(123,911)	(61,321)
Academic and research gifts, net of expenses	214,267	91,415
Contribution income - affiliates	-	157,312
Total nonoperating gains, net	1,658	516,706
Excess of revenues over expenses	486,164	826,605
Other changes in net assets		
Change in net unrealized appreciation on marketable investments	-	(90,243)
Funds utilized for property and equipment	111,641	39,052
Change in funded status of defined benefit plans	(1,415,364)	399,318
Other changes in net assets	2,478	9,433
Cumulative effect of accounting change	1,100,081	-
Increase in unrestricted net assets	$ 285,000	$ 1,184,165

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

Partners HealthCare System, Inc. and Affiliates
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2019 and 2018

(in thousands of dollars)	Unrestricted	Donor Restricted	Total
Net assets at September 30, 2017	$ 5,889,170	$ 1,574,939	$ 7,464,109
Increases (decreases)			
Income from operations	309,899	-	309,899
Income from investments	198,118	35,691	233,809
Change in fair value of interest rate swaps	131,182	-	131,182
Other nonoperating income (expenses)	(61,321)	143,387	82,066
Academic and research gifts, net of expenses	91,415	-	91,415
Contribution income - affiliates	157,312	166,281	323,593
Change in net unrealized appreciation on marketable investments	(90,243)	8,449	(81,794)
Funds utilized for property and equipment	39,052	(18,598)	20,454
Change in funded status of defined benefit plans	399,318	-	399,318
Other changes in net assets	9,433	(10,903)	(1,470)
Change in net assets	1,184,165	324,307	1,508,472
Net assets at September 30, 2018	7,073,335	1,899,246	8,972,581
Increases (decreases)			
Income from operations	484,506	-	484,506
Income (loss) from investments	182,829	(5,536)	177,293
Change in fair value of interest rate swaps	(271,527)	-	(271,527)
Other nonoperating income (expenses)	(123,911)	379,892	255,981
Academic and research gifts, net of expenses	214,267	-	214,267
Funds utilized for property and equipment	111,641	(83,281)	28,360
Change in funded status of defined benefit plans	(1,415,364)	-	(1,415,364)
Other changes in net assets	2,478	1,880	4,358
Cumulative effect of accounting change	1,100,081	197,183	1,297,264
Change in net assets	285,000	490,138	775,138
Net assets at September 30, 2019	$ 7,358,335	$ 2,389,384	$ 9,747,719

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

Partners HealthCare System, Inc. and Affiliates
Consolidated Statements of Cash Flows
Years Ended September 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Cash flows from operating activities		
Change in net assets	$ 775,138	$ 1,508,472
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Contribution income - affiliates	-	(323,593)
Change in funded status of defined benefit plans	1,415,364	(399,318)
Loss on refunding of debt	836	50,638
Change in fair value of interest rate swaps	271,527	(130,115)
Depreciation and amortization	686,374	674,030
Provision for bad debts	-	165,861
Amortization of bond discount, premium and issuance costs	(10,698)	(9,163)
(Gain) loss on disposal of property	(129)	104
Net realized and change in unrealized appreciation on investments	(381,166)	(270,254)
Cumulative effect of accounting change	(1,297,264)	-
Restricted contributions and investment income	(303,785)	(106,734)
Cash premium upon issuance of bonds	-	140,222
Increases (decreases) in cash resulting from a change in		
Patient accounts receivable	(51,508)	(238,003)
Other assets	(41,960)	(83,911)
Accounts payable and other accrued expenses	136,895	42,430
Accrued medical claims and related expenses	(6,848)	(131,639)
Settlements with third-party payers	(1,887)	9,923
Net cash provided by operating activities	1,190,889	898,950
Cash flows from investing activities		
Purchases of property and equipment	(837,584)	(647,470)
Proceeds from sale of property	410	69
Purchase of investments	(3,653,436)	(3,630,869)
Proceeds from sales of investments	2,561,465	2,891,874
Cash acquired through affiliations, net	-	5,955
Net cash used for investing activities	(1,929,145)	(1,380,441)
Cash flows from financing activities		
Borrowings under line of credit	-	52,848
Repayments under line of credit	(52,848)	-
Payments on long-term obligations	(81,071)	(76,740)
Proceeds from long-term obligations, net of financing costs	559,238	1,350,741
Deposits into refunding trusts	(105,454)	(1,292,796)
Restricted contributions and investment income	303,785	106,734
Net cash provided by financing activities	623,650	140,787
Net decrease in cash and equivalents	(114,606)	(340,704)
Cash and equivalents		
Beginning of year	398,413	739,117
End of year	$ 283,807	$ 398,413

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

(in thousands of dollars)

1. Organization and Community Benefit Commitments

Partners HealthCare System, Inc. (PHS) is the sole member of The Massachusetts General Hospital (MGH), Brigham Health, Inc. (BH), NSMC HealthCare, Inc. (NSMC), Newton-Wellesley Health Care System, Inc. (NWHCS), Foundation of the Massachusetts Eye and Ear Infirmary, Inc. (MEEI), Partners Continuing Care, Inc. (PCC), Partners HealthCare International, LLC (PHI) and Partners HealthCare Insurance Holding Company, LLC (PHIHC) which is the sole corporate member of AllWays Health Partners, Inc. (formerly known as Neighborhood Health Plan, Incorporated). The two physicians who serve as the President and Chief Executive Officer of PHS (PHS CEO) and the Chief Clinical Officer of PHS are the members of Partners Community Physicians Organization, Inc. (PCPO). PHS, together with all of its affiliates, is referred to as "Partners HealthCare."

Partners HealthCare operates academic medical centers, community acute care hospitals, facilities that provide both inpatient and outpatient mental health services, urgent care centers, rehabilitation medicine and long-term care services, physician organizations, a home health agency, nursing homes and a graduate level program for health professions. Partners HealthCare provides services to patients primarily from the Greater Boston area as well as New England and beyond. In addition, Partners HealthCare is a nonuniversity-based non-profit private medical research enterprise and is a principal teaching affiliate of the medical and dental schools of Harvard University. Partners HealthCare operates a licensed, not-for-profit managed care organization and a licensed, for-profit insurance company (collectively referred to as AllWays Health) that provide health insurance products and administrative services to the Massachusetts Medicaid program (MassHealth), ConnectorCare (a state subsidized program for adults who meet income and immigration guidelines) and commercial populations.

Community Benefit
Partners HealthCare's community benefit programs include working with community residents and organizations to make measurable, sustainable improvements in the health status of underserved populations. Partners HealthCare's hospitals and licensed affiliated health centers partner with the community to support low-income, vulnerable families to overcome barriers to health and wellbeing. In addition, Partners HealthCare supports initiatives related to equity, social determinants of health and work force development.

The Massachusetts Attorney General's Community Benefits Guidelines direct non-profit acute care hospitals and health maintenance organizations to prepare annual reports documenting the status and level of their community benefit programs and initiatives. These annual reports serve the important purpose of providing the public with access to useful information about these programs and initiatives. Partners HealthCare files its report annually with the Massachusetts Attorney General. The report summarizes community benefit activities on a system-wide basis. In addition, each of the acute care hospitals within Partners HealthCare has a community benefit planning and service delivery structure and files separate, annual community benefit reports. AllWays Health also files a community benefit report annually.

The New Hampshire Attorney General's Community Benefits Reporting Guide requires hospitals and healthcare charitable trusts to develop a plan and submit a report on their community activities. Wentworth-Douglass Hospital (Wentworth-Douglass) and Wentworth-Douglass Physician Corporation annually file a report with the New Hampshire Office of the Attorney General.

(in thousands of dollars)

Charity Care
Partners HealthCare provides care to all emergent patients regardless of their ability to pay. The cost of providing that care is reflected in the consolidated statements of operations. The cost related to those patients for which Partners HealthCare receives either partial or no reimbursement for healthcare services provided is summarized below.

State Programs
Massachusetts
Massachusetts acute care hospitals are partially reimbursed for charity care services through the statewide Health Safety Net Trust Fund (HSN) established under Massachusetts law. A portion of the funding for the HSN is paid by an assessment on acute care hospitals' charges for private sector payers. The statewide assessment was $165,308 in both 2019 and 2018 and the assessment expense on Partners HealthCare's acute care hospitals was $59,918 and $58,794 in 2019 and 2018, respectively.

Acute care hospitals are reimbursed for charity care based on claims for eligible patients and services that are submitted to and adjudicated by the HSN. Payments are based on Medicare rates and payment policies. The HSN was under-funded by approximately $61,461 and $14,421 in 2019 and 2018, respectively. This shortfall is allocated to acute care hospitals based on their share of total statewide patient care costs with approximately $20,564 and $3,686 in 2019 and 2018, respectively, allocated to Partners HealthCare's acute care hospitals. Each hospital's share of the overall state shortfall cannot exceed its total charity care reimbursement. Hospitals with a high proportion of charity care and government funding receive more favorable reimbursement, including limiting their shortfall allocation to no more than 15% of their payments for charity care. In aggregate, Partners HealthCare's acute care hospitals received charity care funding covering 60% and 72% of the estimated cost of charity care provided in 2019 and 2018, respectively.

The Commonwealth of Massachusetts (the Commonwealth) levies an additional assessment on hospitals that is redistributed to the hospitals based on pay-for-performance criteria. The total assessment was $257,500 in both 2019 and 2018 and the assessment expense on Partners HealthCare's hospitals was $93,053 and $93,041 in 2019 and 2018, respectively. The total amount redistributed to hospitals was $265,000 in both 2019 and 2018 of which Partners HealthCare's hospitals received $56,496 and $61,734 in 2019 and 2018, respectively. Additionally, there is a separate assessment for Partners HealthCare's post-acute hospitals which totaled $6,912 and $7,482 in 2019 and 2018, respectively.

New Hampshire
The State of New Hampshire (New Hampshire) imposes a Medicaid Enhancement Tax (MET) on hospital net patient service revenue. For both of New Hampshire's fiscal years ended June 30, 2019 and 2018, the MET imposed was 5.4%. The amount of MET incurred by Wentworth-Douglass was $18,825 and $14,033 in 2019 and 2018, respectively.

New Hampshire acute care hospitals receive disproportionate share payments based on a portion of their charity care relative to other acute care hospitals. Wentworth-Douglass received $9,097 and $9,796 in 2019 and 2018, respectively.

(in thousands of dollars)

Medicaid
Medicaid is a health insurance program jointly funded by the states and the federal government. Each state administers its own program and sets rules for eligibility, benefits and provider payments within broad federal guidelines and in some cases, including the Commonwealth and New Hampshire, within a Waiver Agreement between each state and the federal government. The program provides health care coverage to low-income adults and children. Eligibility is determined by a variety of factors which include income relative to the federal poverty line, age, immigrant status and assets.

Medicaid payments to Partners HealthCare's providers do not cover the full cost of services provided to Medicaid patients. In aggregate, reimbursement from Medicaid covered approximately 64% and 67% of the estimated cost of services provided in 2019 and 2018, respectively.

Federal Program
Medicare
Medicare is a federally sponsored health insurance program for people age 65 or older, under age 65 with certain disabilities and any age with End-Stage Renal Disease. Medicare's payments historically have not kept pace with increases in the cost of care provided at many hospitals. Additionally, payments to physicians have seen little or no increases over the past several years. Compounding this shortfall in payments is the continued shift of care from higher paying inpatient services to lower paying outpatient services.

Consequently, Medicare payments to Partners HealthCare's providers do not cover the full cost of services provided. In aggregate, reimbursement from Medicare covered approximately 73% and 72% of the estimated cost of services provided in 2019 and 2018, respectively.

(in thousands of dollars)

Summary
For charity care, Medicaid and Medicare, the estimated cost of services provided is either obtained directly from a costing system or based on an entity specific ratio of cost to gross charges. In the latter case, cost is derived by applying this ratio to gross charges associated with providing care to charity care, Medicaid and Medicare patients. The following summarizes, by program, the cost of services provided, net reimbursement and cost of services in excess of reimbursement for each year:

	Years Ended September 30,	
	2019	2018
Cost of services provided		
Charity care	$ 84,758	$ 79,437
Medicaid	1,216,139	1,179,095
Medicare	3,947,938	3,604,603
	$ 5,248,835	$ 4,863,135
Net reimbursement		
Charity care	$ 40,251	$ 45,840
Medicaid	781,013	789,822
Medicare	2,876,749	2,596,740
	$ 3,698,013	$ 3,432,402
Cost of services in excess of reimbursement		
Charity care	$ 44,507	$ 33,597
Medicaid	435,126	389,273
Medicare	1,071,189	1,007,863
	$ 1,550,822	$ 1,430,733

In addition to charity care and inadequate funding from the Medicaid and Medicare programs, there are significant losses related to self-pay patients who fail to make payment for services rendered or insured patients who fail to remit co-payments and deductibles as required under the applicable health insurance arrangement. The estimated cost of providing these services was approximately $70,743 and $60,660 for 2019 and 2018, respectively.

2. Summary of Significant Accounting Policies

Basis of Accounting
The accompanying consolidated financial statements have been prepared on the accrual basis of accounting and include the accounts of PHS and its affiliates. Significant interaffiliate accounts and transactions have been eliminated.

(in thousands of dollars)

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. Actual results could differ from those estimates. Significant estimates are made in the areas of patient accounts receivable, research grants receivable, investments, receivables and accrual for settlements with third-party payers, accrued medical claims and related expenses, accrued employee compensation and benefits, accrued professional liability, interest rate swaps liability and accrued other.

Income Taxes
PHS and substantially all of its affiliates are tax-exempt organizations under Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code (IRC) or disregarded entities for tax purposes.

In December 2017, the U.S. Government enacted comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act (Tax Act). The Tax Act, effective in phases beginning in 2018, made broad and complex changes to the U.S. tax code. Beginning in 2018, the Tax Act required Partners HealthCare to consider certain transportation fringe benefits provided to employees as unrelated business taxable income (UBTI). In addition, beginning in 2019, Partners HealthCare was required to determine unrelated business income or loss on an activity-by-activity basis. Partners HealthCare evaluates opportunities to minimize its tax exposure on UBTI by use of tax credits permitted by the IRC. Total tax expense of $3,750 and $14,856 was recognized for the years ended September 30, 2019 and 2018, respectively.

Adoption of New Accounting Guidance
Partners HealthCare adopted the following new Accounting Standards Updates (ASU) in 2019: *Revenue From Contracts with Customers* (Revenue Standard); *Financial Instruments-Overall: Recognition and Measurement of Financial Assets and Financial Liabilities* (Financial Instruments Standard); *Presentation of Financial Statements for Not-for-Profit entities* (Not-For-Profit Standard); and *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (Contributions Standard).

The Revenue Standard implements a single framework for recognition of all revenue earned from customers in exchange contracts. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services by allocating transaction price to identified performance obligations and recognizing revenue as performance obligations are satisfied. Qualitative and quantitative disclosures are required to enable users of financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The Revenue Standard was adopted on October 1, 2018 using the modified retrospective transition method. The adoption of this standard did not have a significant impact on operations of Partners HealthCare and applicable disclosures have been included.

The Financial Instruments Standard made changes to the recognition of and measurement of financial assets. Partners HealthCare now records marketable investments at fair value with changes in fair value recognized as nonoperating investment income. The Financial Instruments Standard was adopted on October 1, 2018 with prospective application and a cumulative effect adjustment at the date of adoption. The impact of adopting this new accounting guidance resulted in a cumulative effect of accounting change of $1,100,081 to unrestricted net assets and $197,183 to donor restricted net assets.

(in thousands of dollars)

The Not-For-Profit Standard makes targeted changes to the not-for-profit financial reporting model. The primary change under the new guidance is the presentation of two net asset classes versus the previously required three. The guidance also requires new disclosure about information useful for assessing liquidity and availability of resources. The Not-For-Profit Standard was adopted on October 1, 2018 using the retrospective transition method. The adoption of this standard did not have a significant impact on operations of Partners HealthCare.

The Contributions Standard clarifies the definition of an exchange and non-exchange transaction and provides guidance on determining whether a non-exchange transaction (contribution) is conditional or unconditional. The Contributions Standard was adopted on October 1, 2018 using the modified prospective transition method. The adoption of this standard did not have a significant impact on operations of Partners HealthCare.

Fair Value of Financial Instruments
The fair value of financial instruments approximates the carrying amount reported in the consolidated balance sheets for cash and equivalents, investments and investments limited as to use, patient accounts receivable, research grants receivable, accounts payable and accrued expenses and interest rate swaps liability. More information can be found in Note 7, Fair Value Measurements.

Cash and Equivalents
Cash and equivalents represent cash, registered money market funds and highly liquid debt instruments with a maturity at the date of purchase of three months or less. Partners HealthCare's cash and equivalents are maintained with several national banks, and cash deposits typically exceed federal insurance limits. It is Partners HealthCare's policy to monitor these banks' financial strength on an ongoing basis, and no losses have been experienced to date.

Investments
Investments in equity securities with readily determinable fair values, debt securities and alternative investments are measured at fair value. Alternative investments, consisting of various hedge funds, private equity funds, private debt funds, other private partnerships and restricted securities of public companies that are not traded on a national securities exchange, are valued based on amounts reported by the fund manager and evaluated by management. Investments in securities sold short or traded on a national securities exchange are valued based on quoted market prices.

Income from investments (including realized gains and losses, unrealized change in value of investments, interest, dividends and endowment income distributions) is included in excess of revenues over expenses unless the income or loss is restricted by donor or law. Income from investments is reported net of investment-related expenses. Prior to the adoption of the Financial Instruments Standard, the change in net unrealized appreciation on certain marketable investments was excluded from excess of revenues over expenses.

Partners HealthCare has an endowment spending policy for pooled endowment funds. A fixed distribution rate for spending is determined each year which will come from either income and/or net accumulated appreciation.

(in thousands of dollars)

Investments Limited as to Use
Investments limited as to use primarily includes assets whose use is contractually limited by external parties as well as assets set aside by the boards (or management) for identified purposes and over which the boards (or management) retain control such that the boards (or management) may, at their discretion, subsequently use such assets for other purposes. Certain investments corresponding to deferred compensation are accounted for such that all income and appreciation (depreciation) is recorded as a direct addition (reduction) to the asset and corresponding liability.

Derivative Instruments
Derivatives are recognized on the balance sheet at fair value with changes in the fair value recorded in excess of revenues over expenses.

Patient Accounts Receivable
The payments received for healthcare services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care payers, commercial insurance companies and patients are subject to explicit and implicit discounts. These discounts are based on contractual agreements, discount policies and management's assessment of historical experiences and are reflected in the period of service.

Research Grants Receivable
Partners HealthCare receives research funding from departments and agencies of the U.S. Government, industry and other foundation sponsors. Research grants receivable include amounts due from these sponsors of externally funded research. These amounts have been billed or are billable to the sponsor, or in limited circumstances, represent accelerated spending in anticipation of future funding. Research grants receivable are reported at net realizable value.

As of September 30, 2019 and 2018, Partners HealthCare estimates it has approximately $3,760,000 and $3,329,000, respectively, of conditional research grants, subject to government appropriations, for future research to be performed. Timing and amounts of funds received are subject to continued government funding and may change over time.

Other Current Assets
Other current assets include prepaid expenses, inventory, nonpatient receivables, current portion of pledges receivable and premiums receivable. Inventory (primarily supplies and pharmaceuticals) is stated at an average cost or the lower of cost (first-in, first-out method) or market.

Property and Equipment
Property and equipment is reported on the basis of cost less accumulated depreciation. Donated items are recorded at fair value at the date of contribution. All research grants received for capital are recorded in the year of expenditure as a change in unrestricted net assets. Property and equipment is reviewed for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. Depreciation of property and equipment is calculated by use of the straight-line method at rates intended to depreciate the cost of assets over their estimated useful lives, which generally range from three to fifty years. Interest costs incurred on borrowed funds during the period of construction of capital assets are capitalized, net of any interest earned, as a component of the cost of acquiring those assets.

(in thousands of dollars)

Asset Retirement Obligations
Asset retirement obligations, reported in accrued other, are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Any changes to the liability due either to the passage of time, better information or the settlement of an obligation are reflected in the current period.

Other Assets
Other assets consist of long-term receivables, intangible assets, prepaid ground rent, malpractice insurance receivables (Note 16), receivable for settlements with third-party payers and investments in healthcare related limited partnerships. The carrying value of other assets is evaluated for impairment if the facts and circumstances suggest that the carrying value may not be recoverable.

Compensated Absences
In accordance with formal policies concerning vacation and other compensated absences, accruals of $312,312 and $298,910 were recorded as of September 30, 2019 and 2018, respectively.

Unexpended Funds on Research Grants
Research grants received in advance of corresponding grant expenditures are accounted for as a direct addition to investments limited as to use and unexpended funds on research grants.

Self-Insurance Reserves
Partners HealthCare is generally self-insured for employee healthcare, disability, workers' compensation and certain other employee benefits. These costs are accounted for on an accrual basis to include estimates of future payments for claims incurred prior to year end.

Net Assets
Donor restricted net assets include (a) the historical dollar amounts of gifts and the income and gains on such gifts which are required by donors to be retained and (b) gifts and the income and gains on these gifts which can be expended but for which restrictions have not yet been met. Such restrictions include purpose restrictions where donors have specified the purpose for which the net assets are to be spent, or time restrictions imposed by donors or implied by the nature of the gift (capital projects, pledges to be paid in the future and life income funds) or by interpretations of law (gains available for appropriation but not appropriated in the current period). Unrestricted net assets include all of the remaining net assets of Partners HealthCare. More information can be found in Note 18, Net Assets.

Realized gains and losses are classified as unrestricted net assets unless they are restricted by the donor or law. Realized gains and net unrealized appreciation on donor restricted gifts are classified as donor restricted until appropriated for spending by Partners HealthCare in accordance with policies established by Partners HealthCare and applicable Uniform Prudent Management of Institutional Funds Acts (UPMIFA). Net losses on donor restricted endowment funds are classified as a reduction to donor restricted net assets.

(in thousands of dollars)

Contributed Securities
Partners HealthCare's policy is to sell securities contributed by donors upon receipt, unless prevented from doing so by donor request. For the years ended September 30, 2019 and 2018, contributed securities of $59,356 and $64,080, respectively, were received and liquidated. Donors restricted $18,949 and $15,328 of the proceeds received from the sale of these contributed securities for long-term purpose for the years ended September 30, 2019 and 2018, respectively.

Statement of Operations
Activities deemed by management to be ongoing, major and central to the provision of healthcare services, teaching, research activities and health insurance are reported as operating revenues and expenses. Other activities are deemed to be nonoperating and include unrestricted gifts (net of fundraising expenses), external community benefit program support, net change in unexpended academic and research gifts, change in fair value of interest rate swaps, substantially all income (loss) from investments and interest on advanced borrowings. Academic and research gifts largely consist of donor contributions (and the related investment income including realized gains and losses) designated to support the clinical, teaching or research efforts of a physician or department as directed by the donor. These gifts are reported as unrestricted, net of related support expenses, when donor restrictions are of a general nature that are inherent in the normal activities of the organization.

The consolidated statements of operations includes excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, include change in net unrealized appreciation on marketable investments (in 2018), contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for acquisition of such assets), change in funded status of defined benefit plans and cumulative effect of accounting change.

Revenues
To determine the appropriate revenue recognition policy, Partners HealthCare first assesses whether the transaction is an exchange or non-exchange transaction in accordance with accounting guidance. In general, an exchange transaction consists of an exchange of goods and/or services for commensurate value. Transactions that consist of transferring goods and/or services without receiving commensurate value in return are considered non-exchange transactions.

For exchange transactions, revenue is recognized as goods and/or services are provided and is based on the amount expected to be received in exchange for those goods and/or services. Revenue recognized as exchange transactions include: net patient service revenue, premium revenue and other revenue.

Non-exchange transactions include contributions and grants for which the service provider does not receive commensurate value in return for the funding.

Gifts
Gifts are reported as other nonoperating gains in the consolidated statements of operations. Unconditional promises to give cash and other assets to Partners HealthCare are reported at fair value at the date the promise is received. Conditional promises to give are recognized when the conditions are substantially met. Gifts are reported as donor restricted support if they are received with donor stipulations that limit the use of the donated assets. Donor restricted contributions whose restrictions are met within the same year as received are reported as unrestricted gifts in the consolidated statements of operations.

(in thousands of dollars)

Gifts of long-lived assets with explicit restrictions that specify use of assets and gifts of cash or other assets that must be used to acquire long-lived assets are reported as additions to donor restricted net assets if the assets are not placed in service during the year.

Grants
Grants and contracts normally provide for the recovery of direct and indirect costs, subject to audit. Partners HealthCare recognizes revenue associated with direct and indirect costs as direct costs are incurred. The recovery of indirect costs is based on predetermined rates for U.S. Government grants and contracts and negotiated rates for other grants and contracts.

Medical Claims and Related Expenses
AllWays Health contracts with various community health centers, hospital-based primary care physician practices and other health care providers for the delivery of services to its members and compensates these providers on a capitated, fee-for-service, per diem or diagnosis-related group (DRG) basis.

The cost of contracted health care services is accrued in the period in which services are provided and include certain estimated amounts. The estimated liability for medical claims and related expenses is actuarially determined based on analysis of historical claims-paid experience, modified for changes in enrollment, inflation and benefit coverage. The liability for medical claims and related expenses represents the anticipated cost of claims incurred but unpaid at the balance sheet date. The estimates for claims expense may be more or less than the amounts ultimately paid when claims are settled. Such changes in estimates are reflected in the current period in the consolidated statements of operations.

In the normal course of business, AllWays Health identifies and recoups overpayments through reductions in future payments made to providers and hospitals. Such overpayments are the result of, among other things, coordination of benefits and provider claim audits. For the years ended September 30, 2019 and 2018, AllWays Health recorded a reduction in its medical claims expense of $32,213 and $37,061, respectively, for such overpayments. As of September 30, 2019 and 2018, approximately $803 and $2,519, respectively, are recorded as receivables related to such overpayments.

Reinsurance
Reinsurance premiums are reported in medical claims and related expenses and reinsurance recoveries are reported as reductions in medical claims and related expenses.

Settlements
AllWays Health contracts with certain providers at negotiated rates based on historical and anticipated experience. These methods of reimbursement result in settlements based on actual versus anticipated experience which could result in either payments due from (to) these providers. Settlements receivable of $2,423 and $798 were recorded in other current assets as of September 30, 2019 and 2018, respectively. Settlements payable of $701 and $6,259 were recorded in accrued medical claims and related expenses as of September 30, 2019 and 2018, respectively. The settlements are intended to include both reported and unreported incurred claims as of September 30, 2019 and 2018.

(in thousands of dollars)

In 2014, the Affordable Care Act introduced new settlements related to a risk adjustment program, a risk corridor program and a reinsurance program designed to mitigate the transitional impact on insurers for new members. The risk corridor program and reinsurance program ended on December 31, 2016 in accordance with the provision of the Affordable Care Act. AllWays Health's estimated net receivable due from the federal government for these programs was $56,370 and $72,526 at September 30, 2019 and 2018, respectively. Similar to the federal program, Executive Office of Health and Human Services of the Commonwealth (EOHHS) has a risk corridor program, and AllWays Health's estimated net payable due to EOHHS was $7,848 and $388 as of September 30, 2019 and 2018, respectively.

Premium Deficiency Reserves
Premium deficiency reserves are assessed and recognized on a product line basis based upon expected premium revenue, medical expense and administrative expense levels, and remaining contractual obligations using historical experience. There were no premium deficiency reserves as of September 30, 2019 or 2018.

Claims Adjustment Expenses
Claims adjustment expenses (CAE) are those costs expected to be incurred in connection with the adjustment and recording of health claims. AllWays Health has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in medical claims and related expenses in the accompanying consolidated statements of operations. Management believes the amount of the liability for unpaid CAE as of September 30, 2019, is adequate to cover AllWays Health's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified (Note 11).

Recent Accounting Guidance
In February 2016, the FASB issued Accounting Standards Updates (ASU) 2016-02, *Leases (Topic 842)*, which requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments, in its balance sheet. The guidance also expands the required quantitative and qualitative disclosures surrounding leases. The standard is effective for Partners HealthCare in 2020, and management is evaluating the impact of this standard on the consolidated financial statements by reviewing the key terms of all lease contracts and implementing new processes and procedures to comply with this standard.

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits (Topic 715), Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The standard requires that the service cost component be presented in the same line item(s) as other employee compensation costs and that the remaining components be presented separately from those line items and outside of operations. The standard is effective for Partners HealthCare in 2020, and amounts related to non-service cost components of pension expense will be reclassified from employee compensation and benefit expenses to nonoperating gains (expenses). The adoption of this guidance is expected to reduce income from operations and increase nonoperating gains (expenses) with no impact on excess of revenues over expenses in the consolidated statements of operations.

Reclassification
Due to the adoption of new accounting guidance, net asset classes in the 2018 consolidated financial statements have been reclassified to conform with the 2019 presentation.

(in thousands of dollars)

3. Acquisitions

MEEI contributed their net assets to PHS on April 1, 2018. As a result, contribution income recorded at the fair value of contributed net assets on the transaction day is reflected in the consolidated statements of changes in net assets as follows:

Unrestricted net assets (in non-operating gains)	$	157,312
Donor restricted net assets		166,281
	$	323,593

Assets, liabilities and net assets assumed as of the acquisition date are as follows:

Assets		
Cash and cash equivalents	$	11,716
Investments and investments limited as to use		282,733
Patient accounts receivable, net		27,650
Property and equipment, net		190,854
Other assets		67,692
Total assets acquired	$	580,645
Liabilities		
Long-term obligations	$	132,671
Accounts payable and accrued expenses		32,608
Accrued employee compensation and benefits		14,099
Accrual for settlements with third-party payers		4,936
Other liabilities		72,738
Total liabilities assumed		257,052
Net assets		
Unrestricted		157,312
Donor restricted		166,281
Total net assets		323,593
Total liabilities and net assets	$	580,645

(in thousands of dollars)

A summary of the financial results of MEEI from April 1, 2018 through September 30, 2018 included in the consolidated s of operations and changes in net assets is as follows:

Total operating revenue	$ 220,061
Total operating expenses	217,011
Income from operations	3,050
Nonoperating gains, net	5,096
Excess of revenues over expenses	8,146
Other changes	159,180
Increase in unrestricted net assets	$ 167,326

A summary of the consolidated financial results of Partners HealthCare for the year ended September 30, 2018, as if the transaction had occurred on October 1, 2017 is as follows (unaudited):

	2018
Total operating revenue	$ 13,518,035
Total operating expenses	13,210,836
Income from operations	307,199
Nonoperating gains, net	520,708
Excess of revenues over expenses	827,907
Pension related changes	399,318
Other changes	(40,406)
Increase in unrestricted net assets	$ 1,186,819

For the year ended September 30, 2018, Partners HealthCare made multiple smaller acquisitions for a combined purchase price, net of cash acquired, of $5,761. In accordance with accounting standards, the purchase price was allocated first to tangible assets and then intangible assets.

4. Operating Revenues

Net Patient Service Revenue
Partners HealthCare maintains agreements with The Centers for Medicare and Medicaid Services under the Medicare program, the Commonwealth under the Medicaid program and various managed care payers that govern payment for services rendered to patients covered by these agreements. The agreements generally provide for per case or per diem rates or payments based on discounted charges for inpatient care and discounted charges or fee schedules for outpatient care. Certain contracts also provide for payments that are contingent upon meeting agreed upon quality and efficiency measures.

(in thousands of dollars)

Partners HealthCare recognizes net patient service revenue associated with services provided to patients who have third-party payer coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, Partners HealthCare recognizes revenue on the basis of its standard rates (subject to discounts) for services provided. On the basis of historical experience, a significant portion of uninsured patients are unable or fail to pay for the services provided. Consequently, Partners HealthCare determined it has provided implicit discounts to uninsured patients in accordance with the Revenue Standard. These discounts represent the difference between amounts billed to patients and amounts expected to be collected based on historical experience. Prior to the adoption of the Revenue Standard, a provision for bad debts of $165,861 was recorded in 2018 that represented charges for services provided that were deemed to be uncollectible. The following summarizes net patient service revenue, net of contractual allowances and discounts by significant payer:

	Years Ended September 30,			
	2019		2018	
Net patient service revenue (net of contractual allowances and discounts)				
Medicare	$ 2,495,102	24.6%	$ 2,225,006	24.1%
Medicare managed care	446,198	4.4%	345,086	3.7%
Medicaid	651,594	6.4%	560,914	6.1%
Medicaid managed care	151,204	1.5%	194,510	2.1%
Massachusett's managed care organizations	3,970,248	39.1%	3,963,921	42.9%
Other commercial	1,906,389	18.8%	1,436,003	15.5%
All others	524,415	5.2%	513,678	5.6%
Total all payers	$ 10,145,150	100.0%	$ 9,239,118	100.0%

Net patient service revenue includes estimated retroactive revenue adjustments due to future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews and investigations. Contracts, laws and regulations governing the Medicare, Medicaid and charity care programs and managed care payer arrangements are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. A portion of the accrual for settlements with third-party payers has been classified as long-term because such amounts, by their nature or by virtue of regulation or legislation, will not be paid within one year.

(in thousands of dollars)

Third-party payers receivable (accrual) consists of the following:

	September 30, 2019	September 30, 2018
Current portion		
Receivable for settlements with third-party payers	$ 116,791	$ 115,561
Accrual for settlements with third-party payers	(75,287)	(68,711)
	41,504	46,850
Long-term portion		
Receivable for settlements with third-party payers included in other assets	10,776	5,774
Accrual for settlements with third-party payers included in accrued other	(26,989)	(29,220)
	(16,213)	(23,446)
Third-party payers receivable (accrual)	$ 25,291	$ 23,404

Partners HealthCare recognizes changes in third-party payer settlements and other estimates in the year of the change in estimate. For the years ended September 30, 2019 and 2018, adjustments to prior year estimates resulted in an increase to income from operations of $40,448 and $51,677, respectively. Subsequent changes to estimated discounts are generally recorded as adjustments to net patient service revenue in the period of change.

Partners HealthCare provides either full or partial charity care to patients who cannot afford to pay for their medical services based on income and family size. Charity care is generally available to qualifying patients for medically necessary services. Partners HealthCare reports certain bad debts related to emergency services as charity care. As there is no expectation of collection, there is no net patient service revenue recorded related to charity care.

Premium Revenue
Premiums are due monthly and are recorded as earned during the period in which members are eligible to receive services. Premiums received prior to the first day of the coverage period are recorded as unearned premiums in accounts payable and accrued expenses.

Academic and Research Revenue
Academic and research revenue is recognized as either an exchange or non-exchange transaction, depending on the contract type. The following table sets forth total academic and research revenue received by Partners HealthCare by funding source:

	Years Ended September 30, 2019		Years Ended September 30, 2018	
National Institute of Health and other federal agencies	$ 890,493	43.3%	$ 844,826	44.3%
Federal subcontracts	188,008	9.1%	184,134	9.7%
Industry/Corporate	162,670	7.9%	156,536	8.2%
Foundations/non-profits and other sponsors	583,800	28.4%	521,625	27.4%
Total research revenue	1,824,971		1,707,121	
Academic revenue	232,361	11.3%	198,905	10.4%
Total academic and research revenue	$ 2,057,332	100.0%	$ 1,906,026	100.0%

(in thousands of dollars)

Other Revenue
Other revenue includes all other operating revenue sources, the most significant being the following:

	Years Ended September 30, 2019	2018
Specialty and retail pharmacy operations	$ 178,994	$ 70,774
Intellectual property and royalties	96,558	30,287
Parking and office rentals	76,110	73,237
Tuition	61,993	59,109
Outsourced services	38,729	39,132
Cafeteria sales	37,729	34,511
Contract administrative fees	33,410	33,228
International contracts	31,246	32,107
Blood factor sales	27,530	16,713
Accountable care organization administration fees	21,118	14,193
Consulting services	15,004	14,166
Investment income	13,759	13,712
Other	325,319	310,467
Total other revenue	$ 957,499	$ 741,636

5. Liquidity and Availability

Cash and investments are managed centrally by PHS under policies developed by the Investment Committee and reviewed by the Finance Committee of the PHS Board of Directors. Wherever possible, funds are commingled and are assigned to one of three investment pools (the Money Market Pool, the Aggregate Bond Pool and the Long Term Pool, collectively, the Pools) which have been structured to provide a range of investment objectives, risk profiles and rates of return appropriate for Partners HealthCare's assets. Funds are allocated among the Pools based on expected liquidity needs as determined by multi-year financial plans, restrictions and management judgment.

The tiered time horizon structure of the Pools is designed to meet anticipated and contingent liquidity needs. The following table sets forth the periods within which funds are available to meet liquidity needs and Pools, based on redemption provisions with investment managers, from which such funds would be drawn as of September 30, 2019:

Investment Pool	Same Day	1 Week	1 Month	3 Months	1 Year	> 1 Year	Total
Money market	$ 251,956	$ -	$ -	$ -	$ -	$ -	$ 251,956
Aggregate bond	459,594	70,043	60,856	-	-	-	590,493
Long term	31,011	1,593,065	2,236,094	1,716,957	837,611	3,455,405	9,870,143
Total	$ 742,561	$ 1,663,108	$ 2,296,950	$ 1,716,957	$ 837,611	$ 3,455,405	$ 10,712,592
Cumulative total	$ 742,561	$ 2,405,669	$ 4,702,619	$ 6,419,576	$ 7,257,187	$ 10,712,592	

(in thousands of dollars)

As of September 30, 2019, the market value of the Money Market pool was $251,956, all of which was comprised of same day available funds. As of September 30, 2019, the market value of the Aggregate Bond Pool was $590,493, of which $459,594 was comprised of same day available funds, which include cash and U.S. Treasuries. Of the remaining $130,899, $70,043 was comprised of separately managed mortgage and asset-backed securities and corporate bonds which could be liquidated within one week, while $60,856 was invested in a commingled fixed income vehicle which could be liquidated within one month.

As of September 30, 2019, Partners HealthCare also had cash and equivalents not included in the Pools of $198,775 and net patient accounts receivable of $1,129,594 that would be available for general expenditures within one year of the balance sheet date.

In addition, Partners HealthCare maintains a $150,000 Credit Agreement (the Credit Agreement) that provides access to same day funds.

6. Investments and Investments Limited as to Use

Investments are either invested in the Pools or separately managed. Substantially all of the affiliates, along with PHS, participate in the Pools. Their respective ownership interests are tracked and updated monthly and are accounted for using the fair value method. Income (including realized gains and losses) from the Pools is allocated to each participant on a monthly basis based on its proportionate interest in the Pools.

Oversight of the management of Partners HealthCare's investable assets, including the Pools and pension assets, is provided by the Investment Committee of PHS Board of Directors which seeks to achieve incremental returns by manager selection and asset allocation (increasing/decreasing allocations within allowable ranges based on current and projected valuations). The Committee is supported by a professional staff, an outside investment consultant and a pension actuarial consultant.

Partners HealthCare utilizes a target allocation policy and balances projected returns, correlation and volatility of various asset classes within the overall risk tolerance. Asset allocations are managed based on relative valuations among and within asset classes and the perceived ability of managers to outperform passive benchmarks. Exposure by asset class is the sum of allocation to those mangers whose mandates most closely fit the listed asset classes. Asset allocation can and will deviate from target exposures and is regularly monitored for rebalancing.

The Pools invest in a variety of assets which include private partnerships whose assets include equity, fixed income and other investments. As of September 30, 2019, the Pools have unfunded commitments of approximately $1,215,079 which will be drawn down by the various general partners over the next several years. The maximum annual drawdown is expected to be 3% to 5% of investments and investments limited as to use.

(in thousands of dollars)

Investments and investments limited as to use are recorded in the balance sheet as follows:

	September 30, 2019	September 30, 2018
Current assets		
Investments	$ 2,791,502	$ 1,942,117
Current portion of investments limited as to use	2,235,171	1,465,354
	5,026,673	3,407,471
Long-term assets		
Investments limited as to use, less current portion	4,498,716	3,716,162
Long-term investments	1,997,617	1,628,972
	$ 11,523,006	$ 8,752,605

Investments limited as to use consist of the following:

	September 30, 2019		September 30, 2018	
	Current Portion	Long-Term Portion	Current Portion	Long-Term Portion
Internally designated funds				
Reserved for capital expenditures	$ 1,153,160	$ -	$ 885,548	$ -
Unexpended academic and research gifts	-	3,659,920	-	2,951,821
Deferred compensation	-	405,032	-	355,294
Other	612,505	398,384	253,006	377,477
	1,765,665	4,463,336	1,138,554	3,684,592
Externally limited funds				
Unexpended funds on research	282,017	-	284,178	-
Contributions held for others	2,051	-	1,610	-
Professional liability trust fund	-	35,380	-	31,570
Held by trustees under debt and other agreements	205,438	-	41,012	-
	469,506	35,380	326,800	31,570
	$ 2,235,171	$ 4,498,716	$ 1,465,354	$ 3,716,162

(in thousands of dollars)

Investments and investments limited as to use as of September 30, 2018 was reported at either fair value or on the equity or cost methods of accounting. The composition of these investments, segregated between pooled investments and those that are separately invested, was as follows:

	September 30, 2018			
	At Fair Value	On Equity Method	On Cost Method	Total
Pooled Investments				
Invested cash equivalents	$ 47,324	$ -	$ -	$ 47,324
Separately managed investments	1,647,937	-	-	1,647,937
Mutual funds	63,370	-	-	63,370
Commingled funds	1,524,184	-	-	1,524,184
Private partnerships	-	1,889,786	2,702,139	4,591,925
	3,282,815	1,889,786	2,702,139	7,874,740
Separately Invested				
Invested cash equivalents	128,063	-	55	128,118
Equities	6,397	-	49,163	55,560
Fixed income securities	24,176	-	-	24,176
Mutual funds	559,945	-	6	559,951
Other	32,186	-	77,874	110,060
	750,767	-	127,098	877,865
	$ 4,033,582	$ 1,889,786	$ 2,829,237	$ 8,752,605

Separately managed investments include cash and equivalents of $174,368, equities of $915,935 and fixed income securities of $557,634 as of September 30, 2018.

(in thousands of dollars)

Investment income and gains (losses) from cash and equivalents, investments, investments limited as to use and beneficial interests in perpetual trusts comprise the following:

	Years Ended September 30, 2019	2018
Unrestricted		
Dividends, interest and other income	$ 55,891	$ 51,491
Endowment income distributions, net of reinvested gains	57,559	46,234
Net realized gains (losses) on investments		
Realized gains	419,858	273,474
Other-than-temporary impairment	-	(58,845)
Change in unrealized appreciation of investments	(97,045)	66,002
Total investment activity included in excess of revenues over expenses	436,263	378,356
Change in net unrealized appreciation on marketable investments	-	(90,243)
Total unrestricted investment activity	436,263	288,113
Donor restricted		
Dividends and interest income	5,630	24,794
Endowment income distributions	(69,519)	(60,520)
Net realized gains (losses) on investments		
Realized gains	91,044	58,944
Other-than-temporary impairment	-	(8,750)
Change in unrealized appreciation of investments	(32,691)	21,223
Change in net unrealized appreciation on marketable investments	-	8,449
Change in value of beneficial interests in perpetual trusts	916	841
Total donor restricted investment activity	(4,620)	44,981
Total investment income and gains (losses)	$ 431,643	$ 333,094

(in thousands of dollars)

Investment income included in operating results and excess of revenues over expenses comprise the following:

	Years Ended September 30,	
	2019	2018
Investment income included in operations and reported in other revenue	$ 13,759	$ 13,712
Investment income included in nonoperating gains and reported in		
Income from investments	182,829	198,118
Academic and research gifts, net of expenses	239,675	166,526
Total investment activity included in excess of revenues over expenses	$ 436,263	$ 378,356

7. Fair Value Measurements

Fair value 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 (also referred to as exit price). Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. In determining fair value, the use of various valuation approaches, including market, income and cost approaches, is permitted.

Fair Value Hierarchy
A fair value hierarchy has been established based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect the reporting entity's assumptions about the inputs market participants would use. The fair value hierarchy requires the reporting entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. In addition, for hierarchy classification purposes, the reporting entity should not look through the form of an investment to the nature of the underlying securities held by an investee.

The hierarchy is described below.

Level 1 Valuations using quoted prices in active markets for identical assets or liabilities. Valuations of these products do not require a significant degree of judgment. Level 1 assets and liabilities primarily include debt and equity securities that are traded in an active exchange market.

(in thousands of dollars)

Level 2 Valuations using observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities; quoted prices for identical or similar assets or liabilities in markets that are not active; broker or dealer quotations; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities primarily include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities and derivative contracts whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 Valuations using unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the reporting entity's assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Valuation Techniques

Pooled investments, separately invested cash equivalents and debt and equity securities are classified within Level 1 or Level 2 of the fair value hierarchy as they are valued using quoted market prices, broker or dealer quotations, or other observable pricing sources. Certain types of investments are classified within Level 3 of the fair value hierarchy because they have little or no market activity and therefore have little or no observable inputs with which to measure fair value.

The valuation of interest rate swaps is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivatives, including the period to maturity, and uses observable market-based inputs, including interest rate curves and implied volatilities.

(in thousands of dollars)

The following tables summarize fair value measurements as of September 30, 2019 and 2018 for financial assets and liabilities measured at fair value on a recurring basis:

	Fair Value Measurements Using				
	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Investments Valued Using NAV as a Practical Expedient	Fair Value at September 30, 2019
Assets					
Pooled investments					
Invested cash equivalents	$ 77,760	$ 174,195	$ -	$ -	$ 251,955
Separately managed investments	1,697,302	265,838	-	-	1,963,140
Mutual funds	70,043	-	-	-	70,043
Commingled funds	-	1,451,470	-	-	1,451,470
Private partnerships and other	-	-	-	6,975,984	6,975,984
	1,845,105	1,891,503	-	6,975,984	10,712,592
Separately invested					
Invested cash equivalents	124,688	-	-	-	124,688
Equities	36,266	-	-	-	36,266
Mutual funds	534,423	33,874	-	-	568,297
Beneficial interests in perpetual assets	-	-	50,457	-	50,457
	695,377	33,874	50,457	-	779,708
	$ 2,540,482	$ 1,925,377	$ 50,457	$ 6,975,984	$ 11,492,300
Interest rate swaps					
Liabilities		$ (510,579)			$ (510,579)

(in thousands of dollars)

	Fair Value Measurements Using			
	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Fair Value at September 30, 2018
Assets				
Pooled investments				
Invested cash equivalents	$ 14,626	$ 32,698	$ -	$ 47,324
Separately managed investments	1,379,248	268,689	-	1,647,937
Mutual funds	63,370	-	-	63,370
Commingled funds	-	1,524,184	-	1,524,184
	1,457,244	1,825,571	-	3,282,815
Separately invested				
Invested cash equivalents	128,063	-	-	128,063
Equities	6,397	-	-	6,397
U.S. Government and domestic fixed income securities	24,176	-	-	24,176
Mutual funds	559,945	-	-	559,945
Beneficial interests in perpetual assets	-	-	32,186	32,186
	718,581	-	32,186	750,767
	$ 2,175,825	$ 1,825,571	$ 32,186	$ 4,033,582
Interest rate swaps				
Assets		$ 15,243		$ 15,243
Liabilities		(254,295)		(254,295)
Net		$ (239,052)		$ (239,052)

(in thousands of dollars)

8. Pledges and Contributions Receivable

Pledges receivable represent unconditional promises to give and are net of allowances for uncollectible amounts. Pledges are recorded at the present value of their estimated future cash flows. Pledges collectible within one year are classified as other current assets, net of allowances, and total $107,586 and $95,292 as of September 30, 2019 and 2018, respectively. Estimated cash flows due after one year are discounted using published treasury bond and note yields that are commensurate with estimated collection risks. The blended discount rate was 1.6% and 2.9% for 2019 and 2018, respectively. Pledges are expected to be collected as follows:

	September 30, 2019	September 30, 2018
Amounts due		
Within one year	$ 127,396	$ 111,277
In one to five years	178,196	160,865
In more than five years	60,339	67,349
Total pledges receivable	365,931	339,491
Less: Unamortized discount	11,714	20,955
	354,217	318,536
Less: Allowance for uncollectibles	24,138	20,937
Net pledges receivable	330,079	297,599
Contributions receivable from trusts	62,431	44,644
	$ 392,510	$ 342,243

9. Property and Equipment

Property and equipment consists of the following:

	September 30, 2019	September 30, 2018
Land and land improvements	$ 341,650	$ 269,280
Buildings and building improvements	8,287,126	7,961,709
Equipment	2,957,515	2,996,429
Construction in progress	609,146	519,291
	12,195,437	11,746,709
Less: Accumulated depreciation	5,638,231	5,344,999
Property and equipment, net	$ 6,557,206	$ 6,401,710

(in thousands of dollars)

Depreciation expense for the years ended September 30, 2019 and 2018 was $681,807 and $670,132, respectively. Interest costs, net of interest earned, aggregating $7,406 and $5,032 were capitalized in 2019 and 2018, respectively.

For the years ended September 30, 2019 and 2018, fully depreciated assets with an original cost of $388,575 and $295,348, respectively, were written off.

10. Levels of Capital and Surplus

Risk-based capital (RBC) is a methodology adopted by the National Association of Insurance Commissioners (NAIC) for determining the minimum level of capital and surplus deemed necessary for an insurer based upon the types of assets held and business written. Pursuant to a guaranty entered into by PHS when it acquired AllWays Health in 2012 (the RBC Guaranty), PHS has committed to maintain AllWays Health's capital and surplus at a specified minimum level, measured quarterly in accordance with an RBC methodology permitted by the Massachusetts Division of Insurance (DOI). The RBC Guaranty may be enforced by the DOI. In 2019, AllWays Health returned capital of $100,000 to PHS. In 2018, PHS provided capital to AllWays Health of $4,000. AllWays Health's current contract with EOHHS requires AllWays Health to maintain a minimum net worth and/or financial insolvency insurance in an amount equal to the Minimum Net Worth calculation as defined in Massachusetts General Law 176G, Section 25. At December 31, 2018 and 2017 (AllWays Health's statutory year end), the minimum net worth requirement, as determined in accordance with EOHHS guidelines, was $64,942 and $143,774, respectively. AllWays Health's statutory net worth was $271,421 and $337,126 at December 31, 2018 and 2017, respectively, and thus exceeded the EOHHS requirements by $206,479 and $193,352, respectively.

11. Accrued Medical Claims and Related Expenses

Accrued medical claims and related expenses include estimates of expected trends in claims severity, frequency, and other factors, which could vary as the claims are ultimately settled and are based principally upon historical experience. For the years ended September 30, 2019 and 2018, changes in estimates resulted in a decrease of accrued medical claims and related expense of $3,613 and $7,796, respectively. Increases (decreases) of this nature occur as the result of claim settlements and recoveries during the current year and as additional information is received regarding individual claims, causing changes from the original estimates of the cost of these claims. Ongoing analysis of the recent loss development trends is also taken into account in evaluating the overall adequacy of the reserves.

(in thousands of dollars)

Changes in accrued medical claims and related expenses are as follows:

	2019	2018
Balance at beginning of year	$ 64,398	$ 196,037
Less:		
Accrual for claims adjustment expenses	(994)	(3,523)
Accrued medical payables - other	(9,874)	(7,197)
Plus: Settlements payable, net	30,506	18,286
Net balance at beginning of year	84,036	203,603
Incurred related to		
Current year	559,723	1,001,666
Prior years	(3,613)	(7,796)
Total incurred	556,110	993,870
Paid related to		
Current year	487,195	935,878
Prior years	63,985	177,559
Total paid	551,180	1,113,437
Net balance at end of year	88,966	84,036
Plus:		
Accrual for claims adjustment expenses	3,040	994
Accrued medical payables - other	1,154	9,874
Less: Settlements payable, net	(35,610)	(30,506)
Balance at end of year	$ 57,550	$ 64,398

Medical claims and related expenses in the accompanying consolidated statements of operations include other nonclaims related costs. These nonclaims related expenses were for directly delivered services and medical cost risk sharing and incentives.

(in thousands of dollars)

12. Long-Term Obligations

Long-term obligations issued by PHS and its affiliates consist of the following:

	September 30, 2019	September 30, 2018
Massachusetts Health and Educational Facilities Authority (Authority) Revenue Bonds		
Series F*, variable interest rate of 1.71% and 1.57%, final maturity in 2040	$ 231,300	$ 232,850
Series G*, variable interest rate of 1.90% and 1.61%, final maturity in 2042	75,000	75,000
Series H*, variable interest rate of 1.38% and 1.59%, final maturity in 2042	167,700	170,005
Series I*, average fixed interest rate of 4.76%, final maturity 2020	18,175	29,480
Series J*, average fixed interest rate of 5.00%, final maturity in 2024	49,035	70,370
Series P*, variable interest rate of 1.54% and 1.52%, final maturity in 2027	150,000	150,000
Massachusetts Development Finance Agency (Agency) Revenue Bonds		
Series K*, average fixed interest rate of 4.75%, variable interest rate of 1.56% and 1.53%, final maturity in 2046	122,170	136,360
Series L, average fixed interest rate of 4.93%, final maturity in 2032	87,705	95,065
Series M*, average fixed interest rate of 4.96%, variable interest rate of 1.75% and 1.59%, final maturity in 2048	295,000	347,500
Series N*, variable interest rate of 2.06% and 2.07%, final maturity in 2044	131,300	132,850
Series O*, average fixed interest rate of 4.58%, variable interest rate of 2.06% and 2.04%, final maturity in 2050	307,840	312,040
Series Q*, average fixed interest rate of 4.80%, final maturity in 2047	420,280	422,695
Series R*, variable interest rate of 1.97% and 1.99%, final maturity in 2052	100,000	100,000
Series S*, average fixed interest rate of 4.63%, variable interest rate of 2.05% and 2.03%, final maturity in 2047	942,850	948,105
Series T*, variable interest rate of 2.12%, final maturity of 2049	158,250	-
MEEI Series D*, variable rate of n/a and 3.31%, final maturity in 2038	-	54,703
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2017, average fixed interest rate of 5.00%, final maturity in 2041	97,405	99,565
PHS Taxable Debt		
Series 2007 taxable bonds, fixed interest rate of 6.26%, final maturity in 2037	100,000	100,000
Series 2011 taxable bonds, fixed interest rate of 3.44%, final maturity in 2021	250,000	250,000
2012 Taxable Senior Notes, fixed interest rate of 4.11%, final maturity in 2052	400,000	400,000
2014 Taxable Senior Notes, fixed interest rate of 4.73%, final maturity in 2044	150,000	150,000
Series 2015 taxable bonds, fixed interest rate of 4.12%, final maturity in 2055	300,000	300,000
2016 Taxable Senior Notes, fixed interest rate of 3.89%, final maturity in 2046	225,000	225,000
Series 2017 taxable bonds, fixed interest rate of 3.77%, final maturity in 2048	303,644	303,644
2018 Taxable Senior Notes, fixed interest rate of 4.60%, final maturity in 2049	400,000	-
Other obligations	6,912	10,308
Line of credit	-	52,848
Capital lease obligations	1,870	3,181
Total long-term obligations, par value	5,491,436	5,171,569
Unamortized discounts and premiums, net	247,170	259,487
Deferred financing costs	(23,245)	(25,698)
Total long-term obligations, net	5,715,361	5,405,358
Less: Current portion	455,165	459,390
	$ 5,260,196	$ 4,945,968

* Denotes series is issued in multiple subseries.
Variable interest rates are presented at September 30, 2019 and 2018, respectively.

(in thousands of dollars)

Aggregate maturities and payments of long-term obligations during the next five years and thereafter (including the impact of unamortized discounts and premiums, net and deferred financing costs) and other amounts classified as current liabilities, are as follows:

	Scheduled Maturities	Bonds Supported by Partners HealthCare Liquidity	Bonds Supported by Bank Facilities	Total
2020	$ 83,720	$ 215,195	$ 156,250	$ 455,165
2021	332,354	-	-	332,354
2022	101,303	-	-	101,303
2023	103,969	-	-	103,969
2024	109,812	-	-	109,812
Thereafter	4,612,758	-	-	4,612,758
	$ 5,343,916	$ 215,195	$ 156,250	$ 5,715,361

The scheduled maturities represent annual payments as required under debt repayment schedules. The current portion of long-term obligations includes the payments scheduled to be made in 2020, bonds supported by Partners HealthCare liquidity that can be tendered prior to September 30, 2020, and bonds supported by bank facilities with financial institutions (standby bond purchase agreements or letters of credit) that expire prior to September 30, 2020. The bonds supported by Partners HealthCare liquidity provide the bondholder with an option to tender the bonds to Partners HealthCare. Accordingly, these bonds are classified as a current liability. The bonds supported by bank facilities provide the bondholder with an option to tender the bonds to the liquidity provider. Generally accepted accounting principles require bonds backed by bank facilities expiring within one year of the balance sheet date as well as potential principal amortization under bank facilities' term out provisions due within one year of the balance sheet date to be classified as a current liability.

If bonds supported by bank facilities cannot be remarketed the repayment terms of those bank facilities could result in repayments of $56,250 in 2020, $156,961 in 2021, $106,961 in 2022, $44,461 in 2023, $11,111 in 2024 and $5,556 thereafter. If the bonds supported by Partners HealthCare liquidity cannot be remarketed, payments on these bonds would include $215,195 in 2020, $86,600 in 2021, $50,230 in 2022, $119,870 in 2023, $69,250 in 2024 and $191,935 thereafter.

(in thousands of dollars)

Scheduled maturities of long-term debt for each of the next five years (excluding the impact of unamortized discounts and premiums, net and deferred financing costs), assuming bonds backed by bank facilities are remarketed and the standby purchase agreements are renewed and bonds supported by Partners HealthCare liquidity are remarketed, are as follows:

2020	$ 83,720
2021	334,959
2022	104,108
2023	106,974
2024	112,917
Thereafter	4,748,757
	$ 5,491,435

Interest expense paid during the years ended September 30, 2019 and 2018 was $230,348 and $201,628, respectively.

In January 2019, PHS issued $158,250 of Partners HealthCare System Series 2019 T Revenue Bonds. The bond proceeds were used to refund Massachusetts Eye and Ear Infirmary Series D Bonds ($55,402), refund Series M-2 Bonds ($50,000) and repay the borrowing under the Credit Agreement ($52,848).

In December 2018 and January 2019, PHS issued $350,000 and $50,000, respectively, of Partners HealthCare System 2018 Taxable Senior Notes. Proceeds from the notes will be used to finance certain capital projects.

In December 2017, PHS issued $948,105 of Partners HealthCare System Series 2017 S Revenue Bonds, plus bond premium of $122,734. The bond proceeds, net of issuance costs of $5,359 were used to refund portions of Series G ($191,532), Series I ($111,556), Series J ($344,484), Series K ($44,331), Series L ($231,658) and Series M ($141,920).

In December 2017, PHS issued $99,565 of Partners HealthCare System Series 2017 NH Revenue Bonds, plus bond premium of $17,488. The bond proceeds, net of issuance costs of $562 were used to refund Wentworth-Douglass Hospital Series 2011 ($97,206), Series 2016A ($14,325) and Series 2016B ($4,960).

In December 2017, PHS issued $303,644 of Partners HealthCare System Series 2017 Taxable Bonds. The bond proceeds, net of issuance costs of $1,943, were used to refund portions of Series K Bonds ($50,054) and to finance certain capital projects ($251,647).

Partners HealthCare bonds are general obligations of PHS supported by guarantees from BH, The Brigham and Women's Hospital, Inc., MGH and The General Hospital Corporation which may be suspended under certain conditions.

PHS and affiliate debt agreements contain certain covenants, including a minimum debt service coverage ratio and limitations on additional indebtedness and asset transfers.

(in thousands of dollars)

Credit Agreement
Partners HealthCare maintains a $150,000 Credit Agreement that provides access to same day funds. Advances under the Credit Agreement bear a variable rate of interest based on the London Interbank Offered Rate (LIBOR). As of September 30, 2019, there were no amounts outstanding under the Credit Agreement. The Credit Agreement expires in June 2020.

13. Derivatives

Interest Rate Swaps
Partners HealthCare utilizes swap contracts to manage fluctuations in cash flows resulting from interest rate risk on certain of its variable rate bonds. These bonds expose Partners HealthCare to variability in interest payments due to changes in interest rates. Management believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, Partners HealthCare entered into various swap contracts involving the exchange of fixed rate payments by Partners HealthCare for variable rate payments from several counterparties based on a percentage of LIBOR.

By using swap contracts to manage the risk of changes in interest rates, Partners HealthCare exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the swap contracts. When the fair value of a swap contract is positive, the counterparty has a liability to Partners HealthCare, which creates credit risk. Partners HealthCare minimizes its credit risk by entering into swap contracts with several counterparties and requiring the counterparty to post collateral for the benefit of Partners HealthCare based on the credit rating of the counterparty and the fair value of the swap contract. Conversely, when the fair value of a swap contract is negative, Partners HealthCare has a liability to the counterparty and, therefore, it does not possess credit risk. Under certain circumstances, Partners HealthCare may be required to post collateral for the benefit of the counterparty. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

(in thousands of dollars)

The following is a summary of the outstanding positions under these swap contracts as of September 30, 2019:

Effective Date	Notional Amount	Maturity	Rate Paid	Rate Received
5/1/03	$ 150,000	7/1/35	4.40%	67% 1-month LIBOR
10/15/03	9,945	1/1/31	3.85%	70% 1-month LIBOR
7/1/05	150,000	7/1/40	3.63%	67% 1-month LIBOR
7/1/05	22,400	7/1/25	5.11%	67% 6-month LIBOR
9/1/05	3,350	1/1/23	3.26%	70% 1-month LIBOR
7/1/07	150,000	7/1/42	3.46%	67% 1-month LIBOR
7/1/09	100,000	7/1/44	3.71%	67% 1-month LIBOR
7/1/11	100,000	7/1/46	3.74%	67% 1-month LIBOR
7/1/13	100,000	7/1/48	3.80%	67% 1-month LIBOR
7/1/15	50,000	7/1/50	3.80%	67% 1-month LIBOR
4/1/16	100,000	7/1/52	3.76%	67% 1-month LIBOR
7/1/17	50,000	7/1/52	3.74%	67% 1-month LIBOR
7/1/19	50,000	7/1/49	1.85%	67% 1-month LIBOR
7/1/21	50,000	7/1/51	1.84%	67% 1-month LIBOR
7/1/23	50,000	7/1/53	1.82%	67% 1-month LIBOR
7/1/24	100,000	7/1/54	1.81%	67% 1-month LIBOR
7/1/25	50,000	7/1/55	1.77%	67% 1-month LIBOR
7/1/26	100,000	7/1/56	1.78%	67% 1-month LIBOR
7/1/27	100,000	7/1/57	1.78%	67% 1-month LIBOR
	$ 1,485,695			

Partners HealthCare's swap contracts contain provisions that require collateral to be posted if the fair value of the swap exceeds certain thresholds. The collateral thresholds reflect the current credit ratings issued by major credit rating agencies on Partners HealthCare's and the counterparty's debt. Declines in Partners HealthCare's or the counterparty's credit ratings would result in lower collateral thresholds and, consequently, the potential for additional collateral postings by Partners HealthCare or the counterparty. As of September 30, 2019 and 2018, Partners HealthCare had posted collateral of $204,916 and $40,279, respectively. Partners HealthCare has established procedures to ensure that liquidity and securities are available to meet collateral posting requirements.

Upon the occurrence of certain events of default or termination events identified in the swap contracts, either Partners HealthCare or the counterparty could terminate the contracts in accordance with their terms. Termination results in the payment of a termination amount by one party that attempts to compensate the other party for its economic losses. If interest rates at the time of termination are lower than those specified in the swap contract, Partners HealthCare would make a payment to the counterparty. Conversely, if interest rates at such time are higher, the counterparty would make a payment to Partners HealthCare.

(in thousands of dollars)

14. Commitments

Leases
Partners HealthCare has capital and noncancelable operating leases for certain buildings and equipment. Minimum future lease commitments under noncancelable leases for the next five years and thereafter are as follows:

	Capital Leases	Operating Leases
2020	$ 1,170	$ 185,630
2021	754	171,807
2022	-	151,033
2023	-	137,278
2024	-	112,198
Thereafter	-	539,233
Total lease payments	1,924	$ 1,297,179
Less: Amount representing interest	54	
Capital lease obligations at September 30, 2019	$ 1,870	

Rental expense under operating leases approximated $192,208 and $187,800 in 2019 and 2018, respectively.

15. Pension and Postretirement Healthcare Benefit Plans

Substantially all employees of Partners HealthCare are covered under noncontributory defined benefit pension plans and various defined contribution pension plans. In addition, certain affiliates provide subsidized healthcare benefits for retired employees on a self-insured basis, with the benefit obligation being partially funded. These retiree healthcare benefits are administered through an insurance company and are accounted for on the accrual basis, which includes an estimate of future payments for claims incurred.

In 2019, a voluntary retirement program was offered to a sub-set of Newton-Wellesley Hospital employees who met specific criteria. For those employees who accepted the voluntary retirement package, the benefits of this program were conveyed as increased contributions to the defined benefit pension plan and the postretirement health plan. The total cost of this program was approximately $31,803, of which approximately $29,266 was for the defined benefit plan and $2,537 was for the postretirement plan. In September 2019, approximately $28,400 was funded into the defined benefit plan related to this program with the remaining $866 being funded in October 2019.

(in thousands of dollars)

Total expense for these plans consists of the following:

	Years Ended September 30, 2019	2018
Defined benefit plans	$ 256,768	$ 276,619
Defined contribution plans	179,195	166,743
Postretirement healthcare benefit plans	(110)	(3,345)
	$ 435,853	$ 440,017

Information regarding benefit obligations, plan assets, funded status, expected cash flows and net periodic benefit cost follows within this footnote.

Benefit Obligations

	Defined Benefit Pension Plans		Postretirement Healthcare Benefit Plans	
	2019	2018	2019	2018
Change in benefit obligations				
Benefit obligations at beginning of year	$ 7,028,994	$ 6,916,236	$ 171,425	$ 161,100
Service cost	324,429	329,653	3,105	3,157
Interest cost	309,280	278,872	6,618	4,902
Plan amendments (gain) loss	827	(6,487)	-	-
Actuarial (gain) loss	1,231,610	(309,035)	17,396	511
Special termination benefits	29,266	-	2,537	-
Benefits paid	(227,558)	(307,111)	(8,464)	(7,851)
Expenses paid	(13,017)	(15,760)	-	-
Employee contributions	129	142	8,620	9,606
Acquisition	-	142,484	-	-
Benefit obligations at end of year	$ 8,683,960	$ 7,028,994	$ 201,237	$ 171,425

The accumulated benefit obligation for all defined benefit pension plans at the end of 2019 and 2018 was $8,267,644 and $6,695,351, respectively.

	Defined Benefit Pension Plans		Postretirement Healthcare Benefit Plans	
	2019	2018	2019	2018
Weighted-average assumptions used to determine end of year benefit obligation				
Discount rate	3.40%	4.31%	3.05% - 3.30%	3.80% - 4.30%
Rate of compensation increase	3.00% - 4.45%	3.00% - 4.45%	N/A	N/A
Postretirement healthcare cost trend rate for next year	N/A	N/A	5.50%	6.00%
Rate to which the cost trend rate is to decline	N/A	N/A	5.00%	5.00%
Year that rate reaches the ultimate trend rate	N/A	N/A	2020	2020

(in thousands of dollars)

Assumed healthcare cost trend rates have a significant effect on the amounts reported for the postretirement healthcare plans. A one-percentage-point change in assumed healthcare cost trend rates would have the following effect:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
Effect on postretirement benefit obligation	$ 3,321	$ (3,734)

Plan Assets

	Defined Benefit Pension Plans		Postretirement Healthcare Benefit Plans	
	2019	2018	2019	2018
Change in plan assets				
Fair value of plan assets at beginning of year	$ 6,527,812	$ 6,039,237	$ 117,742	$ 103,262
Actual return on plan assets	253,581	422,552	(534)	5,391
Employer contributions	258,277	288,643	4,408	7,334
Employee contributions	129	142	8,620	9,606
Benefits paid	(227,558)	(307,111)	(8,464)	(7,851)
Expenses paid	(13,017)	(15,760)	-	-
Acquisition	-	100,109	-	-
Fair value of plan assets at end of year	$ 6,799,224	$ 6,527,812	$ 121,772	$ 117,742

The assets of the defined benefit pension plans are aggregated in a single master trust (Master Trust) and managed as one asset pool. The investment objective for the Master Trust is to achieve the highest reasonable total return after considering (i) plan liabilities, (ii) funding status and projected cash flows, (iii) projected market returns, valuations and correlations for various asset classes and (iv) ability and willingness to incur market risk.

Within the Master Trust, assets are allocated to managers with investment mandates that may range from a single sub-asset class to very broad mandates; with restrictions that range from long-only to unconstrained; and with management structures ranging from separately managed funds to mutual/commingled funds to private partnerships. Less market sensitive managers employ long/short equity and diversified strategies. Investment risks (concentration, correlation, valuation, liquidity, leverage, mandate compliance, etc.) are monitored at the manager level as well as the pool level.

(in thousands of dollars)

The following table presents the capital allocations, reported exposures of the allocations and policy benchmarks by manager mandate within the Master Trust. Some managers, particularly less market sensitive managers, invest capital among multiple asset classes. Beginning in October 2018, the Long Term Policy Benchmark is 70% Morgan Stanley Capital International All Country World Index and 30% Barclays Global Aggregate Bond. Prior to October 2018, the Long Term Policy benchmark was set annually as a policy weighted calculation of multiple and private benchmarks and the weight of these benchmarks was changed each fiscal year at the direction of the PHS Investment Committee.

	September 30, 2019		September 30, 2018		
	Dollars	Reported Exposures	Dollars	Reported Exposures	Policy Benchmark
Global equity	$ 865,191	12.7 %	$ 834,907	12.8 %	11.0 %
Traditional U.S. equity	750,220	11.2 %	832,940	12.8 %	13.0 %
Traditional foreign developed equity	781,198	11.5 %	812,674	12.4 %	12.0 %
Traditional emerging markets equity	713,761	10.5 %	770,919	11.8 %	13.0 %
Private equity	763,774	11.2 %	580,925	8.9 %	8.0 %
Real assets	271,875	4.0 %	223,624	3.4 %	3.0 %
Less Market Sensitive managers	2,287,076	33.6 %	2,198,471	33.7 %	35.0 %
Fixed income managers	358,123	5.3 %	273,352	4.2 %	5.0 %
	$ 6,799,224	100.0 %	$ 6,527,812	100.0 %	100.0 %

The postretirement healthcare benefit plans assets are invested in commingled funds with the objective of achieving returns to satisfy plan obligations and with a level of volatility commensurate with Partners HealthCare's overall financial profile.

The following table presents plan assets, by type of investment, as of September 30, 2019 and 2018 measured at fair value on a recurring basis using the fair value hierarchy defined in Note 7:

	Fair Value Measurements Using			
	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Investments Valued Using NAV as a Practical Expedient	Fair Value at September 30, 2019
Defined benefit pension plans				
Invested cash equivalents	$ 103,891	$ -	$ -	$ 103,891
Separately managed investments	666,531	191,541	310	858,382
Commingled funds	-	1,506,425	-	1,506,425
Private partnerships	88,551	-	4,241,975	4,330,526
	858,973	1,697,966	4,242,285	6,799,224
Postretirement healthcare benefit plans				
Commingled funds	28,405	81,577	11,790	121,772
Total plan assets	$ 887,378	$ 1,779,543	$ 4,254,075	$ 6,920,996

(in thousands of dollars)

	Fair Value Measurements Using			
	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Investments Valued Using NAV as a Practical Expedient	Fair Value at September 30, 2018
Defined benefit pension plans				
Invested cash equivalents	$ 43,228	$ -	$ -	$ 43,228
Separately managed investments	664,321	304,620	-	968,941
Commingled funds	-	1,708,124	-	1,708,124
Private partnerships	-	-	3,807,519	3,807,519
	707,549	2,012,744	3,807,519	6,527,812
Postretirement healthcare benefit plans				
Commingled funds	19,474	83,863	14,405	117,742
Total plan assets	$ 727,023	$ 2,096,607	$ 3,821,924	$ 6,645,554

In evaluating the Level at which private partnerships have been classified within the fair value hierarchy, management has assessed factors including, but not limited to price transparency, the ability to redeem these investments at net asset value at the measurement date, and the existence or absence of certain restrictions at the measurement date. Investments in private partnerships generally have limited redemption options for investors and, subsequent to final closing, may or may not permit subscriptions by new or existing investors. These entities may also have the ability to impose gates, lockups and other restrictions on an investor's ability to readily redeem out of their investment interest in the fund. As of September 30, 2019 and 2018, Partners HealthCare has excluded all assets from the fair value hierarchy for which fair value is measured using net asset value per share as a practical expedient.

(in thousands of dollars)

Funded Status

The funded status of the plans recognized in the balance sheet and the amounts recognized in unrestricted net assets follows:

	Defined Benefit Pension Plans		Postretirement Healthcare Benefit Plans	
	2019	2018	2019	2018
End of year				
Fair value of plan assets at measurement date	$ 6,799,224	$ 6,527,812	$ 121,772	$ 117,742
Benefit obligations at measurement date	(8,683,960)	(7,028,994)	(201,237)	(171,425)
Funded status	$ (1,884,736)	$ (501,182)	$ (79,465)	$ (53,683)
Amounts recognized in the balance sheet consist of				
Current liabilities	$ (2,562)	$ (1,820)	$ (1,161)	$ (1,488)
Long-term liabilities	(1,882,174)	(499,362)	(78,304)	(52,195)
	$ (1,884,736)	$ (501,182)	$ (79,465)	$ (53,683)
Amounts not yet recognized in net periodic benefit cost and included in unrestricted net assets consist of				
Actuarial net loss (gain)	$ 2,858,791	$ 1,508,828	$ 41,230	$ 16,214
Prior service cost (credit)	(261,883)	(296,658)	(18,931)	(24,220)
	$ 2,596,908	$ 1,212,170	$ 22,299	$ (8,006)
Amounts recognized in unrestricted net assets consist of				
Current year actuarial (gain) loss	$ 1,440,052	$ (298,585)	$ 25,870	$ 2,085
Amortization of actuarial gain (loss)	(89,760)	(133,111)	(861)	(847)
Current year prior service cost (credit)	827	(6,487)	-	-
Amortization of prior service (cost) credit	33,947	32,338	5,289	5,289
	$ 1,385,066	$ (405,845)	$ 30,298	$ 6,527

At the end of 2019 and 2018, the projected benefit obligation, accumulated benefit obligation and fair value of plan assets for pension plans with an accumulated benefit obligation in excess of plan assets were as follows:

	2019	2018
Accumulated benefit obligation in excess of plan assets		
Projected benefit obligation	$ 8,683,960	$ 7,028,994
Accumulated benefit obligation	8,267,644	6,695,351
Fair value of plan assets	6,799,224	6,527,812

(in thousands of dollars)

Expected Cash Flows

Information about the expected cash flows for the defined benefit and postretirement healthcare benefit plans is as follows:

	Defined Benefit Pension Plans	Postretirement Healthcare Benefit Plans	Medicare Subsidy
Expected employer contributions			
2020	$ 348,862	$ 3,247	
Expected benefit payments (receipts)			
2020	$ 315,969	$ 10,629	$ (24)
2021	344,627	11,509	(21)
2022	363,424	12,344	(19)
2023	390,881	13,068	(15)
2024	406,963	13,719	(13)
2025-2029	2,330,152	73,141	(40)

Net Periodic Benefit Cost

	Defined Benefit Pension Plans		Postretirement Healthcare Benefit Plans	
	2019	2018	2019	2018
Service cost	$ 324,429	$ 329,653	$ 3,105	$ 3,157
Interest cost	309,280	278,872	6,618	4,902
Expected return on plan assets	(462,020)	(432,679)	(7,942)	(6,962)
Special termination benefits	29,266	-	2,537	-
Amortization of				
Prior service cost (credit)	(33,947)	(32,338)	(5,289)	(5,289)
Actuarial net (gain) loss	89,760	133,111	861	847
Net periodic benefit cost	$ 256,768	$ 276,619	$ (110)	$ (3,345)

(in thousands of dollars)

Amounts expected to be amortized from unrestricted net assets into net periodic benefit cost during the year ending September 30, 2020 are as follows:

	Defined Benefit Pension Plans	Postretirement Healthcare Benefit Plans
Actuarial net loss (gain)	$ 168,383	$ 3,661
Prior service cost (credit)	(34,095)	(5,289)

	Defined Benefit Pension Plans		Postretirement Healthcare Benefit Plans	
	2019	2018	2019	2018
Weighted-average assumptions used to determine net periodic pension and postretirement cost				
Discount rate	4.31 %	3.90% - 4.00%	3.80% - 4.30%	2.85% - 3.85%
Expected return on plan assets	7.25 %	6.90% - 7.25%	6.75 %	6.75 %
Rate of compensation increase	3.00% - 4.45%	3.00% - 4.45%	N/A	N/A
Healthcare cost trend rate for this year	N/A	N/A	6.00%	5.00% - 6.50%
Rate to which the cost trend rate is to decline	N/A	N/A	5.00%	5.00%
Year that rate reaches the ultimate trend rate	N/A	N/A	2021	2021

Partners HealthCare uses a long-term return assumption which is validated annually by obtaining long-term asset return, volatility and correlation projections for relevant asset class indexes; modifying volatility and correlations to reflect the actual historical experience of the active managers; calculating the expected return using benchmark weights and indexes; and comparing the return assumption to the sum of the expected return and the historical outperformance of the actual return versus the benchmark. Partners HealthCare regularly monitors the active risk of the Master Trust by a statistical regression of the return series of the actual portfolio to that of the policy benchmark.

Assumed healthcare cost trend rates have a significant effect on the amounts reported for the postretirement healthcare plans. A one-percentage-point change in assumed healthcare cost trend rates would have the following effect:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
Effect on service and interest cost	$ 89	$ (71)

(in thousands of dollars)

16. Professional Liability Insurance

Partners HealthCare insures substantially all of its professional and general liability risk on a claims-made basis in cooperation with other healthcare organizations in the Greater Boston area through a captive insurance company, Controlled Risk Insurance Company Ltd. (CRICO). PHS owns 11% of CRICO. The investment is accounted for on the cost basis of accounting. The policies cover claims made during their respective terms, but not those occurrences for which claims may be made after expiration of the policy, except for certain tail liabilities which CRICO has assumed on an occurrence basis through December 31, 2019. Management intends to renew its coverage on a claims-made basis and has no reason to believe that it will be prevented from such renewal. During 2018, CRICO announced and paid a dividend to member organizations. As a result, Partners HealthCare recognized a dividend of $84,900 as a nonoperating gain.

Partners HealthCare follows the accounting policy of establishing reserves to cover the ultimate costs of medical malpractice claims, which include costs associated with litigating or settling claims. The liability also includes an estimated tail liability, established to cover all malpractice claims incurred but not reported to the insurance company as of the end of the year. The total malpractice liability of $542,136 and $512,516 as of September 30, 2019 and 2018, respectively, is presented as an accrued professional liability in the consolidated balance sheets. These reserves have been recorded on a discounted basis using an interest rate of 3.25% and 4.0% as of September 30, 2019 and 2018, respectively.

Partners HealthCare also recognizes an insurance receivable from CRICO, at the same time that it recognizes the liability, measured on the same basis as the liability, subject to the need for a valuation allowance for uncollectible amounts. The insurance receivable of $459,634 and $433,120 as of September 30, 2019 and 2018, respectively, is reported as a component of other assets in the consolidated balance sheets.

Management is not aware of any claims against Partners HealthCare or factors affecting CRICO that would cause the expense for professional liability risks to vary materially from the amount provided.

17. Concentration of Credit Risk

Financial instruments that potentially subject Partners HealthCare to concentration of credit risk consist of patient accounts receivable, research grants receivable, pledges receivable, premiums receivable, certain investments and interest rate swaps.

Partners HealthCare receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payers, including Medicare, Medicaid, Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Research funding is provided through many government and private sponsors. AllWays Health receives a portion of its premium revenue from the Commonwealth. Pledges receivable are due from multiple donors. Partners HealthCare assesses the credit risk for pledges based on history and the financial wherewithal of donors, most of which are individuals or organizations well known to Partners HealthCare.

(in thousands of dollars)

Investments, which include government and agency securities, stocks and corporate bonds, and private partnerships and other investments, are not concentrated in any corporation or industry or with any single counterparty. Alternative investments are less liquid than Partners HealthCare's other investments. The reported values of the alternative investments may differ significantly from the values that would have been used had a ready market for those securities existed. These instruments may contain elements of both credit and market risk. Such risks include, but are not limited to, limited liquidity, absence of oversight, dependence upon key individuals, emphasis on speculative investments and nondisclosure of portfolio composition.

Partners HealthCare minimizes the credit risk it is exposed to under interest rate swap agreements by utilizing several counterparties and requiring the counterparties to post collateral for the benefit of Partners HealthCare when the fair value of the swap is positive. Partners HealthCare minimizes its counterparty risk by contracting with nine counterparties, none of which accounts for more than 20% of the aggregate notional amount of the swap contracts.

18. Net Assets

Donor restricted net assets are available for the following purposes:

	September 30, 2019	September 30, 2018
Donor restricted		
Charity care	$ 173,946	$ 138,327
Buildings and equipment	133,542	126,020
Clinical care, research and academic	2,081,896	1,634,899
	$ 2,389,384	$ 1,899,246

Endowment
Partners HealthCare's endowment consists of numerous individual funds established for a variety of purposes and includes both donor restricted endowment funds and funds designated by boards to function as endowment.

Partners HealthCare has interpreted UPMIFA as requiring the preservation of the value of the original gift of the donor restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Partners HealthCare classifies as donor restricted net assets the original value of all gifts with donor stipulations to maintain in perpetuity, accumulated gains required to be maintained in perpetuity by explicit donor stipulation or accumulated gains which have been appropriated for expenditure in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Partners HealthCare considers several factors in making a determination to appropriate or accumulate donor restricted endowment funds. These factors include: the duration and preservation of the fund; the purposes of the organization and the donor restricted endowment fund; general economic conditions; the possible effect of inflation and deflation; the expected total return from income and the appreciation of investments; other resources of the organization; and the investment policies of the organization.

(in thousands of dollars)

Endowment Funds with Deficits
From time to time, the value of assets associated with individual donor restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts. These deficits generally result from unfavorable market fluctuations that occurred after the investment of new donor restricted contributions or subsequent endowment additions. When such endowment deficits exist, they are classified as a reduction to donor restricted net assets.

The following presents the endowment net asset composition by type of fund as of September 30, 2019 and 2018 and the changes in endowment assets for the years ended September 30, 2019 and 2018:

	Unrestricted	Donor Restricted	Total
Endowment net asset composition by type of fund as of September 30, 2019			
Donor-restricted endowment funds	$ -	$ 1,839,545	$ 1,839,545
Board-designated endowment funds	1,171,631	-	1,171,631
Total funds	$ 1,171,631	$ 1,839,545	$ 3,011,176

	Unrestricted	Donor Restricted	Total
Changes in endowment net assets			
Endowment net assets at September 30, 2018	$ 1,264,410	$ 1,365,096	$ 2,629,506
Investment return			
Investment income	3,563	5,379	8,942
Net realized and unrealized appreciation (depreciation)	39,907	60,014	99,921
Total investment return	43,470	65,393	108,863
Contributions	7,773	286,193	293,966
Appropriation of endowment assets for expenditure	(50,141)	(69,938)	(120,079)
Other changes	(93,881)	192,801	98,920
Total changes	(92,779)	474,449	381,670
Endowment net assets at September 30, 2019	$ 1,171,631	$ 1,839,545	$ 3,011,176

(in thousands of dollars)

	Unrestricted	Donor Restricted	Total
Endowment net asset composition by type of fund as of September 30, 2018			
Donor-restricted endowment funds	$ -	$ 1,365,096	$ 1,365,096
Board-designated endowment funds	1,264,410	-	1,264,410
Total funds	$ 1,264,410	$ 1,365,096	$ 2,629,506

	Unrestricted	Donor Restricted	Total
Changes in endowment net assets			
Endowment net assets at September 30, 2017	$ 1,193,485	$ 1,165,593	$ 2,359,078
Investment return			
Investment income	3,372	32,124	35,496
Net realized and unrealized appreciation (depreciation)	73,148	85,502	158,650
Total investment return	76,520	117,626	194,146
Contributions	7,416	71,212	78,628
Appropriation of endowment assets for expenditure	(47,305)	(60,203)	(107,508)
Other changes	34,294	70,868	105,162
Total changes	70,925	199,503	270,428
Endowment net assets at September 30, 2018	$ 1,264,410	$ 1,365,096	$ 2,629,506

19. Functional Expenses

Expenses by functional classification are allocated based on management's judgement, nature of the expense and historical experience and are as follows:

	Healthcare services	Research and academic	Insurance	General and administrative	Year Ended September 30, 2019
Operating expenses					
Employee compensation and benefit expense	$ 5,975,215	$ -	$ 57,906	$ 1,076,888	$ 7,110,009
Supplies and other expenses	3,229,298	-	52,091	57,942	3,339,331
Medical claims and related expenses	-	-	556,110	-	556,110
Direct academic and research expenses	-	1,594,085	-	-	1,594,085
Depreciation and amortization expenses	603,794	-	-	82,580	686,374
Interest expense	128,900	-	-	52,022	180,922
Total operating expenses	$ 9,937,207	$ 1,594,085	$ 666,107	$ 1,269,432	$ 13,466,831

(in thousands of dollars)

Direct academic and research expenses include $924,570 of employee compensation and benefit expense and $669,515 of supplies and other expenses for the year ended September 30, 2019.

	Healthcare services	Research and academic	Insurance	General and administrative	Year Ended September 30, 2019
Nonoperating expenses					
Employee compensation and benefit expense	$ -	$ -	$ -	$ 61,256	$ 61,256
Supplies and other expenses	-	-	-	58,634	58,634
Interest expense	-	-	-	23,552	23,552
Total nonoperating expenses	$ -	$ -	$ -	$ 143,442	$ 143,442

	Healthcare services	Research and academic	Insurance	General and administrative	Year Ended September 30, 2018
Operating expenses					
Employee compensation and benefit expense	$ 5,535,828	$ -	$ 60,916	$ 1,038,837	$ 6,635,581
Supplies and other expenses	2,875,811	-	62,064	89,957	3,027,832
Medical claims and related expenses	-	-	993,870	-	993,870
Direct academic and research expenses	-	1,485,467	-	-	1,485,467
Depreciation and amortization expenses	583,960	-	-	90,070	674,030
Interest expense	130,590	-	-	50,000	180,590
Total operating expenses	$ 9,126,189	$ 1,485,467	$ 1,116,850	$ 1,268,864	$ 12,997,370

Direct academic and research expenses include $861,570 of employee compensation and benefit expense and $623,897 of supplies and other expenses for the year ended September 30, 2018.

	Healthcare services	Research and academic	Insurance	General and administrative	Year Ended September 30, 2018
Nonoperating expenses					
Employee compensation and benefit expense	$ -	$ -	$ -	$ 57,927	$ 57,927
Supplies and other expenses	-	-	-	47,476	47,476
Interest expense	-	-	-	23,914	23,914
Total nonoperating expenses	$ -	$ -	$ -	$ 129,317	$ 129,317

20. Contingencies

Partners HealthCare is subject to complaints, claims and litigation which arise in the normal course of business. In addition, Partners HealthCare is subject to reviews and investigations by various federal and state government agencies to assure compliance with applicable laws, some of which are subject to different interpretations. Governmental review of compliance by healthcare organizations, including Partners HealthCare, has increased.

(in thousands of dollars)

21. Pending Transactions

On April 12, 2019, MGH and Wentworth-Douglas entered into a definitive affiliation agreement with Exeter Health Resources, Inc. This transaction is currently being reviewed by state and federal agencies.

22. Subsequent Events

Partners HealthCare has assessed the impact of subsequent events through December 6, 2019, the date the audited financial statements were issued. During this period, there were no subsequent events that require adjustment to the audited financial statements.

Report of Independent Auditors

To the Board of Directors of
Partners HealthCare System, Inc. and Affiliates

We have audited the consolidated financial statements of Partners HealthCare System, Inc. and its affiliates as of and for the year ended September 30, 2019 and our report thereon appears on pages 1 and 2 of this document. That audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, changes in net assets and cash flows of the individual companies and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, changes in net assets and cash flows of the individual companies.

PricewaterhouseCoopers LLP

December 6, 2019

PricewaterhouseCoopers LLP, 101 Seaport Boulevard, Suite 500, Boston, MA 02210
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Partners HealthCare System, Inc. and Affiliates
Consolidating Balance Sheets
September 30, 2019

(dollars in thousands)	BH and Affiliates	MGH and Affiliates	NSMC and Affiliates	NWHCS and Affiliates	MEEI and Affiliates	PCC and Affiliates	PCPO	ABWayx Health and Affiliates	PHS	Eliminations	Consolidated
Assets											
Current assets											
Cash and equivalents	$ (15,966)	$ 139,204	$ 37,839	$ 11,984	$ 86,453	$ 39,624	$ (21,113)	$ 55,093	$ (48,309)	$ -	$ 283,807
Investments	650,392	1,603,063	(1,284)	146,600	(16,094)	(1,196)	43,727	-	471,700	(105,406)	2,791,502
Current portion of investments limited as to use	387,813	779,508	54,136	46,667	23,185	37,594	33,729	-	767,120	105,406	2,235,171
Patient accounts receivable, net	404,003	547,453	57,807	55,371	23,989	55,534	5,148	-	(14,053)	(5,468)	1,129,594
Due from affiliates	476	-	-	-	-	-	-	-	218,753	(217,229)	-
Research grants receivable	55,672	72,088	-	-	8,283	814	-	-	(400)	-	136,557
Other current assets	147,645	204,110	10,253	15,530	15,231	10,422	3,493	145,160	85,844	(60,834)	556,954
Receivable for settlements with third-party payers	17,463	30,252	8,038	2,263	569	897	300	-	57,271	-	116,791
Current portion of notes receivable from affiliates	-	26	-	-	-	-	-	-	299,322	(299,348)	-
Total current assets	1,646,498	3,375,714	166,590	278,355	141,626	143,569	65,284	200,253	1,815,348	(582,879)	7,250,376
Investments limited as to use, less current portion	1,117,137	2,713,509	48,349	33,484	114,925	37,230	723	155,637	277,722	-	4,498,716
Long-term investments	278,708	1,429,937	44,295	79,139	158,595	5,652	-	-	1,271	-	1,997,617
Net pledges and contributions receivable, less current portion	84,260	176,715	1,325	2,566	10,439	9,619	-	-	-	-	284,924
Property and equipment, net	1,838,545	2,851,204	383,120	243,065	183,878	290,240	8,140	2,121	676,693	-	6,557,206
Other assets	323,977	236,298	28,256	25,039	16,462	58	2,888	-	9,658	-	643,534
Notes receivable from affiliates, less current portion	-	157	-	-	-	-	-	-	3,578,650	(3,578,807)	-
Total assets	$ 5,389,123	$ 10,783,552	$ 651,935	$ 662,548	$ 625,925	$ 486,368	$ 77,035	$ 358,011	$ 6,359,542	$ (4,161,686)	$ 21,232,373
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term obligations	$ -	$ 4	$ -	$ -	$ 3,909	$ 175	$ -	$ -	$ 451,077	$ -	$ 455,165
Current portion of notes payable to affiliates	110,352	109,558	55,929	14,306	8,688	2,537	-	-	-	(299,348)	-
Accounts payable and accrued expenses	76,845	147,620	12,503	14,338	13,280	9,630	23,335	65,825	481,823	(54,380)	790,620
Accrued medical claims and related expenses	-	-	-	-	-	-	-	63,018	-	(5,468)	57,550
Accrued employee compensation and benefits	274,031	402,273	42,388	33,564	18,551	33,958	7,753	8,780	112,572	-	932,870
Accrual for settlements with third-party payers	6,819	38,062	2,393	4,030	6,012	585	-	-	25,347	(5,961)	75,287
Unexpended funds on research grants	165,423	86,430	(84)	57	8,818	1,529	-	-	44	-	262,017
Due to affiliates	58,419	98,046	5,435	14,427	15,803	5,387	17,610	1,944	651	(217,722)	-
Total current liabilities	691,889	875,993	118,564	80,722	73,839	53,801	48,699	137,567	1,071,514	(582,879)	2,573,709
Other liabilities											
Accrued professional liability	224,072	244,042	30,030	30,568	13,424	-	-	-	-	-	542,136
Accrued employee benefits	146,637	308,873	13,615	11,727	6,970	3,205	723	393	1,818,831	-	2,410,974
Interest rate swaps liability	-	-	-	-	-	-	-	-	510,579	-	510,579
Accrued other	10,937	50,119	5,103	5,427	5,209	893	-	-	109,372	-	187,060
Long-term obligations, less current portion	-	(785)	-	-	419	1,738	-	-	5,258,824	-	5,260,196
Notes payable to affiliates, less current portion	1,394,372	1,195,390	695,594	130,559	132,988	29,804	-	-	-	(3,578,807)	-
Total liabilities	2,467,907	2,877,632	862,906	259,003	232,849	89,541	49,422	137,960	8,869,120	(4,161,686)	11,484,654
Net assets											
Unrestricted	2,529,976	8,430,072	(255,460)	321,024	219,137	376,780	27,613	220,051	(2,510,849)	-	7,358,335
Donor restricted	391,240	1,575,848	44,488	82,521	173,939	20,067	-	-	1,271	-	2,389,354
Total net assets	2,921,216	8,105,920	(210,971)	403,545	393,076	396,847	27,613	220,051	(2,509,578)	-	9,747,719
Total liabilities and net assets	$ 5,389,123	$ 10,783,552	$ 651,935	$ 662,548	$ 625,925	$ 486,388	$ 77,035	$ 358,011	$ 6,359,542	$ (4,161,686)	$ 21,232,373

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

Partners HealthCare System, Inc. and Affiliates
Consolidating Balance Sheets
September 30, 2018

(dollars in thousands)	BH and Affiliates	MGH and Affiliates	NSMC and Affiliates	NWHCS and Affiliates	NEEI and Affiliates	PCC and Affiliates	PCPO	NHP and Affiliates	PHS	Eliminations	Consolidated
Assets											
Current assets											
Cash and equivalents	$ 88,809	$ 156,167	$ 20,776	$ 53,482	$ 27,263	$ 41,564	$ (27,225)	$ 84,135	$ (48,539)	$ -	$ 396,413
Investments	397,706	1,395,885	1,702	156,057	-	1,437	41,275	21,814	572,738	(646,357)	1,942,117
Current portion of investments limited as to use	389,597	601,566	49,479	36,396	4,488	44,355	47,382	-	271,610	40,279	1,485,354
Patient accounts receivable, net	390,052	514,347	54,894	50,527	22,958	53,008	5,539	-	(9,251)	(3,888)	1,078,086
Due from affiliates	-	-	-	-	-	-	-	-	145,981	(145,981)	-
Research grants receivable	66,691	86,474	-	-	-	1,374	-	-	-	-	154,449
Other current assets	110,170	154,337	8,448	12,618	31,357	6,141	3,124	151,851	58,211	(19,246)	517,812
Receivable for settlements with third-party payers	16,331	30,094	11,317	9,024	-	361	348	-	52,088	-	115,561
Current portion of notes receivable from affiliates	-	25	-	-	-	-	-	-	296,579	(296,604)	-
Total current assets	1,439,426	2,838,995	146,717	314,086	85,976	148,240	70,443	257,401	1,342,385	(1,071,677)	5,671,792
Investments limited as to use, less current portion	1,030,809	2,552,831	42,674	32,548	3,754	29,690	430	200,347	318,803	(495,722)	3,716,162
Long-term investments	266,956	1,166,520	43,338	75,899	268,487	3,865	-	-	1,279	(197,493)	1,628,972
Net pledges and contributions receivable, less current portion	80,417	130,382	2,112	2,287	21,849	10,674	-	-	-	-	246,951
Property and equipment, net	1,842,561	2,835,026	317,361	231,878	191,418	302,682	5,830	2,969	671,885	-	6,401,710
Other assets	323,020	217,023	25,871	26,893	20,549	-	3,436	-	21,350	-	637,944
Notes receivable from affiliates, less current portion	55,356	183	-	-	-	-	-	-	3,426,641	(3,482,180)	-
Total assets	$ 5,038,545	$ 9,841,080	$ 578,294	$ 683,399	$ 591,233	$ 495,171	$ 80,141	$ 460,717	$ 5,782,243	$ (5,247,272)	$ 18,303,531
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term obligations	$ -	$ -	$ -	$ -	$ 6,081	$ 166	$ -	$ -	$ 453,143	$ -	$ 459,390
Current portion of notes payable to affiliates	105,734	108,941	62,565	12,710	4,239	2,415	-	-	-	(296,604)	-
Accounts payable and accrued expenses	74,059	139,858	13,525	6,211	36,478	10,287	38,057	41,073	347,300	(9,869)	636,890
Accrued medical claims and related expenses	-	-	-	-	-	-	-	68,396	-	(3,898)	64,398
Accrued employee compensation and benefits	249,973	359,636	39,555	39,783	17,375	32,698	7,235	6,775	110,125	-	854,375
Accrual for settlements with third-party payers	4,400	28,284	2,601	560	4,063	4,556	-	-	33,838	(10,591)	68,711
Unexpended funds on research grants	182,981	90,257	(50)	46	-	822	-	-	122	-	254,178
Due to affiliates	64,097	48,351	3,982	16,093	-	3,104	5,449	2,112	1,459	(144,647)	-
Total current liabilities	691,244	776,357	122,178	86,403	68,237	54,248	50,741	118,346	945,987	(465,799)	2,427,942
Other liabilities											
Accrued professional liability	211,897	230,766	26,813	25,983	13,057	-	-	-	-	-	512,516
Accrued employee benefits	345,701	482,507	30,949	4,807	27,255	3,237	430	347	63,042	-	958,275
Interest rate swaps liability	-	-	-	-	-	-	-	-	254,295	-	254,295
Accrued other	34,904	55,900	4,220	7,979	13,857	857	-	-	114,137	-	231,854
Long-term obligations, less current portion	-	(803)	-	-	56,780	1,838	-	-	4,888,053	-	4,945,868
Notes payable to affiliates, less current portion	1,309,838	1,328,077	611,833	121,878	78,114	32,440	-	-	-	(3,482,180)	-
Total liabilities	2,593,584	2,872,804	785,993	231,850	257,400	92,720	51,171	118,693	6,265,514	(3,947,979)	9,330,950
Net assets											
Unrestricted	2,073,778	5,551,706	(262,272)	373,822	167,326	385,129	28,970	342,024	(484,553)	(1,101,799)	7,073,335
Donor restricted	371,182	1,416,550	44,573	78,327	166,507	17,322	-	-	1,279	(197,494)	1,899,246
Total net assets	2,444,961	6,968,256	(217,699)	452,349	333,833	402,451	28,970	342,024	(483,271)	(1,299,293)	8,972,581
Total liabilities and net assets	$ 5,038,545	$ 9,841,060	$ 578,294	$ 683,399	$ 591,233	$ 495,171	$ 80,141	$ 460,717	$ 5,782,243	$ (5,247,272)	$ 18,303,531

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

Partners HealthCare System, Inc. and Affiliates
Consolidating Statements of Operations
Year Ended September 30, 2019

(Dollars in thousands)	BH and Affiliates	MGH and Affiliates	NSMC and Affiliates	NWHCS and Affiliates	MEEI and Affiliates	PCC and Affiliates	PCPO	AllWays Health and Affiliates	PHS	Eliminations	Consolidated
Operating revenues											
Net patient service revenue	$ 3,388,058	$ 4,965,445	$ 559,524	$ 588,098	$ 349,781	$ 386,352	$ 67,096	$ -	$ 42,418	$ (201,832)	$ 10,145,150
Premium revenue	-	-	-	-	-	-	-	793,699	-	(2,343)	791,356
Direct academic and research revenue	566,983	941,151	1,662	7,678	52,766	10,774	-	-	13,071	-	1,594,085
Indirect academic and research revenue	174,040	282,586	(18)	550	21,514	3,045	-	-	1,530	-	483,247
Other revenue	190,899	549,152	38,895	23,848	23,557	5,475	41,887	23,658	1,118,761	(1,059,783)	957,499
Total operating revenues	4,320,980	6,718,384	600,063	620,274	447,628	415,646	105,983	817,357	1,175,780	(1,262,738)	13,951,337
Operating expenses											
Employee compensation and benefit expenses	1,995,888	3,125,399	356,637	371,111	217,804	302,825	69,917	66,027	604,879	(10,278)	7,110,009
Supplies and other expenses	1,225,270	1,827,368	186,580	226,950	148,087	107,977	49,099	59,397	299,453	(790,850)	3,339,331
Medical claims and related expenses	-	-	-	-	-	-	-	717,710	-	(161,600)	556,110
Direct academic and research expenses	566,983	941,151	1,662	7,678	52,766	10,774	-	-	13,071	-	1,594,085
Depreciation and amortization expenses	210,219	298,073	29,615	33,222	21,453	21,251	1,950	846	69,735	-	686,374
Interest expense	53,025	49,531	24,535	4,131	5,741	1,437	-	-	179,983	(137,481)	180,922
Total operating expenses	4,051,385	6,241,522	609,029	643,092	445,851	444,074	120,966	843,980	1,167,121	(1,100,189)	13,466,831
Income (loss) from operations	278,595	476,842	(8,966)	(42,818)	1,777	(28,428)	(14,983)	(26,623)	8,659	(162,549)	484,506
Nonoperating gains (expenses)											
Income from investments	11,071	55,102	3,433	9,133	7,794	2,479	2,302	6,893	69,104	15,518	182,829
Change in fair value of interest rate swaps	-	-	-	-	-	-	-	-	(271,527)	-	(271,527)
Other nonoperating income (expenses)	(22,160)	(58,494)	(858)	(3,860)	267	(4,071)	-	-	(43,179)	8,294	(123,911)
Academic and research gifts, net of expenses	83,213	136,312	3,830	(91)	17,559	7,928	-	-	(3,309)	(13,175)	214,267
Contribution income - affiliates	-	-	-	-	-	-	-	-	-	-	-
System development funding	(53,315)	(71,642)	(8,891)	(8,982)	-	(7,337)	-	(2,243)	-	153,660	-
Total nonoperating gains (expenses), net	(1,211)	63,078	(2,486)	(4,800)	25,620	(1,031)	2,302	4,650	(248,911)	184,297	1,658
Excess (deficit) of revenues over expenses	277,384	539,920	(11,452)	(47,418)	27,397	(29,479)	(9,681)	(21,973)	(240,252)	1,718	486,164
Other changes in net assets											
Funds utilized for property and equipment	17,521	89,852	(1)	2,738	1,268	263	-	-	-	-	111,641
Change in funded status of defined benefit plans	(11,995)	(9,810)	(2,294)	(2,711)	1	-	-	-	(1,388,555)	-	(1,415,364)
Other change in net assets	92	-	-	-	(963)	-	-	-	3,349	-	2,478
Cumulative effect of accounting change	-	-	-	-	-	-	-	-	-	1,100,081	1,100,081
Transfers from (to) affiliates	173,195	258,404	20,550	(4,607)	24,108	20,887	8,324	(100,000)	(400,841)	-	-
Increase (decrease) in unrestricted net assets	$ 456,197	$ 878,366	$ 6,803	$ (51,998)	$ 51,811	$ (8,349)	$ (1,357)	$ (121,973)	$ (2,026,299)	$ 1,101,799	$ 285,000

The accompanying notes are an integral part of these consolidating financial statements.

Partners HealthCare System, Inc. and Affiliates
Consolidating Statements of Operations
Year Ended September 30, 2018

(dollars in thousands)	BH and Affiliates	MGH and Affiliates	NSMC and Affiliates	NWHCS and Affiliates	MEEI and Affiliates	PCC and Affiliates	PCPO	NHP and Affiliates	PHS	Eliminations	Consolidated
Operating revenues											
Net patient service revenue	$ 3,187,347	$ 4,606,217	$ 533,599	$ 541,150	$ 168,887	$ 386,889	$ 63,756	$ -	$ 27,576	$ (286,285)	$ 9,239,118
Premium revenue	-	-	-	-	-	-	-	1,424,920	-	(4,431)	1,420,489
Direct academic and research revenue	585,690	855,474	1,416	8,861	16,903	10,214	-	-	6,709	-	1,485,467
Indirect academic and research revenue	167,844	239,871	31	493	9,488	1,997	-	-	835	-	420,559
Other revenue	170,364	403,683	20,853	21,517	24,803	5,256	39,018	2,678	1,023,965	(970,501)	741,636
Total operating revenues	4,121,445	6,105,245	555,899	572,021	220,081	404,356	102,776	1,427,598	1,059,085	(1,261,217)	13,307,269
Operating expenses											
Employee compensation and benefit expenses	1,881,023	2,968,559	350,782	317,908	103,938	291,309	66,337	69,460	573,418	2,847	6,635,581
Supplies and other expenses	1,176,042	1,655,185	179,873	194,835	83,168	103,778	43,770	70,768	230,619	(710,006)	3,027,832
Medical claims and related expenses	-	-	-	-	-	-	-	1,246,808	-	(254,938)	993,870
Direct academic and research expenses	585,690	855,474	1,416	8,861	16,903	10,214	-	-	6,709	-	1,485,467
Depreciation and amortization expenses	202,628	299,412	28,211	32,553	10,772	21,191	1,911	1,155	76,199	-	674,030
Interest expense	55,271	52,639	23,782	4,585	2,230	1,524	-	-	177,970	(137,611)	180,590
Total operating expenses	3,900,852	5,831,469	593,864	558,742	217,011	428,016	112,018	1,390,192	1,064,915	(1,099,709)	12,997,370
Income (loss) from operations	220,593	273,776	(37,965)	13,279	3,050	(23,660)	(9,242)	37,406	(5,830)	(161,508)	309,899
Nonoperating gains (expenses)											
Income from investments	43,385	160,841	3,072	12,153	9,175	2,410	2,598	6,954	27,841	(69,511)	198,118
Change in fair value of interest rate swaps	-	503	-	-	2,405	-	-	-	128,274	-	131,182
Other nonoperating income (expenses)	(12,441)	(46,351)	(794)	(4,015)	(6,484)	(1,018)	-	-	36	9,747	(61,321)
Academic and research gifts, net of expenses	42,380	67,608	3,282	(7,394)	-	4,676	-	-	(1,067)	(18,250)	91,415
Contribution income - affiliates	-	-	-	-	-	-	-	-	157,312	-	157,312
System development funding	(50,140)	(70,271)	(6,873)	(9,396)	-	(7,472)	-	(2,543)	-	148,685	-
Total nonoperating gains (expenses), net	23,184	111,530	(3,333)	(8,852)	5,096	(1,205)	2,598	4,411	312,396	70,681	516,706
Excess (deficit) of revenues over expenses	243,777	385,306	(41,298)	4,427	8,146	(24,865)	(6,644)	41,817	306,566	(90,827)	826,605
Other changes in net assets											
Change in net unrealized appreciation on marketable investments	3	-	242	-	(4,975)	-	-	(3,418)	-	(82,095)	(90,243)
Funds utilized for property and equipment	12,030	19,538	2,424	4,446	129	485	-	-	-	-	39,052
Change in funded status of defined benefit plans	93,591	293,698	3,696	(220)	6,713	-	-	-	1,839	-	399,318
Other change in net assets	(502)	-	-	965	-	-	-	-	8,967	-	9,433
Transfers from (to) affiliates	6,508	(52,914)	17,013	1,958	157,313	25,890	4,669	4,000	(164,437)	-	-
Increase (decrease) in unrestricted net assets	$ 355,407	$ 845,829	$ (17,923)	$ 11,778	$ 167,326	$ 1,510	$ (1,975)	$ 42,399	$ 152,735	$ (172,922)	$ 1,184,165

The accompanying notes are an integral part of these consolidating financial statements.

Partners HealthCare System, Inc. and Affiliates
Consolidating Statements of Changes in Net Assets
Year Ended September 30, 2019

(dollars in thousands)	BH and Affiliates	MGH and Affiliates	NSMC and Affiliates	NWHCS and Affiliates	MEEI and Affiliates	PCC and Affiliates	PCPO	AllWays Health and Affiliates	PHS	Eliminations	Consolidated
Unrestricted											
Net assets at September 30, 2018	$ 2,073,779	$ 5,551,706	$ (262,272)	$ 373,022	$ 187,326	$ 385,129	$ 28,970	$ 342,024	$ (484,550)	$ (1,101,799)	$ 7,073,335
Increases (decreases)											
Income (loss) from operations	278,585	476,842	(8,986)	(42,618)	1,777	(28,428)	(11,883)	(26,623)	6,659	(182,548)	464,506
Income (loss) from investments	11,071	55,102	3,433	9,133	7,794	2,479	2,302	8,893	69,104	15,516	182,829
Change in fair value of interest rate swaps	-	-	-	-	-	-	-	-	(271,527)	-	(271,527)
Other nonoperating income (expenses)	(22,180)	(58,484)	(858)	(3,860)	257	(4,071)	-	-	(43,179)	8,264	(123,911)
Academic and research gifts, net of expenses	63,213	138,312	3,830	(91)	17,559	7,928	-	-	(3,309)	(13,175)	214,267
System development funding	(53,315)	(71,642)	(8,891)	(9,862)	-	(7,387)	-	(2,243)	-	153,860	-
Funds utilized for property and equipment	17,521	89,852	(1)	2,738	1,268	263	-	-	-	-	111,641
Change in funded status of defined benefit plans	(11,995)	(9,810)	(2,294)	(2,711)	1	-	-	-	(1,388,555)	-	(1,415,364)
Other change in net assets	92	-	-	-	(963)	-	-	-	3,349	-	2,478
Cumulative effect of accounting change	-	-	-	-	-	-	-	-	-	1,100,081	1,100,081
Transfers from (to) affiliates	173,195	258,404	20,550	(4,607)	24,108	23,887	8,324	(100,000)	(400,841)	-	-
Change in unrestricted net assets	456,187	878,366	8,803	(51,995)	51,811	(3,349)	(1,357)	(121,973)	(2,026,299)	1,101,798	285,000
Net assets at September 30, 2019	$ 2,529,978	$ 6,430,072	$ (255,469)	$ 321,024	$ 219,137	$ 379,780	$ 27,613	$ 220,051	$ (2,510,849)	$ -	$ 7,358,335
Donor restricted											
Net assets at September, 2018	$ 371,182	$ 1,416,550	$ 44,573	$ 79,327	$ 168,587	$ 17,322	$ -	$ -	$ 1,279	$ (197,494)	$ 1,899,246
Increases (decreases)											
Income (loss) from investments	(1,382)	(2,419)	67	(185)	(2,276)	358	-	-	(6)	311	(5,536)
Other nonoperating income (expenses)	24,110	339,780	375	6,090	7,168	2,369	-	-	-	-	379,892
Funds utilized for property and equipment	(2,670)	(77,900)	-	(2,711)	-	-	-	-	-	-	(83,281)
Other change in net assets	-	(163)	(517)	-	2,542	18	-	-	-	-	1,880
Cumulative effect of accounting change	-	-	-	-	-	-	-	-	-	197,183	197,183
Change in donor restricted net assets	20,058	259,298	(75)	3,194	7,432	2,745	-	-	(6)	197,494	490,138
Net assets at September 30, 2019	$ 391,240	$ 1,675,848	$ 44,498	$ 82,521	$ 173,939	$ 20,067	$ -	$ -	$ 1,271	$ -	$ 2,389,384

The accompanying notes are an integral part of these consolidating financial statements.

Partners HealthCare System, Inc. and Affiliates
Consolidating Statements of Changes in Net Assets
Year Ended September 30, 2018

(dollars in thousands)	BH and Affiliates	MGH and Affiliates	NSMC and Affiliates	NWHCS and Affiliates	MEEI and Affiliates	PCC and Affiliates	PCPO	NHP and Affiliates	PHS	Eliminations	Consolidated
Unrestricted											
Net assets at September 30, 2017	$ 1,718,372	$ 4,905,877	$ (244,349)	$ 381,243	$ -	$ 383,619	$ 30,845	$ 289,525	$ (637,285)	$ (928,877)	$ 5,899,170
Increase (decrease)											
Income (loss) from operations	220,593	273,776	(37,965)	13,279	3,050	(23,660)	(9,242)	37,406	(5,830)	(161,506)	309,899
Income (loss) from investments	43,385	189,041	3,072	12,153	9,175	2,410	2,598	6,954	27,841	(89,511)	196,118
Change in fair value of interest rate swaps	-	503	-	-	2,405	-	-	-	128,274	-	131,182
Other nonoperating income (expenses)	(12,441)	(46,351)	(794)	(4,015)	(5,484)	(1,019)	-	-	36	9,747	(61,321)
Academic and research gifts, net of expenses	42,380	67,608	3,262	(7,394)	-	4,876	-	-	(1,067)	(16,250)	91,415
Contribution income - affiliates	-	-	-	-	-	-	-	-	157,312	-	157,312
System development funding	(50,140)	(70,271)	(8,873)	(9,396)	-	(7,472)	-	(2,543)	-	148,695	-
Change in unrealized appreciation on marketable investments	3	-	242	-	(4,975)	-	-	(3,419)	-	(52,095)	(60,243)
Funds utilized for property and equipment	12,030	19,538	2,424	4,446	129	485	-	-	-	-	39,052
Change in funded status of defined benefit plans	93,591	293,589	3,696	(220)	6,713	-	-	-	1,639	-	399,318
Other change in net assets	(502)	-	-	958	-	-	-	-	8,967	-	9,423
Transfers from (to) affiliates	6,508	(52,914)	17,013	1,958	157,313	25,890	4,889	4,000	(164,437)	-	-
Change in unrestricted net assets	355,407	645,829	(17,923)	11,779	167,328	1,510	(1,975)	42,398	152,735	(172,922)	1,184,165
Net assets at September 30, 2018	$ 2,073,779	$ 5,551,706	$ (262,272)	$ 373,022	$ 167,328	$ 385,129	$ 28,970	$ 342,024	$ (484,550)	$ (1,101,799)	$ 7,073,335
Donor restricted											
Net assets at September, 2017	$ 320,005	$ 1,318,783	$ 45,473	$ 76,809	$ -	$ 14,841	$ -	$ -	$ 1,899	$ (202,851)	$ 1,574,939
Increase (decrease)											
Income (loss) from investments	5,572	25,180	945	2,055	10,866	369	-	-	37	(9,334)	35,691
Other nonoperating income (expenses)	50,722	81,824	(2,478)	5,878	5,990	2,120	-	-	(657)	-	143,387
Contribution income - affiliates	-	-	-	-	-	-	-	-	166,281	-	166,281
Change in net unrealized appreciation on marketable investments	-	222	52	-	(5,516)	-	-	-	-	14,691	8,449
Funds utilized for property and equipment	(5,117)	(9,036)	-	(4,445)	-	-	-	-	-	-	(18,598)
Other change in net assets	-	(403)	580	(963)	(10,104)	(8)	-	-	-	-	(10,903)
Transfers from (to) affiliates	-	-	-	-	166,281	-	-	-	(166,281)	-	-
Change in donor restricted net assets	51,177	97,787	(900)	2,516	166,507	2,481	-	-	(620)	5,357	324,307
Net assets at September 30, 2018	$ 371,182	$ 1,416,550	$ 44,573	$ 79,327	$ 166,507	$ 17,322	$ -	$ -	$ 1,279	$ (197,494)	$ 1,899,246

The accompanying notes are an integral part of these consolidating financial statements.

Partners HealthCare System, Inc. and Affiliates
Notes to Supplemental Consolidating Information
September 30, 2019 and 2018

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheets, statements of operations and statements of changes in net assets of Partners HealthCare. Significant interaffiliate accounts and transactions have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

Wentworth-Douglass Hospital
789 Central Avenue
Dover, NH 03820

Board of Trustees as November 1, 2020

Chairman – Carol Bailey
Vice Chairman – John Salmon
Treasurer – James Brannen
Secretary – Atty. Michael Bolduc
Interim President & CEO – Jeffrey Hughes (ex-officio, non-voting)

Dr. Marcela Del Carmen
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Dr. Anne Kalter
Dr. Terri Lally (ex-officio, voting)
Ingo Roemer
Dr. Andrew Warshaw

Emeritus Trustees
Robert DeColfmacker
Dr. Roger Evans
Ann Torr

CAROL J. STILES

LICENSED CLINICAL SOCIAL WORKER

Highly skilled career professional with 25 years of experience in inpatient and outpatient settings, providing co-occurring mental health and substance misuse treatment to individuals and groups, utilizing evidence based treatment modalities.

PROFESSIONAL EXPERIENCE

Jan 15 – present **Integrated Care at Wentworth Health Partners,** *Dover, NH*

Behavioral Health Clinician: Provide individual, couples and family behavioral health interventions, participate in clinical peer collaboration, conduct intake assessments, document in electronic medical records, consults with health providers and other community professionals regarding patient care.

Dec 96 – Sept 2015 **Maine Behavioral Health Care,** *474 Main St. Springvale, ME 04072*

Program Manager: Supervise 10 case managers in two different MBH locations, provide weekly supervision, conduct intakes, triage and assign clients, review cases to insure compliance with insurance regulations, carry caseload.

Clinical Supervisor *Kittery Office* for Assertive Community Treatment team: Provided clinical supervision to masters and bachelor level clinicians. Screened and referred clients to appropriate level of care, audited records to insure compliance with licensing and insurance regulations.

CAROL J. STILES

Emergency, Acute Care, and Outpatient Clinician, *Kittery Office:* Evaluated emergency walk-ins, conducted mobile crisis evaluations, and acute care follow up. Coordinated intake and cross program referrals. Provided individual, couples, and family therapy for those in need of brief as well as long term treatment. Supervised masters level student interns for the Kittery office.

Community Support Worker, *Springvale Office:* Developed and implemented client treatment plans, provided supportive therapy, psycho-education and advocacy to clients with chronic and persistent mental illness. Referred clients to community supports and appropriate human service agencies.

Nov 95 – Dec 96 **CMG Health. Inc.,** *1600 Hooksett Road Hooksett, NH 03106*

***Behavioral Health Care Case Manager*:** Acted as liaison between insurance carrier, provider, and patient. Authorized treatment and developed treatment plans with outpatient therapists and physicians. Managed mental health benefits on a computerized system.

Jan 88 – Nov 95 **Portsmouth Pavilion,** *343 Borthwick Av., Portsmouth, NH 03801*

Psychiatric Social Worker: Treatment team leader for multi-disciplinary treatment team, performed psychosocial assessments provided therapeutic intervention, discharge planning, and referrals for inpatient and outpatient services. Conducted case conferences, acted as community liaison and conducted network meetings, monitored utilization management, supervised masters level interns, lead psycho educational and process groups for co-occurring clients, provided individual, couples and family therapy in both inpatient and outpatient settings.

June 84 – May 87 **New Hampshire Hospital,** *105 Pleasant Street Concord, NH 03301*

Psychiatric Social Worker: Provided therapeutic intervention to patients with chronic and persistent mental illness in an inpatient setting. Collaborated with a team of case managers who were responsible for provided daily support, advocacy, discharge planning and interdisciplinary collaboration with other treatment providers. Performed psychosocial assessments, formulated treatment plans, discharge plans and referrals for patients. Documented evidence to support court petitions and provided court testimony. Provided services and support for geriatric patients and their families.

CAROL J. STILES

PROFESSIONAL LICENSURE

Licensed Independent Clinical Social Worker, NH# 418

Licensed Alcohol and Drug Counselor, ME#

Licensed Clinical Social Worker, ME # 4329

EDUCATIONAL EXPERIENCE

University of Connecticut — Storrs, CT
Master of Social Work

University of New Hampshire — Durham, NH
Bachelor of Arts in Social Services

PROFESSIONAL TRAININGS

New England Institute of Addiction Studies NEIAS.
32 CEUS in Clinical Supervision Foundation, August 2014

Behavioral Tech LLC,
Ten-day intensive training course in Dialectical Behavioral Therapy, June 2012

References available upon request

Jennifer Stout

Work Experience

Senior Clinician
Hope on Haven Hill - Rochester, NH
September 2016 to Present

As a founding member of this organization, worked to build structure and programming from the ground up. Worked to develop policies and procedures, train staff, and develop curriculum for an 8-bed residential facility treating substance use and co-occurring disorders for pregnant and parenting women that opened 12/16. Currently oversee programming and facilitate treatment at 3 levels of care including residential, intensive outpatient, and outpatient individual and group therapy. Carry a caseload of individual clients. Supervise clinical staff towards licensure.

Intensive Outpatient Director
Goodwin Community Health - Somersworth, NH
March 2016 to September 2016

Worked with agency staff to design and implement an Intensive Outpatient program at Goodwin Community Health to treat co-occurring disorders. Developed a curriculum for a 3-phased program. Work with community agencies including hospitals, corrections, and health centers to screen, assess, and admit clients into the program, monitor their progress, and develop a plan for completion.

Therapist
ROAD To a Better Life - Somersworth, NH
June 2014 to June 2016

Provided initial assessment and treatment planning for clients participating in Suboxone treatment program.
Maintained a caseload of individual therapy clients diagnosed with co-occurring disorders. Planned and facilitated 3-4 therapy groups per week, including gender specific programming for women, exploring topics such as the science of addiction, relapse prevention, recovery skills and healthy relationships.

Substance Abuse and Mental Health Counselor
Manchester Community Health Center - Manchester, NH
March 2015 to March 2016

Provided individual assessment and treatment for individuals with mental health and substance use disorders in a community health care setting. Provide brief and longer term counseling, as well as specialized substance abuse and trauma treatment to clients as appropriate, including Seeking Safety, DBT, and Progressive Counting. Work with medical staff, interpreters, nutritionists and community workers to provide integrated care for a diverse population.
Supervise clinicians towards MLADC certification.

Substance Abuse Counselor
Families First, Healthcare for the Homeless - Portsmouth, NH

September 2010 to June 2014
Provided individual and group substance abuse counseling in the community to individuals who were homeless. Worked closely with medical and care coordination staff on the mobile health care van to meet and offer services to clients in a timely manner. Offered assessment, treatment planning and ongoing counseling using motivational interviewing, cognitive behavioral, DBT, and trauma-informed approaches. Offered crisis intervention services as needed, often working closely with other local agencies to respond best to clients needs.

Clinical Case Manager, Crisis Clinician
Counseling Services Inc - Biddeford, ME
September 2004 to August 2010

-Clinician, Crisis Response Services: Provided telephone support and assessment, as well as face-to-face assessments for adults and children experiencing psychiatric emergencies. Work with clients, agency supervisors and psychiatrists to create a disposition that maintains client safety in the least restrictive setting.
-Clinical Case Manager: Provided supportive counseling and case management services to adults with severe and persistent mental illness. As member of Intensive Community Integration team, worked with clients needing a high level of care. Facilitated family meetings, provided crisis intervention services, took part in weekly multi-disciplinary team meeting. Co-facilitated skills building and activity group weekly.

Education

MSW
Boston University - Boston, MA
September 2002 to May 2006

Master's in Sociology
University of Pennsylvania - Philadelphia, PA
September 1999 to January 2002

Bachelor's in Sociology
Haverford College - Haverford, PA
September 1993 to May 1997

Skills

Trained in DBT, EMDR Basic level, CBT

Trainings/ Presentations:

Home Visitor Conference, DHHS, NH, 2014: "The Impact of Adverse Childhood Experiences on Home Visiting in New Hampshire".
National Healthcare for the Homeless Annual Conference, 2014: "Understanding Homelessness, Adverse Childhood Experiences, and High Risk Behaviors".
Staff Training, Trauma-Informed Care, Ethics, and Healthy Boundaries: Crossroads House, Portsmouth NH, 2015, 2016, 2017.
Parkland Medical Center Behavioral Health Unit, Lunch and Learn: "Trauma Informed Care and Understanding Challenging Behaviors", 2017.
New Hampshire Addiction Summit, "Understanding High Risk Behaviors and Providing Trauma-Informed Care", 2017.
Mass General Hospital Institute of Health Professionals: "Trauma-Informed Care for Nurses", 2016, 2017.
UNH Department of Professional Development: "Trauma-Informed Care Training", Full-Day Training for Clinicians and School Professionals, 2017, 2018.
IDN-6 "Trauma Informed Care for Paraprofessionals", September 24th, October 30th, 2018: Frisbee Hospital and Community Campus
"Understanding Professional Ethics and Boundaries": October 2018, Crossroads House, Portsmouth, NH

Certifications/Licenses

LICSW, February 2019
MLADC, June 2020
CCTP (Certified Clinical Trauma Professional)

Kathleen Breton

Summary

Dedicated and focused administrative Assistant with over 20 years' experience. Who excels at prioritizing and completing multiple tasks. With great customer service with clients and coworkers.

Highlights

Self-directed

Professional and mature

Dedicated team player

Strong interpersonal skills

Medical terminology

Mail management

Meeting planning

Patient charting

Insurance eligibility verifications

Documentation

Customer Service

Strong work ethic Maintains strict confidentiality

Computer skills

Scheduling

Ordering supplies

Medical records

Referrals

Extensive phone skills

Strong problem solver

Time management

Problem resolution

Report analysis

Employee training and development

Insurance verification

Patient care advocacy

Accomplishments

Scheduling

Facilitated onboarding of new employees by scheduling training, answering questions and processing paperwork.

Multitasking

Administration

Answered multiple phone lines, transferred calls to corresponding departments, filed patient records and billed accordingly.

Demonstrated proficiencies in telephone, e-mail, fax and front-desk reception within high-volume environment.

Customer Service

Handled customers effectively by identifying needs, quickly gaining trust, approaching complex situations and resolving problems to maximize efficiency.

Administration

Performed administration tasks such as filing, developing spreadsheets, faxing reports, photocopying collateral and scanning documents for inter-departmental use.

Research

Investigated any necessary information for proper billing for insurance companies, patients and DMEs such as proper billing codes.

Experience

June 2006 to Current

Rochester Pulmonary Medicine Rochester , NH

Patient Service Rep

Completed registration quickly and cordially for all new patients. Scanning, importing medical documentation. Scheduled radiology/diagnostic testing. Provided administrative support for three physicians. Processed incoming and outgoing referrals. Scheduled surgeries and procedures in conjunction with Surgical Coordinator.

Maintained an organized logging system for tracking test results. Demonstrated knowledge of HIPAA Privacy and Security Regulations by appropriately handling patient information. Collected and posted copayments. Ordered office supplies/scheduled meetings. Purged outdated files. Disseminated information to correct department, individual or outside location. Trained new employees.

May 2006 to June 2008

Beacon Internal Medicine Portsmouth, NH

Medical Office Specialist

Insurance authorization/Scheduling testing and appointments/Medical Records/Customer Service/Billing

May 2003 to May 2006

Filenes Dept Store Newington , NH

Customer Service/Lead

Customer Service/cashier/Lead/trainer/Displayed stock/Signage

Education

1975 Spaulding High School Rochester, NH

High School Diploma Buisness

Kristen N. Wilkinson, LCMHC

[redacted]

LICENSURE

Licensed Clinical Mental Health Counselor, State of New Hampshire

EDUCATION

Boston University, Boston, MA
Certificate in the Treatment of Trauma — June 2019

University of North Florida, Jacksonville, FL
Master of Science in Clinical Mental Health Counseling — August 2011

University of Florida, Gainesville, FL
Bachelor of Arts in Philosophy and in Classical Studies — May 2008

PROFESSIONAL EXPERIENCE

Seacoast Mental Health Center, Exeter, NH
Therapist — July 2017 – Present

- Provided family, group, and individual psychotherapy, case management, functional support services, crisis intervention and management, advocacy, and psychoeducation to a caseload of 60-70 individuals with mental health and/or co-occurring substance use disorders.
- Trained and practiced extensively in evidence-based practices such as Integrated Treatment of Co-Occurring Disorders, Motivational Interviewing, Dialectal Behavioral Therapy, Cognitive Behavioral Therapy, Illness Management and Recovery, Stages of Change, and Behavioral Family Therapy.
- Specialized in the treatment of co-occurring disorders, substance use, trauma, and Borderline Personality Disorder.
- Utilized multiple theoretical orientations, including Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Cognitive Processing Therapy, and Sensorimotor Psychotherapy.

WestBridge Community Services, Manchester, NH
Clinical Care Manager / ACT Clinician — February 2016 – July 2017

- Provided psychiatric and case management services to men with co-occurring substance use and severe and persistent mental health diagnoses.
- Provided family, group, and individual psychotherapy, as well as care management, functional support services, psychoeducation, and crisis management, to approximately 30 participants and their families.
- Worked closely with a multidisciplinary treatment team that included Master's level clinicians, Psychiatrists, Peer Support Specialists, Registered Nurses, Supportive Employment specialists, and residential and outreach specialists.

Mental Health Center of Greater Manchester, Manchester, NH
Clinical Case Manager / ACT Clinician — August 2013 – February 2016

- Provided psychiatric and case management services to individuals with co-occurring substance use and severe and persistent mental health diagnoses in a community-based setting.
- Provided family, group, and individual psychotherapy, case management, functional support services, psychiatric evaluation, emergency assessment, crisis intervention and management, advocacy, and psychoeducation.
- Managed a caseload of 15 individuals with a shared team caseload of approximately 120.
- Held privileges to perform psychiatric examinations at Elliot Hospital and Catholic Medical Center.

Habit OPCO, Lowell, MA
Substance Abuse Clinician — July 2012 – January 2013

- Provided substance abuse treatment and harm-reduction care to opiate-addicted adults.
- Maintained an average caseload of 75 patients, which included providing group and individual counseling, treatment planning, progress tracking, and case management.

Wekiva Springs Wellness Center, Jacksonville, FL
Clinical Services Intern — April 2010 – August 2011

- Conducted assessments (psychosocial, substance abuse, suicidal ideation, mental status, etc.), therapeutic and psychoeducational groups, individual psychotherapy, family contacts and psychotherapy, and crisis intervention.
- Trained in CPR, Crisis and Restraint, First Aid, HIPAA, and HIV/AIDS, as well as working with active-duty and reserve military with special focus on Traumatic Brain Injuries.

MIECHEN KINGSLEY

Professional Summary

Experienced human service professional passionate about helping children and families to live better lives. Skilled at crisis management techniques, efficient and accurate documentation and relationship building.

Skills

- Microsoft Office | Office Equipment
- Attention to Detail in Documentation
- Interviewing and Assessment
- Time Management
- Compassionate
- Empathetic
- Crisis Management
- Communication Skills

Education

Bachelor of Science, Psychology | *Granite State College, Concord, NH*

Associate in Arts, Liberal Arts Teacher Preparation | *Great Bay Community College, Portsmouth, NH*

Employment History

Parent Aide | Child and Family Services, Seacoast & Concord, NH

August 2017 - Present

- Provide supervised visitation, document cases and create reports
- Connect parents to resources in their community for food, transportation, utilities, education and job opportunities
- Provide Addiction support and community resources for counseling and groups.
- Collaborate with Department of Health and Human Services to meet Client goals and objectives.

Bus Driver | First Student, Dover, NH

January 2009 - Present

- Build positive relationships with students, teachers and parents
- Maintain safe environment during crisis situations using crisis management techniques
- Maintain records including attendance forms and clinical data and prepare reports

Personal Care Assistant | Atlantic Home Life Senior Care, Dover, NH

May 2017 – July 2018

- Provide home patient care and assistance including transportation and utilizing physical therapy techniques
- Teach daily living activities and offer emotional and social support

Peter Y. Fifield Ed D., LCMHC, MLADC

Relative Work Experience

Manager of Behavioral Health Services 2018-Present
The Doorway at Wentworth-Douglass
Wentworth-Douglass Hospital *Dover, NH*

- Manager of direct care services relative to all day-to-day operations of the Doorway and Integrated Behavioral Health
- Provide consultation and specialized education for all hospital staff members
- Supervise all Behavioral Health staff members at the Doorway and Integrated BH locations
- Create, manage and forecast budget spending
- Strategic planning for all Behavioral Health options within the Hospital System and within primary care settings

Adjunct Faculty 2015-Present
University of New England *Portland, ME*

- Advisor for Doctoral cohorts within the Education Department
- Provided direct feedback and advice to students regarding doctoral dissertation process
- Consulted directly with other UNE faculty, IRB members, and student affiliates regarding all phases of the dissertation process

Manager of Integrated Behavioral Health Services 2012-2018
Integrated Behavioral Health Specialist 2008-2012
Families First Health and Support Center *Portsmouth, NH*

- Manager of all integration and collaborative services include-ing mental health and substance abuse assessment and treatment, nutrition, care coordination, home visiting and other social services in an urban FQHC
- Responsible for startup of Integrated Behavioral Health program including creation of all operational, financial and clinical protocols
- Consulting member for local and regional integration projects regarding integrated care for clients of all ages
- Counseling therapist for low income individuals utilizing a wide range of therapeutic assessments and interventions for clients of all ages living with mental health and substance abuse disorders
- Member of Trauma Informed Care Integration Steering Committee
- Supervisor for all Behavioral Health and Home Visiting staff

- Member of regional collaborative network including local and
- regional hospitals, community mental health, specialty care and social services

Adjunct Faculty 2012-2016
University of MA, Medical School-Center for Integrated Primary Care *Worchester, MA*

- Design and instruction of an online, interactive Motivational Interviewing class for university and Center for Behavioral Health students

Adjunct Faculty 2012-2014
New England College *Henniker, NH*

- Design and implementation of graduate level class on integrated primary care behavioral health
- Instruction of graduate students including lecture, grading, curriculum design and administrative duties
- Instructor of integrated care therapeutic approaches, billing and systems design, philosophy of care, and multidisciplinary communication models

Integrated Behavioral Health Specialist 2006-2008
Summit Community Care Clinic *Frisco, CO*

- Provide diagnostic evaluation, assessment and mental health counseling for adolescents and adults seeking individual and group treatment
- Substance Abuse and DUI Intake Assessment Coordinator
- Group counselor for Colorado Outpatient Eagle Summit (COPES) substance dependence group therapy
- On-Call Emergency Mental Health Services Therapist
- Member of Summit Community Connections Integration Program

Operations Manager, Experiential Educator and Facilitator 1998-2006
Breckenridge Outdoor Education Center *Breckenridge, CO*

- Manager of plant, property and equipment for wilderness therapy facility, interns and wilderness staff
- Facilitator of wilderness therapy sessions with children and adults of all abilities including trauma survivors, individuals living with physical and mental disabilities, veterans and adjudicated youth
- Team Building Facilitator for Professional Challenge Program leading groups such as; The National Guard, Veterans Association, Denver Police Department, U.S. Ski and Swim Teams etc.

Education Ed. D: Educational/Medical Leadership 2012-2015

University of New England Biddiford, ME

Non-Matriculated Student 2009-2010
Rivier University Nashua, NH

M.S. Counseling Psychology 2005-2008
University of West Alabama Livingston, AL

B.S. Kinesiology; Experiential/Outdoor Education 1994-1998
University of New Hampshire Durham, NH

Professional Presentations

Motivational Interviewing for Health Behavior Change (2018). Harvard Institute of Lifestyle Medicine, Boston, MA.

Trauma Informed Care (2018). New Hampshire Behavioral Health Association Conference, Manchester, NH.

Motivational Interviewing for Medical Providers (2018). New England Ostomy Association Conference, Manchester, NH.

Motivational Interviewing for Health Behavior Change (2017). Harvard Institute of Lifestyle Medicine, Boston, MA

Motivational Interviewing for Health Behavior Change (2016). Harvard Institute of Lifestyle Medicine, Boston, MA

Motivational Interviewing for Health Behavior Change (2015). Harvard Institute of Lifestyle Medicine, Boston, MA

What is Next? Advancing Healthcare from Provider-Centered to Patient-Centered to Family-Centered. (2014). Collaborative Family Healthcare Association Washington, DC.

Motivational Interviewing for Health Behavior Change (2014). Harvard Institute of Lifestyle Medicine, Boston, MA

What is Next? Advancing Healthcare from Provider-Centered to Patient-Centered to Family-Centered. (2014). Collaborative Family Healthcare Association Washington, DC.

Integration of Smoking Cessation Protocols in Primary Care Using QuitWorks New Hampshire (2012). New Hampshire Health Association, Concord NH.

Patient-Centered Asthma Care: Making What we Know Works Operational—EMR Track Examples from the Field (2012). NH Asthma Conference, Concord, NH.

Navigating the Legal and ethical Foundations of Informed Consent and Confidentiality in Integrated Care (2012). Collaborative Family Healthcare Association, Austin TX.

Reducing Tobacco Use in New Hampshire: An Opportunity to Integrate the Work of Primary Care, Public Health, Oral Health and Behavioral Health (2012). New Hampshire Public Health Forum, Concord, NH.

Best Practices for Informed Consent and Confidentiality in Integrated Behavioral Health Setting: Results of a Standardized Survey of Experts and Practitioners (2011). Collaborative Family Healthcare Association, Philadelphia, PA.

Smoking Cessation Interventions and Treatment in the Primary Care Setting (2011). New Hampshire WIC Conference, Concord, NH.

Hard but not Impossible: Institutionalizing Ask, Assist and Refer to QuitWorks-into Primary Care (2011). New Hampshire Chronic Disease Conference, Concord, NH.

H.I.T. or MIS? Best Practices for Collaboration in a Health Information Technology Environment (2010). Collaborative Family Healthcare Association, Louisville, KY.

Data Blitz (2010). Collaborative Family Healthcare Association, Louisville, KY.

Helping Mental Health Practitioners Integrate into the Primary Care Setting (2008), West Slope Casa Psychiatry Symposium, Glenwood Springs, CO Presentations

Integrated Care in Summit County, Colorado (2008). Invited presentation at the Second National Learning Congress of the National Council for Community Behavioral Healthcare, Primary Care Mental Health Integration Project, Washington, DC.

Integrated Care in Summit County, CO (2007). Invited presentation at the Second National Learning Congress of the National Council for Community Behavioral Healthcare, Primary Care Mental Health Integration Project, Chicago, IL.

Professional Publications

Fifield, P., Suzuki, J., Minski, S., Carty, J. (2019). Motivational Interviewing and Behavioral Change. In *Lifestyle Medicine.* Manuscript in preparation.

Hudgins, C., Rose, S., Fifield, P., & Arnault, S. (2014). The ethics of integration: Where policy and practice collide. In *Medical Family Therapy: Advanced applications* (pp. 381-402). New York, NY: Springer.

Hudgins, C., Rose, S., Fifield, P., & Arnault, S. (2013). Navigating the legal and ethical foundations of informed consent and confidentiality in integrated care. *Family, Systems & Health: The Journal of Collaborative Family Healthcare, Special Edition.*

Reitz, R., Common, K., Fifield, P., & Stiasny, E. (2011). Collaboration in the presence of an electronic health record. *Families, Systems, & Health: The Journal of Collaborative Family Healthcare , 30* (1), 72-80.

Reitz, R., Fifield, P., & Whistler, P. (2011). Integrating a Behavioral Health

Consultant into your practice. *Family Practice Management , 18* (1), 18-21.

Fifield, P. (2010). Book Review: Behavioral consultation and primary care: A guide to integrating services. *Families, Systems, & Health: The Journal of Collaborative Family Healthcare , 28* (1), pp. 72-73.

Licenses and Certifications

Licensed Clinical Mental Health Counselor: *State of New Hampshire—2010 Present*

Master Licensed Alcohol and Drug Counselor: *State of Hampshire—2012-Present*

Motivational Interviewing Network of Trainers: *Member/Trainer—2011-Present*

Crisis Prevention Institute: *Nonviolent De-escalation Trainer*

Certified Prime For Life Instructor: Prime For Life Training—2015

Critical Incident Stress Management: *Group and Individual Certified—2008*

Professional Affiliations

Collaborative Family Healthcare Association; Member—Membership and IT Committees & Former Editing Manager *CFHA Blog*

Family Medicine Education Consortium; Member

International Society for Traumatic Stress Studies; Member

American Mental Health Counselors Association; Member

The New Hampshire Mental Health Counselors Association; Member

Community Involvement

Town of Kittery Maine: Kittery Travel Soccer U9-U12 Soccer Coach, U10 Baseball Coach, U9 Lacrosse Coach-2014-Present

Kittery Civil Rights Advocates: 2017-Present

Integrated Delivery Network Region 6: Integrated Care Clinical Advisory Team Member, 2016-Present

Disaster Behavioral Health Response Team: Volunteer Response Team member, 2012-Present

Seacoast Care Collaborative: Special Committee on Community Care Coordination, 2012-2014

Seacoast Integrated Network of Care, Rockingham County New Hampshire; Steering Committee Member, 2008-2012

New Hampshire Integrated Primary Care Learning Collaborative; Member, 2008-Present

Veterans of Foreign Wars and American Legion Local Chapter; Member, 2004-

Present

Other Research

Assessment and integration of Trauma Informed Care concepts within an urban FQHC, 2016-2018

Assessment of Relational Coordination factors in medical teams and the outcomes on activation levels in patients with chronic illness, 2013-2016

Integrated Care Effects on Hypertensive Patient's BioPsyhoSocial Indicators in a Primary Care Setting, 2012-2014

Families First Health and Support Center and Antioch New England: Community Based Participatory Research Integrated Healthcare Outcomes Project, 2008-2011

Qualitative Delphi Study on Health Information Technology use and HIPAA in the Collaborative Healthcare Setting, 2010 -2011

Summit Community Care Clinic and The National Community Council for \ Behavioral Health: Collaborative for Integrated Care Improvement, 2007-2008

[redacted]

Allison Tuttle, MSW Candidate, LADC

[redacted]

Summary of Qualifications

- Able to effectively multi-task in a fast-paced environment without sacrificing high-quality customer service
- Knowledge of abnormal psychology, chemical dependency and developmental disabilities
- Strong problem-solving and organizational skills
- Ability to think clearly in chaotic situations
- Experience managing teams and training new employees
- Licensed as a drug and alcohol counselor in the state of NH (LADC)

Professional Experience

Families First Health and Support Center July 2016-Present
Behavioral Health Specialist/Intensive Outpatient Program Coordinator
- Provide support to individuals struggling with addiction and mental illness
- Facilitate treatment through group and individual therapy
- Conduct assessments using ASAM placement criteria
- Refer individuals to the appropriate level of care and assist with transitions to that level of care
- Provide integrated behavioral health services
- Worked on the medication assisted treatment team
- Utilized evidence based treatment methods
- Provided case management and aftercare planning services
- Created a curriculum for a new intensive outpatient program

Southeastern NH Services Dover, NH July 2013-June 2016
Substance Use Disorder Counselor
- Provided support to individuals struggling with addiction.
- Enforced rules to maintain a structured and safe environment for consumers
- Facilitated treatment through group and individual therapy
- Conducted phone screenings and assessments
- Assisted consumers throughout the intake process
- Provided case management and aftercare planning services

Easter Seals NH, Stratham, NH March 2012- November 2013
Emergency Response Team/ Direct Support Associate November 2010-November 2011
- Provided support for adults and adolescents with developmental and mental health disabilities
- Assisted in activities promoting inclusion, such as job placement, on the job assistance, and drivers education tutoring
- Worked independently with clients of all levels

Julies Ristorante, Ogunquit, ME May 2010-August 2010
Assistant Manager (Summer Seasonal)
- Generated repeat business by providing excellent customer service
- Worked 40 hrs/wk while in college, and maintained a 3.7 G.P.A
- Assisted customers with issues regarding service and food
- Assisted owner in money management and scheduling issues

Education

Hesser College Manchester, NH
Bachelor's Degree in Psychology (GPA: 3.68) October 2011
University of New Hampshire Manchester, NH May 2018
Master's Degree in Social Work

Brandee Prevost

[redacted]

Education

UNIVERSITY OF NEW HAMPSHIRE
Master of Social Work
Durham, NH
Passed MLADC Licensure Exam: Expected Licensure, February 2020

SALEM STATE UNIVERSITY
Bachelor of Arts: Psychology
Salem, MA

Experience

Hope on Haven Hill — August 2018 to Current
Clinician
Rochester , NH
Provide clinical services to residential clients with dually diagnosed mental illness and substance use disorders.

- Complete assessments, treatment plans and maintain weekly individual counseling with residents
- Facilitate weekly group therapy for residents, to include Seeking Safety, Recovery Skills, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy
- Collaborate with various community stakeholders, to include the Department of Children, Youth and Families, to promote client and children well-being and recovery
- Provide compassionate, holistic, evidence and trauma informed care to residents

Portsmouth Regional Hospital — October 2017 to July 2018
Intern
Portsmouth , NH

- Work directly with individuals admitted to both Portsmouth Regional Hospital's outpatient partial hospitalization program, as well as individuals requiring mental health evaluations in the hospital
- Become familiar with hospital based social work in terms of its function, and associated terminology
- Foster an understanding of the multidisciplinary team approach that is used in a hospital setting to treat individuals with mental health and substance misuse issues
- Co-facilitate daily groups with individuals
- Become familiar with evidence-based therapeutic interventions such as cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT)
- Interact with individuals and aid in the development of coping skills, symptom management (mental health) and assist with discharge planning
- Perform psychosocial assessments

NASW-NH — January 2017 to August 2017
Intern
Concord, NH

- Strived to advance the profession of social work, including name recognition and positive visibility in the media, including social media, press releases, etc
- Worked to increase student and professional membership and involvement with NH-NASW. Was an active member of NH-NASW committees and regularly attended meetings including monthly board meetings; monthly Clinical Committee meetings; monthly Mental Health Coalition meetings; monthly Social and Legislative Action Committee meetings; and Diversity Awareness Committee meetings

- Learned about current legislative issues in NH, as well as lobbying skills and assisting with written testimony. Assisted Executive Directive with office tasks as needed such as taking minutes, preparing agendas, and meeting preparation, Assisted in expanding CEU topics and programming, learned how to write a CEU application. Assisedt with increasing funding and locating additional sources of income available to NH-NASW. Attended all applicable workshops, trainings, committee, coalition, and board meetings when appropriate

Greengard Center for Autism — May 2015 to March 2017
ABA Therapeutic Instructor
Portsmouth , NH

- Worked 1:1 with clients on the autism spectrum in the home/day center setting on increasing independence and self-advocacy skills
- Built community awareness and utilization
- Created and implemented programs which promoted goals of the client

Cooperative Middle School — August 2014 to February 2015
Paraprofessional
Stratham, NH

- Provided classroom support for student with behavioral issues and learning disabilities
- Worked collaboratively with BCBA developing and implementing behavioral plan, as well as providing student with positive behavioral support in the classroom as well as unstructured times

Salem Public School District — August 2011 to November 2013
Behavior Specialist
Salem, MA

- Conducted Teacher & Student Interviews, Narrative Observation, ABC Data Recording ,Behavior Support Plan, Behavior Management Plan, FBA, Data Collection and Graphing
- Implemented Visuals using Boardmaker, wrote social stories, and taught self-regulation
- Implemented individual and class wide incentive plans working for preferred reinforcer
- Modeled plan for teachers and support staff to ensure fidelity of treatment
- Worked with School Adjustment Counselors to ensure plan was being followed through with and data collection was taking place in absence of Behavior Specialist
- Worked with students before and during plan implementation to ensure students were successfully earning reinforcer
- Attended IST and IEP meetings and worked closely with all facets of Administration and school staff
- Attended two day Brian Iwata conference, PBIS conference and in-house training during PDD, and CPI certified

Strengthening Families Program — December 2010 to January 2012
Faciltator
Danvers , MA
SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.
As facilitator, I oversaw the semester-long course in which families of children, ages 6 to 11, came together once a week to share a meal, learn new skills and then practice together as a family.

Great Oak Elementary School — September 2006 to June 2010
Paraprofessional

Danvers, MA

- Provided teacher support for integrated preschool classroom
- Incorporated therapy routine designed by occupational therapist, physical therapist and speech pathologist into curriculum
- Maintained activities of daily living for children with intellectual and developmental disabilities in the classroom

NAGLY
Youth Counselor
Salem, MA

- Provided support and counseling to lesbian, gay, bisexual, transgender and questioning youth

Hope on Haven Hill

Professional Trainings & Certifications

- Continuum: ASAM Criteria Assessment
- Suicide Prevention Training-Counseling on Access to Lethal Means
- Registered Behavior Technician Training (40 hours)
- Crisis Prevention Intervention Training
- Olweus Bullying Prevention Program

Casey A. Lord

Education:

Masters of Science in Operations & Project Management
Southern New Hampshire University, Manchester, NH
Anticipated Graduation: April 2019

Bachelor of Science in Psychology
Salem State College, Salem, MA
Graduation: May 2017

Associates of Science, Medical Training
McIntosh College, Dover NH
Graduation: December 2006

Employment History:

July 2014-Current

Lynn Community Health Center, Behavioral Health Department
BH Manager, Provider Scheduling & Productivity Analyst; EPIC Site Specialist

- Build/keep provider schedule templates
- Harpers payroll system
- Crystal & Business Objects reporting; statistical analysis of scheduling, appointments, billing, and no show rates.
- QI- Peer Review Process
- QI- Medication Adherence
- JCHO & Insurance audits
- Review and analysis of provider productivity and outcome measurements.
- EPIC EMR Workflows
- EPIC system issues & training
- Creating Policies and Protocols
- LEAN Principles

Feb 2014-July 2014

Lynn Community Health Center, Behavioral Health Department
Advanced Utilization Coordinator

- Identifying insurance issues
- Insurance denial reports
- Communication with Mass Health and Private insurance companies
- Obtaining prior authorization for behavioral health visits
- Billing

June 2011- Dec 2014

North Shore Medical Center, Salem Hospital
Pharmacy Technician

- Use of Omnicell computer system
- Performs arithmetical calculations required for the preparation of sterile products
- Manufacturing IV medication in a sterile field; Manufacturing Chemo Therapy IV
- Employee Satisfaction Team

- Developed a training program
- Knowledge of Joint Commission

Sept 2010- June 2011 **Express Scripts-Freedom Fertility Pharmacy**
Pharmacy Technician
- Answer patient questions related to pharmacy benefits, and pharmacy claim information
- Prepare and verify new prescription orders and refill orders while maintaining productivity and quality standards
- Select and retrieve appropriate medications, compound and dispense medical prescriptions, verify quantities, and prepare labels for bottles.
- Using a pharmacy claim system: verifying and processing prescription through insurance

July 2008- May 2010 **Tufts Health Plan**
Appeals and Grievances Analyst
- Responsible for identifying, investigating, and processing member appeals within NCQA and state mandated timelines
- Obtained all necessary medical records, benefit documents, and relevant information to create a case to process an appeal and present to a board of medical directors.

Aug 2007-July 2008 **Tufts Health Plan**
Member Services Specialist
- On first call resolution when taking incoming calls from Tufts Health Plan Members, Providers, and Pharmacies regarding benefits, claims, policies, and procedures
- Assisted in clarifying member's benefits, coverage and help callers obtain authorization for prescription drugs
- Researched all requests sent by member services specialists for possible backdates of primary care physicians for members who had claims denied due to not selecting primary physician

References: References will be provided upon request

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Peter Fifield	Manager of BH Services	$102,960	50%	$51,480
Jenn Stout	Clinical Supervisor	$96,406	100%	$96,406
Allison Tuttle	Clinician	$69,990	60%	$43,464
Kristen Wilkinson	Clinician	$43,254	100%	$43,254
Carol Stiles	Clinician	$65,924	25%	$16,481
Brandee Prevost	Care Coordinator	$65,208	100%	$65,208
Maichen Kingsley	CRSW	$53,040	100%	$53,040
Casey Joseph	Practice Coordinator	$50,622	100%	$50,622
Kathleen Bretton	Patient Service Representative	$37,731	100%	$37,731

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the Access and Delivery Hub for Opioid Use Disorder Services Contract

This 1st Amendment to the Access and Delivery Hub for Opioid Use Disorder Services contract (hereinafter referred to as "Amendment #1") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Catholic Medical Center, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at 100 McGregor Street, Manchester, NH 03102.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on March 11, 2020 (Item #9A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Section 1, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement and increase the price limitation to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $4,919,123.

3. Modify Exhibit B, Scope of Services, by replacing in its entirety with Exhibit B Amendment #1, Scope of Services, in order to update all references to current funding sources and related requirements, which is attached hereto and incorporated by reference herein.
4. Modify Exhibit C, Payment Terms, by replacing in its entirety with Exhibit C Amendment #1, Payment Terms, in order to bring payment terms into compliance with current Department of Administrative Services Manual of Procedures standards, which is attached hereto and incorporated by reference herein.
5. Modify Exhibit C-1, Budget by reducing the total budget amount by $878,709, which is identified as unspent funding of which $802,501 is being carried forward to fund the activities in this Agreement for SFY 21 (September 30, 2020 through December 31, 2020), as specified in Exhibit C-3 Amendment #1 NCE and of which $76,208 is being carried forward to fund the activities in this Agreement for SFY 21 (January 1, 2021 through June 30, 2021), as specified, in part, in Exhibit C-5 Amendment #1 SOR II..
6. Add Exhibit C-3 Amendment #1 NCE, which is attached hereto and incorporated by reference herein.
7. Add Exhibit C-4 Amendment #1 Gov Comm, which is attached hereto and incorporated by reference herein.
8. Add Exhibit C-5 Amendment #1 SOR II, which is attached hereto and incorporated by reference herein.
9. Add Exhibit C-6 Amendment #1 GovComm, which is attached hereto and incorporated by

reference herein.

10. Add Exhibit C-7 Amendment #1 SOR II, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #1 remain in full force and effect. This amendment shall be effective retroactive to September 29, 2020, upon Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/16/2020
Date

DocuSigned by:
Katja Fox
ED9D05B04CC3442...
Name: Katja Fox
Title: Director

Catholic Medical Center

12/15/2020
Date

DocuSigned by:
Alex Walker
2265780949DC4E9...
Name: Alex Walker
Title: Chief Operating Officer

New Hampshire Department of Health and Human Services
Access and Delivery Hub for Opioid Use Disorder Services

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/17/2020
Date

DocuSigned by:
D5CA9202E32C4AE...
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor shall submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

1.3. All Exhibits B Amendment #1 through K are attached hereto and incorporated by reference herein.

2. Statement of Work

2.1. The Contractor shall develop, implement and operationalize a regional Access and Delivery Hub for Opioid Use Disorder (from herein referred to as the "Doorway") for substance use disorder (SUD) treatment and recovery support service access in accordance with the terms and conditions approved by Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant.

2.2. The Contractor shall provide residents in the Greater Manchester Region with access to referrals to SUD treatment and recovery support services and other health and social services.

2.3. The Contractor shall participate in technical assistance, guidance, and oversight activities, as directed by the Department, for continued development and enhancement of Doorway services.

2.4. The Contractor shall collaborate with the Department to assess capacity and resource needs, as evidenced by a feasibility and sustainability plan, to provide services either directly, or indirectly through a professional services agreement approved by the Department, that include, but are not limited to:

2.4.1. Care coordination to support evidence-based medication assisted treatment (MAT) induction services consistent with the principles of the Medication First model.

2.4.2. Coordination of outpatient and inpatient SUD services, in accordance with the American Society of Addiction Medicine (ASAM).

2.4.3. Coordination of services and support outside of Doorway operating hours specified in Paragraph 3.1.1., while awaiting intake with the Doorway.

2.4.4. Expanding provisions for Core Doorway services to additional eligible SOR populations, as defined in Paragraph 4.2.1.

2.5. The Contractor shall collaborate with the Department, throughout the contract period, to identify gaps in financial and staffing resources required in Section 5. Staffing.

2.6. The Contractor shall ensure formalized coordination with 2-1-1 NH and other agencies and community-based programs that make up the components of the Doorway System to ensure services and supports are available to individuals after Doorway operating hours. The Contractor shall ensure coordination includes, but is not limited to:

2.6.1. Establishing a Qualified Services Arrangement (QSA) or Memorandum of Understanding (MOU) for after hour services and supports, which includes but are not limited to:

2.6.1.1. A process that ensures a client's preferred Doorway receives information on the client, outcomes, and events for continued follow-up.

2.6.1.2. A process for sharing information about each client to allow for prompt follow-up care and supports, in accordance with applicable state and federal requirements, that includes but is not limited to:

2.6.1.2.1. Any locations to which the client was referred for respite care or housing.

2.6.1.2.2. Other services offered or provided to the client.

2.6.2. Collaborating with the Department to:

2.6.2.1. Implement a centralized closed loop referral system, utilizing the technology solution procured by the Department in order to improve care coordination and client outcomes.

2.6.2.2. Develop a plan no later than December 2020 identifying timelines and requirements for implementing the closed loop referral system.

2.6.3. Enabling the sharing of information and resources, which include, but are not limited to:

2.6.3.1. Patient demographics.

2.6.3.2. Referrals made, accepted, and outstanding.

2.6.3.3. Services rendered.

2.6.3.4. Identification of resource providers involved in each client's care.

2.7. The Contractor, with the assistance of the Department, shall establish formalized agreements to enroll and contract with:

2.7.1. Medicaid Managed Care Organizations (MCO) to coordinate case management efforts on behalf of the client.

2.7.2. Private insurance carriers to coordinate case management efforts on behalf of the client.

2.8. The Contractor shall create policies relative to obtaining patient consent for disclosure of protected health information, as required by state administrative rules and federal and state laws, for agreements reached with MCOs and private insurance carriers as outlined in Subsection 2.7.

2.9. The Contractor shall develop a Department-approved conflict of interest policy related to Doorway services and referrals to SUD treatment and recovery supports and services programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

2.10. The Contractor shall participate in regularly scheduled learning and educational sessions with other Doorways that are hosted, and/or recommended, by the Department.

2.11. The Contractor shall convene or participate in regional community partner meetings to provide information and receive feedback regarding the Doorway services. The Contractor shall:

2.11.1. Ensure regional community partners include, but are not limited to:

2.11.1.1. Municipal leaders.

2.11.1.2. Regional Public Health Networks.

2.11.1.3. Continuum of Care Facilitators.

2.11.1.4. Health care providers.

2.11.1.5. Social services providers.

2.11.1.6. Other stakeholders, as appropriate.

2.11.2. Ensure meeting agendas include, but are not limited to:

2.11.2.1. Receiving input on successes of services.

2.11.2.2. Sharing challenges experienced since the last regional community partner meeting.

2.11.2.3. Sharing methods and actions that can be taken to improve transitions and process flows.

2.11.3. Provide meeting minutes to partners and the Department no later than ten (10) days following each community partners meetings.

2.12. The Contractor shall inform the Department of the regional goals to be included in the future development of needs assessments the Contractor and its regional partners have during the contract period, including, but not limited to, goals pertaining to:

2.12.1. Naloxone use.

2.12.2. Enhanced coverage and services to enable reduced Emergency Room use.

2.12.3. Reducing overdose related fatalities.

3. Scope of Work for Doorway Activities

3.1. The Contractor shall ensure that, unless an alternative schedule for the Doorway to meet the needs of the community is proposed and approved by the Department, the Doorway provides, in one (1) location, at a minimum:

3.1.1. Hours of operation that includes:

3.1.1.1. 8:00 am to 5:00 pm Monday through Friday.

3.1.1.2. Expanded hours as agreed to by the Department.

3.1.2. A physical location for clients to receive face-to-face services, ensuring any request for a change in location is submitted to the Department no later than thirty (30) days prior to the requested move for Department approval.

3.1.3. Telehealth services consistent with guidelines set forth by the Department.

3.1.4. Telephonic services for calls referred to the Doorway by 2-1-1 NH.

3.1.5. Initial intake and screening to assess an individual's potential need for Doorway services.

3.1.6. Crisis intervention and stabilization counseling services provided by a licensed clinician for any individual in an acute Opioid Use Disorder (OUD)-related crisis who requires immediate non-emergency intervention. If the

individual is calling rather than physically presenting at the Doorway, the Contractor shall ensure services include, but are not limited to:

3.1.6.1. Directing callers to dial 911 if a client is in imminent danger or there is an emergency.

3.1.6.2. If the client is unable or unwilling to call 911, the Doorway shall immediately contact emergency or mobile crisis services.

3.1.7. Clinical evaluations that include:

3.1.7.1. Evaluations of all ASAM Criteria (ASAM, October 2013), domains.

3.1.7.2. A level of care recommendation based on ASAM Criteria (October 2013).

3.1.7.3. Identification of client strengths and resources that can be used to support treatment and recovery.

3.1.8. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Subsection 3.1.8. The Contractor shall ensure the clinical service plan includes, but is not limited to:

3.1.8.1. Determination of an initial ASAM level of care.

3.1.8.2. Identification of any needs the client may have relative to supportive services including, but not limited to:

3.1.8.2.1. Physical health needs.

3.1.8.2.2. Mental health and other behavioral health needs.

3.1.8.2.3. Peer recovery support services needs.

3.1.8.2.4. Social services needs.

3.1.8.2.5. Criminal justice needs that include Corrections, Drug Court, and Division for Children, Youth, and Families (DCYF) matters.

3.1.8.3. A plan for addressing all areas of need identified in Paragraph 3.1.8. by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.8.4. Plans for referrals to external providers to offer interim services, when the level of care identified in Paragraph 3.1.8. is not available to the client within forty-eight (48) hours of service plan development, which are defined as:

3.1.8.4.1. A minimum of one (1) sixty (60) minute individual or group outpatient session per week; and/or

3.1.8.4.2. Recovery support services, as needed by the client; and/or

3.1.8.4.3. Daily calls to the client to assess and respond to any emergent needs; and/or

3.1.8.4.4. Respite shelter while awaiting treatment and recovery services.

3.1.9. A staff person, which can be a licensed clinician, Certified Recovery Support Worker (CRSW), or other non-clinical support staff, capable of assisting specialty populations with accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.9.1. Veterans and service members.

3.1.9.2. Pregnant, postpartum, and parenting women.

3.1.9.3. DCYF involved families.

3.1.9.4. Individuals at-risk of or with HIV/AIDS.

3.1.9.5. Adolescents.

3.1.10. Facilitated referrals to SUD treatment and recovery support and other health and social services, which shall include, but not be limited to:

3.1.10.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.10.2. Determining referrals based on the service plan developed in Paragraph 3.1.8.

3.1.10.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.10.4. Contacting the provider agency on behalf of the client, as appropriate.

3.1.10.5. Assisting clients with meeting the financial requirements for accessing services including, but not limited to:

3.1.10.5.1. Identifying sources of financial assistance for accessing services and supports.

3.1.10.5.2. Providing assistance with accessing financial assistance including, but not limited to:

3.1.10.5.2.1. Assisting the client with making contact with the assistance agency, as appropriate.

3.1.10.5.2.2. Contacting the assistance agency on behalf of the client, as appropriate.

3.1.10.5.2.3. Supporting the client in meeting the admission, entrance, and intake requirements of the assistance agency.

3.1.10.5.3. When no other payer is available, assisting clients with accessing services by maintaining a flexible needs fund specific to the Doorway region that supports clients who meet the eligibility criteria for assistance under a Department-approved Flexible Needs Fund Policy with their financial needs, which may include, but are not limited to:

3.1.10.5.3.1. Transportation for eligible clients to and from recovery-related medical appointments, treatment programs, and other locations;

3.1.10.5.3.2. Childcare to permit an eligible client who is a parent or caregiver to attend recovery-related medical appointments, treatment programs, and other appointments;

3.1.10.5.3.3. Payment of short-term housing costs or other costs necessary to remove financial barriers to obtaining or retaining safe housing, such as payment of security deposits or unpaid utility bills;

3.1.10.5.3.4. Provision of light snacks not to exceed three dollars ($3.00) per eligible client;

3.1.10.5.3.5. Provision of clothing appropriate for cold weather, job interviews, or work; and

3.1.10.5.3.6. Other uses preapproved in writing by the Department.

3.1.10.5.4. Assisting individuals in need of respite shelter resources while awaiting treatment and recovery services using available resources consistent with the Department's guidance. The Contractor shall:

3.1.10.5.4.1. Collaborate with the Department on a respite shelter voucher guidance and related procedures to determine eligibility for respite shelter resources based on criteria that include but are not limited to confirming an individual is:

3.1.10.5.4.1.1. A Doorway client;

3.1.10.5.4.1.2. In need of respite shelter while awaiting treatment and recovery services; and

3.1.10.5.4.1.3. In need of obtaining financial assistance to access short-term, temporary shelter.

3.1.11. Continuous case management services which include, but are not limited to:

3.1.11.1. Ongoing assessment of the clinical evaluation in Paragraph 3.1.8. for individuals to ensure the appropriate levels of care and supports identified are appropriate and revising the levels of care based on response to receiving interim services and supports.

3.1.11.2. Ongoing assessment in collaboration or consultation with the client's external service provider(s) of necessary support services to address needs identified in the evaluation or by the client's service provider that may create barriers to the client entering and/or maintaining treatment and/or recovery.

3.1.11.3. Supporting clients with meeting the admission, entrance, and intake requirements of the provider agency.

3.1.11.4. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service provider(s) until a discharge Government Performance and Results Act (GPRA) interview is completed. The Contractor shall ensure follow-up and support includes, but is not limited to:

3.1.11.4.1. Attempting to contact each client at a minimum, once per week until the discharge GPRA interview is completed, according to the following guidelines:

3.1.11.4.1.1. Attempt the first contact by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available.

3.1.11.4.1.2. If the attempt in Unit 3.1.12.4.1. is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) business days and no later than three (3) business days after the first attempt.

3.1.11.4.1.3. If the attempt in Subunit 3.1.12.4.1.2. is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) business days and no later than three (3) business days after the second attempt.

3.1.11.4.1.4. Documenting all efforts of contact in a manner approved by the Department.

3.1.11.5. When the follow-up in Subparagraph 3.1.12.4. results in a determination that the individual is at risk of self-harm, the

Contractor shall proceed in alignment with best practices for the prevention of suicide.

3.1.11.6. When possible, client contact and outreach shall be conducted in coordination and consultation with the client's external service provider to ensure continuous communication and collaboration between the Doorway and service provider.

3.1.11.7. Each successful contact shall include, but not be limited to:

3.1.11.7.1.1. Inquiring on the status of each client's recovery and experience with their external service provider.

3.1.11.7.1.2. Identifying client needs.

3.1.11.7.1.3. Assisting the client with addressing needs, as identified in Part 3.1.11.5.3.

3.1.11.7.1.4. Providing early intervention to clients who have relapsed or whose recovery is at risk.

3.1.11.8. Collecting and documenting attempts to collect client-level data at multiple intervals including, but not limited to ensuring the GPRA Interview tool is completed and entered into the SAMHSA's Performance Accountability and Reporting System (SPARS), at a minimum:

3.1.11.8.1. At intake or no later than seven (7) calendar days after the GPRA interview is conducted.

3.1.11.8.2. Six (6) months post intake into Doorway services.

3.1.11.8.3. Upon discharge from the initially referred service.

3.1.11.9. Documenting any loss of contact in the SPARS system using the appropriate process and protocols as defined by SAMHSA through technical assistance provided under the SOR grant.

3.1.11.10. Ensuring contingency management strategies are utilized to increase client engagement in follow-up GPRA interviews, which may include, but are not limited to gift cards provided to clients for follow-up participation at each follow-up interview, which shall not exceed thirty dollars ($30) in value, ensuring payments are not used to incentivize participation in treatment.

3.1.11.11. Assisting individuals who are unable to secure financial resources, with enrollment in public or private insurance programs including but not limited to New Hampshire Medicaid, Medicare, and or waiver programs within fourteen (14) calendar days after intake.

3.1.11.12. Providing Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the Department's Naloxone Distribution Policy.

3.2. The Contractor shall obtain consent forms from all clients served, either in-person, telehealth or other electronic means, to ensure compliance with all applicable state and federal confidentiality laws.

3.3. The Contractor shall provide services in accordance with:

3.3.1. The twelve (12) Core Functions of the Alcohol and Other Drug Counselor.

3.3.2. The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.

3.3.3. The four (4) recovery domains, as described by the International Credentialing and Reciprocity Consortium.

3.3.4. TIP 27: Comprehensive Case Management for Substance Abuse Treatment.

3.4. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers that include the utilization of the closed loop referral system procured by the Department.

3.5. The Contractor shall provide information to all individuals seeking services on how to file a grievance in the event of dissatisfaction with services provided. The Contractor shall ensure each individual seeking services receives information on:

3.5.1. The steps to filing an informal complaint with the Contractor, including the specific contact person to whom the complaint should be sent.

3.5.2. The steps to filing an official grievance with the Contractor and the Department with specific instructions on where and to whom the official grievance should be addressed.

3.6. The Contractor shall provide written policies and the formalized agreements to the Department for review and approval within twenty (20) business days of the contract

effective date and thereafter when new agreements are entered into, policies are adopted, or when information is requested by the Department that include, but not limited to:

3.6.1. Privacy notices and consent forms.

3.6.2. Conflict of interest and financial assistance documentation.

3.6.3. Shelter vouchers.

3.6.4. Referrals and evaluation from other providers.

3.6.5. Complaints.

3.6.6. Grievances.

3.6.7. Formalized agreements with community partners and other agencies that include, but are not limited to:

3.6.7.1. 2-1-1 NH.

3.6.7.2. Other Doorway partners.

3.6.7.3. Providers and supports available after normal Doorway operating hours.

4. Subcontracting for the Doorways

4.1. The Doorway shall submit all subcontracts the Doorway proposes to enter into for services funded through this contract to the Department for approval prior to execution.

4.2. The Doorway may subcontract, with prior approval of the Department, for support and assistance in providing core Doorway services, which include:

4.2.1. Screening;

4.2.2. Assessment;

4.2.3. Evaluation;

4.2.4. Referral;

4.2.5. Continuous case management;

4.2.6. GPRA data completion; and

4.2.7. Naloxone distribution.

4.3. The Doorway shall at all times be responsible for continuous oversight of, and compliance with, all Core Doorway services and shall be the single point of contact with the Department for those Core services.

4.4. Any subcontract for support and assistance in providing Core Doorway services shall ensure that the patient experience is consistent across the continuum of Core Doorway services and the subcontracted entities and personnel are at all times acting, in name and in fact, as agents of the Doorway. The Doorway shall consolidate Core Doorway services, to the greatest extent practicable, in a single location.

4.5. The Doorway may collaborate with the Department to identify and obtain the services of an agent to handle the fiscal and administrative processes for payment of flexible needs funds, ensuring all uses of flexible needs funds are approved by the Doorway, in accordance with approved policies.

5. Staffing

5.1. The Contractor shall ensure staff during regular hours of operation includes, at a minimum:

5.1.1. One (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically.

5.1.2. One (1) CRSW with the ability to fulfill recovery support and care coordination functions.

5.1.3. One (1) staff person, who can be a licensed clinician, CRSW, or other non-clinical support staff, capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.2. The Contractor shall ensure sufficient staffing levels appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Doorway.

5.3. The Contractor may provide alternative staffing, either temporary or long-term, for Department approval, thirty (30) calendar days before making the change to staffing.

5.4. The Contractor shall ensure all unlicensed staff providing treatment, education or recovery support services are directly supervised by a licensed supervisor.

5.5. The Contractor shall ensure no licensed supervisor supervises more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.6. The Contractor shall ensure peer clinical supervision is provided for all clinicians including, but not limited to:

5.6.1. Weekly discussion of cases with suggestions for resources or alternative approaches.

5.6.2. Group supervision to help optimize the learning experience, when enough candidates are under supervision.

5.7. The Contractor shall ensure staff meet all training requirements, which may be satisfied through existing licensure requirements and/or Department-approved alternative training curriculums or certifications and include, but are not limited to:

5.7.1. For all clinical staff:

5.7.1.1. Suicide prevention and early warning signs.

5.7.1.2. The 12 Core Functions of the Alcohol and Other Drug Counselor.

5.7.1.3. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics.

5.7.1.4. An approved course on the twelve (12) core functions and The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within twelve (12) months of hire.

5.7.1.5. A Department-approved ethics course within twelve (12) months of hire.

5.7.2. For recovery support staff and other non-clinical staff working directly with clients:

5.7.2.1. Knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee.

5.7.2.2. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics, and confidentiality safeguards in accordance with HIPAA and 42 CFR Part 2, and state rules and laws.

5.7.2.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium

5.7.2.4. An approved ethics course within twelve (12) months of hire.

5.7.3. Ensuring all recovery support staff and clinical staff receive annual continuous education regarding SUD.

5.7.4. Providing in-service training to all staff involved in client care within fifteen (15) business days of the contract effective date, or the staff person's start date, on the following:

5.7.4.1. The contract requirements.

5.7.4.2. All other relevant policies and procedures provided by the Department.

5.8. The Contractor shall provide staff, subcontractors, or end users as defined in Exhibit K with periodic training in practices and procedures to ensure compliance with information security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.9. The Contractor shall notify the Department in writing:

5.9.1. Within one (1) week of hire of a new administrator, coordinator or any staff person essential to meeting the terms and conditions of this contract.

5.9.2. Within seven (7) calendar days when there is not sufficient staffing to perform all required services for more than one (1) month.

5.10. The Contractor shall have policies and procedures, as approved by the Department, related to student interns to address minimum coursework, experience, and core competencies for those interns having direct contact with individuals served by this contract.

5.11. The Contractor shall ensure that student interns complete a Department-approved ethics course and a Department-approved course on the twelve (12) core functions as described in Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within six (6) months of beginning their internship.

6. Records.

6.1. The Contractor shall maintain the following records, to be provided to the Department upon request:

6.1.1. Books, records, documents and other electronic or physical data evident of all expenses incurred, and all income received by the Contractor related to Exhibit A, Scope of Services.

6.1.2. All records shall be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all costs and expenses, and are acceptable to the Department, to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

6.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

6.1.4. Medical records on each patient/recipient of services.

7. Health Insurance Portability and Accountability Act and Confidentiality:

7.1. The Contractor is a covered entity as defined under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 160, 162 and 164, and shall comply with all confidentiality requirements and safeguards set forth in state and federal law and rules. The Contractor is also a SUD provider as defined under 42 CFR Part 2 and shall safeguard confidential information as required. The Contractor shall ensure compliance with all consent and notice requirements prohibiting the redisclosure of confidential information in accordance with 42 CFR Part 2.

7.2. All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the disclosure of any protected health information shall be in accordance with the regulatory provisions of HIPAA, 42 CFR Part 2, and applicable state and federal laws and rules. Further, the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, their attorney or guardian. Notwithstanding anything to the contrary contained herein, the covenants and conditions contained in this Section 7. of Exhibit A, Scope of Services shall survive the termination of the Contract for any reason whatsoever.

8. Reporting Requirements.

8.1. The Contractor shall comply with all aspects of the Department of Health and Human Services Bureau of Quality Assurance and Improvement Sentinel Event Reporting and Review Policy PO.1003 (referred to as PO. 1003), effective April 24, 2019, and any subsequent versions and/or amendments.

8.2. The Contractor shall report to the Department of Health and Human Services Bureau of Drug and Alcohol Services within twenty-four (24) hours and follow up with written documentation submitted to the Bureau of Quality Assurance and Improvement within seventy-two (72) hours, as specified in PO.1003, any sentinel event that occurs with any individual who is receiving services under this contract. This does not replace the responsibility of the Contractor's responsibility to notify the appropriate authority if the Contractor suspects a crime has occurred.

8.3. The Contractor shall provide any information requested by the Department as follow up to a sentinel event report, or to complete a sentinel event review, with or without involvement in a requested sentinel event review.

8.4. The Contractor shall submit monthly activity reports on templates provided by the Department with data elements that include, but may not be limited to:

8.4.1. Call counts.

8.4.2. Counts of clients seen, separately identifying new clients and clients who revisit the Doorway after being administratively discharged.

8.4.3. Reason types.

8.4.4. Count of clinical evaluations.

8.4.5. Count of referrals made and type.

8.4.6. Naloxone distribution.

8.4.7. Referral statuses.

8.4.8. Recovery monitoring contacts.

8.4.9. Service wait times, flex fund utilization.

8.4.10. Respite shelter utilization.

8.5. The Contractor shall submit reports on naloxone kits distributed, utilizing a template provided by the Department.

8.6. The Contractor shall report on required data points specific to this SOR grant as identified by SAMHSA over the grant period.

8.7. The Contractor shall be required to prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department or SAMHSA.

9. Performance Measures

9.1. The Department seeks to actively and regularly collaborate with providers to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

9.2. The Department may collect other key data and metrics from Contractor(s), including client-level demographic, performance, and service data.

9.3. The Department may identify expectations for active and regular collaboration, including key performance measures, in the resulting contract. Where applicable, Contractor(s) must collect and share data with the Department in a format specified by the Department.

10. Contract Management

10.1. The Contractor shall participate in periodic meetings with the Department to review the operational status of the Doorway, for the duration of the contract.

10.2. The Contractor shall participate in operational site reviews on a schedule provided by the Department. All contract deliverables, programs, and activities shall be subject to review during this time. The Contractor shall:

10.2.1. Ensure the Department has access sufficient for monitoring of contract compliance requirements.

10.2.2. Ensure the Department is provided with access that includes but is not limited to:

10.2.2.1. Data.

10.2.2.2. Financial records.

10.2.2.3. Scheduled access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.4. Unannounced access to Contractor work sites, locations, work spaces and associated facilities.

10.2.2.5. Scheduled access to Contractor principals and staff.

10.3. The Contractor shall provide a Doorway information sheet and work plan regarding the Doorway's operations to the Department, annually, for review in the format prescribed by the Department.

11. SOR Grant Standards

11.1. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

11.2. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review the proposed plan for contract implementation.

11.3. The Contractor and/or referred providers shall ensure that only Food and Drug Administration approved MAT for OUD is utilized.

11.4. The Contractor and referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

11.5. The Contractor and referred providers shall ensure that all uses of flexible needs funds and respite shelter funds are in compliance with the Department and SAMHSA requirements, which includes, but is not limited to ensuring recovery housing facilities utilized by clients are certified based on national standards aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

11.6. The Contractor and referred providers shall ensure staff who are trained in Presumptive Eligibility for Medicaid are available to assist clients with enrolling in public or private health insurance.

11.7. The Contractor and referred providers shall accept clients on MAT and facilitate access to MAT on-site or through referral for all clients supported with SOR Grant funds, as clinically appropriate.

11.8. The Contractor and referred providers shall coordinate with the NH Ryan White HIV/AIDs program for clients identified as at risk of, or with, HIV/AIDS.

11.9. The Contractor and referred providers shall ensure that all clients are regularly screened for tobacco use, treatment needs and referral to the QuitLine as part of treatment planning.

11.10. The Contractor shall collaborate with the Department to ensure compliance with all appropriate Department, State of NH, SAMHSA, and other Federal terms, conditions, and requirements.

11.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

11.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

11.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

11.11.3. This marijuana restriction applies to all subcontracts and MOUs that receive SOR funding.

11.11.4. Attestations will be provided to the Contractor by the Department.

11.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

11.12. The Contractor shall refer to Exhibit B for grant terms and conditions including, but not limited to:

11.12.1. Invoicing.

11.12.2. Funding restrictions.

11.12.3. Billing.

12. Data Management Requirements

12.1. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements, which is attached hereto and incorporated by reference herein.

13. Termination Report/Transition Plan

13.1. In the event of early termination of the Agreement, the Contractor shall, within fifteen (15) days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

13.2. The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

13.3. In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

13.4. The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

13.5. During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

14. Credits and Copyright Ownership

14.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement, "The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

14.2. All materials produced or purchased under the contract shall have prior approval from the Department before printing, production, distribution or use. The Department will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. The Contractor shall not reproduce any materials produced under the contract without prior written approval from the Department.

15. Operation of Facilities: Compliance with Laws and Regulations

15.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be

required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. Equal Employment Opportunity Plan (EEOP)

16.1. The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non- profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. Equipment Purchases

17.1. The Contractor shall submit to the Department's Contract Unit a list of the purchased office equipment (with funding from this Contract). The list shall include office equipment such as, but not limited to, laptop computers, printers/scanners, and phones with the make, model, and serial number of each piece of office equipment.

17.2. The Contractor shall return said office equipment in Subsection 17.1. to the Department's Contract Unit within thirty (30) days from the completion date of the Contract.

18. Compliance with Federal and State Laws

18.1. If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

18.2. Time and Manner of Determination.

18.2.1. Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

18.3. Documentation

18.3.1. In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

18.4. Fair Hearings

18.4.1. The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

EXHIBIT C Amendment #1

Payment Terms

1. This Agreement is funded by:
   1.1. 97.28% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI081685, and as awarded on 09/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN H79TI083326.
   1.2. 2.72% Other Funds from Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment Funds.
2. Governor Commission Funds
   2.1. The Contractor shall utilze funds in Exhibit C-4 Amendment #1 GovComm and Exhibit C-6 Amendment #1 GovComm for the purpose of providing services and supports to clients whose needs to not make them eliglbe to receive SOR-funded services and supports.
   2.2. The Contractor shall collaborate with the Department to determine appropriate services and supports along with developing and submitting reports and invoices that are separate from reports and invoices submitted for SOR grant funds.
3. For the purposes of this Agreement:
   3.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR §200.330.
   3.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   3.3. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibit C-1, Budget through Exhibit C-7 Amendment #1 SOR II.
5. The Contractor shall seek payment for services, as follows:
   5.1. First, the Contractor shall charge the client's private insurance or other payor sources.
   5.2. Second, the Contractor shall charge Medicare.
   5.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      5.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.

5.3.2. Medicaid Fee for Service: The Contractor shall bill Medicaid for services on the Fee for Service (FFS) schedule.

5.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.

5.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.

6. The Contractor shall submit an invoice in a form satisfactory to the State by the fifteenth (15th) working day of the following month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment. Invoices shall be net any other revenue received towards the services billed in fulfillment of this agreement. The Contractor shall ensure:

6.1. Backup documentation includes, but is not limited to:

6.1.1. General Ledger showing revenue and expenses for the contract.

6.1.2. Timesheets and/or time cards that support the hours employees worked for wages reported under this contract.

6.1.2.1. Per 45 CFR Part 75.430(i)(1) Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed.

6.1.2.2. Attestation and time tracking templates, which are available to the Department upon request.

6.1.3. Invoices supporting expenses reported:

6.1.3.1. Unallowable expenses include, but are not limited to:

6.1.3.1.1. Amounts belonging to other programs.

6.1.3.1.2. Amounts prior to effective date of contract.

6.1.3.1.3. Construction or renovation expenses.

6.1.3.1.4. Food or water for employees.

6.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.

6.1.3.1.6. Fines, fees, or penalties.

6.1.3.1.7. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference

grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed three dollars ($3.00) per person for clients.

6.1.3.1.8. Cell phones and cell phone minutes for clients.

6.1.4. Receipts for expenses within the applicable state fiscal year.

6.1.5. Cost center reports.

6.1.6. Profit and loss report.

6.1.7. Remittance Advices from the insurances billed. Remittance Advices do not need to be supplied with the invoice, but should be retained to be available upon request.

6.1.8. Information requested by the Department verifying allocation or offset based on third party revenue received.

6.1.9. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

7. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the Funding Opportunity Announcement (FOA).

8. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to melissa.girard@dhhs.nh.gov, or invoices may be mailed to:

   SOR Financial Manager
   Department of Health and Human Services
   105 Pleasant Street
   Concord, NH 03301

9. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

10. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available.

11. 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.

12. The Contractor must provide the services in Exhibit B, Amendment #1 Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B Amendment #1, Scope of Services, including failure to submit required monthly and/or quarterly reports.

14. Notwithstanding Paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

15. Audits

15.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

15.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

15.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

15.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

15.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

15.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

15.4. Any Contractor that receives an amount equal to or greater than $250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA if the Department's risk assessment determination indicates the Contractor is high-risk.

15.5. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region
SS-2019-BDAS-05-ACCESS-09
Budget Period: SFY21 09/30/20-12/31/20 (NCE)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 83,203.00	$ -	$ 83,203.00	$ -	$ -	$ -	$ 83,203.00	$ -	$ 83,203.00
2. Employee Benefits	$ 24,961.00	$ -	$ 24,961.00	$ -	$ -	$ -	$ 24,961.00	$ -	$ 24,961.00
3. Consultants	$ 28,000.00	$ -	$ 28,000.00	$ -	$ -	$ -	$ 28,000.00	$ -	$ 28,000.00
4. Equipment:	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
5. Supplies:	$ 181,500.00	$ -	$ 181,500.00	$ -	$ -	$ -	$ 181,500.00	$ -	$ 181,500.00
6. Travel	$ 1,000.00	$ -	$ 1,000.00	$ -	$ -	$ -	$ 1,000.00	$ -	$ 1,000.00
7. Occupancy	$ 17,500.00	$ -	$ 17,500.00	$ -	$ -	$ -	$ 17,500.00	$ -	$ 17,500.00
8. Current Expenses	$ 3,150.00	$ -	$ 3,150.00	$ -	$ -	$ -	$ 3,150.00	$ -	$ 3,150.00
9. Software	$ 1.00	$ -	$ 1.00	$ -	$ -	$ -	$ 1.00	$ -	$ 1.00
10. Marketing/Communications	$ 5,000.00	$ -	$ 5,000.00	$ -	$ -	$ -	$ 5,000.00	$ -	$ 5,000.00
11. Staff Education and Training	$ 2,500.00	$ -	$ 2,500.00	$ -	$ -	$ -	$ 2,500.00	$ -	$ 2,500.00
12. Subcontracts/Agreements	$ 71,500.00	$ -	$ 71,500.00	$ -	$ -	$ -	$ 71,500.00	$ -	$ 71,500.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Respite	$ 230,000.00	$ -	$ 230,000.00	$ -	$ -	$ -	$ 230,000.00	$ -	$ 230,000.00
Flex Funds	$ 152,686.00	$ -	$ 152,686.00	$ -	$ -	$ -	$ 152,686.00	$ -	$ 152,686.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 802,501.00	$ -	$ 802,501.00	$ -	$ -	$ -	$ 802,501.00	$ -	$ 802,501.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS AW

Date 12/15/2020

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region
SS-2019-BDAS-05-ACCESS-09

Budget Period: SFY21 09/30/20-06/30/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 18,750.00	$ -	$ 18,750.00	$ -	$ -	$ -	$ 18,750.00	$ -	$ 18,750.00
2. Employee Benefits	$ 5,625.00	$ -	$ 5,625.00	$ -	$ -	$ -	$ 5,625.00	$ -	$ 5,625.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements		$ -	$ -	$ -	$ -	$ -		$ -	$ -
13. Other (specific details mandatory):	$ 77,734.00	$ -	$ 77,734.00	$ -	$ -	$ -	$ 77,734.00	$ -	$ 77,734.00
Respite	$ 68,250.00	$ -	$ 68,250.00	$ -	$ -	$ -	$ 68,250.00	$ -	$ 68,250.00
Flex	$ 38,133.00	$ -	$ 38,133.00	$ -	$ -	$ -	$ 38,133.00	$ -	$ 38,133.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 208,492.00	$ -	$ 208,492.00	$ -	$ -	$ -	$ 208,492.00	$ -	$ 208,492.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS

Date 12/15/2020

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region
SS-2019-BDAS-05-ACCESS-09

Budget Period: SFY21 01/01/21-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 159,158.00	$ -	$ 159,158.00	$ -	$ -	$ -	$ 159,158.00	$ -	$ 159,158.00
2. Employee Benefits	$ 47,748.00	$ -	$ 47,748.00	$ -	$ -	$ -	$ 47,748.00	$ -	$ 47,748.00
3. Consultants	$ 52,000.00	$ -	$ 52,000.00	$ -	$ -	$ -	$ 52,000.00	$ -	$ 52,000.00
4. Equipment:	$ 3,000.00	$ -	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00	$ -	$ 3,000.00
5. Supplies:	$ 363,000.00	$ -	$ 363,000.00	$ -	$ -	$ -	$ 363,000.00	$ -	$ 363,000.00
6. Travel	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00	$ -	$ 2,000.00
7. Occupancy	$ 35,000.00	$ -	$ 35,000.00	$ -	$ -	$ -	$ 35,000.00	$ -	$ 35,000.00
8. Current Expenses	$ 6,900.00	$ -	$ 6,900.00	$ -	$ -	$ -	$ 6,900.00	$ -	$ 6,900.00
9. Software	$ 1.00	$ -	$ 1.00	$ -	$ -	$ -	$ 1.00	$ -	$ 1.00
10. Marketing/Communications	$ 10,000.00	$ -	$ 10,000.00	$ -	$ -	$ -	$ 10,000.00	$ -	$ 10,000.00
11. Staff Education and Training	$ 5,000.00	$ -	$ 5,000.00	$ -	$ -	$ -	$ 5,000.00	$ -	$ 5,000.00
12. Subcontracts/Agreements	$ 141,900.00	$ -	$ 141,900.00	$ -	$ -	$ -	$ 141,900.00	$ -	$ 141,900.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Respite	$ 452,500.00	$ -	$ 452,500.00	$ -	$ -	$ -	$ 452,500.00	$ -	$ 452,500.00
Flex Funds	$ 567,793.00	$ -	$ 567,793.00	$ -	$ -	$ -	$ 567,793.00	$ -	$ 567,793.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 1,846,000.00	$ -	$ 1,846,000.00	$ -	$ -	$ -	$ 1,846,000.00	$ -	$ 1,846,000.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS AW

Date 12/15/2020

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region
SS-2019-BDAS-05-ACCESS-09
Budget Period: SFY22 07/01/21-09/29/21 (GovComm)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 6,250.00	$ -	$ 6,250.00	$ -	$ -	$ -	$ 6,250.00	$ -	$ 6,250.00
2. Employee Benefits	$ 1,875.00	$ -	$ 1,875.00	$ -	$ -	$ -	$ 1,875.00	$ -	$ 1,875.00
3. Consultants		$ -	$ -	$ -	$ -	$ -		$ -	$ -
4. Equipment:		$ -	$ -	$ -	$ -	$ -		$ -	$ -
5. Supplies:		$ -	$ -	$ -	$ -	$ -		$ -	$ -
6. Travel		$ -	$ -	$ -	$ -	$ -		$ -	$ -
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses		$ -	$ -	$ -	$ -	$ -		$ -	$ -
9. Software		$ -	$ -	$ -	$ -	$ -		$ -	$ -
10. Marketing/Communications		$ -	$ -	$ -	$ -	$ -		$ -	$ -
11. Staff Education and Training		$ -	$ -	$ -	$ -	$ -		$ -	$ -
12. Subcontracts/Agreements	$ 26,284.00	$ -	$ 26,284.00	$ -	$ -	$ -	$ 26,284.00	$ -	$ 26,284.00
13. Other (specific details mandatory):		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Respite	$ 23,000.00	$ -	$ 23,000.00	$ -	$ -	$ -	$ 23,000.00	$ -	$ 23,000.00
Flex	$ 12,088.00	$ -	$ 12,088.00	$ -	$ -	$ -	$ 12,088.00	$ -	$ 12,088.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 69,497.00	$ -	$ 69,497.00	$ -	$ -	$ -	$ 69,497.00	$ -	$ 69,497.00

Indirect As A Percent of Direct 0.0%

Contractor Initials DS AW

Date 12/15/2020

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Catholic Medical Center

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services (from herein referred to as the "Doorway"), Greater Manchester Region
SS-2019-BDAS-05-ACCESS-09

Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 85,701.00	$ -	$ 85,701.00	$ -	$ -	$ -	$ 85,701.00	$ -	$ 85,701.00
2. Employee Benefits	$ 25,711.00	$ -	$ 25,711.00	$ -	$ -	$ -	$ 25,711.00	$ -	$ 25,711.00
3. Consultants	$ 28,000.00	$ -	$ 28,000.00	$ -	$ -	$ -	$ 28,000.00	$ -	$ 28,000.00
4. Equipment:	$ 1,500.00	$ -	$ 1,500.00	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
5. Supplies:	$ 181,500.00	$ -	$ 181,500.00	$ -	$ -	$ -	$ 181,500.00	$ -	$ 181,500.00
6. Travel	$ 1,000.00	$ -	$ 1,000.00	$ -	$ -	$ -	$ 1,000.00	$ -	$ 1,000.00
7. Occupancy	$ 17,500.00	$ -	$ 17,500.00	$ -	$ -	$ -	$ 17,500.00	$ -	$ 17,500.00
8. Current Expenses	$ 3,150.00	$ -	$ 3,150.00	$ -	$ -	$ -	$ 3,150.00	$ -	$ 3,150.00
9. Software	$ 1.00	$ -	$ 1.00	$ -	$ -	$ -	$ 1.00	$ -	$ 1.00
10. Marketing/Communications	$ 5,000.00	$ -	$ 5,000.00	$ -	$ -	$ -	$ 5,000.00	$ -	$ 5,000.00
11. Staff Education and Training	$ 2,500.00	$ -	$ 2,500.00	$ -	$ -	$ -	$ 2,500.00	$ -	$ 2,500.00
12. Subcontracts/Agreements	$ 72,800.00	$ -	$ 72,800.00	$ -	$ -	$ -	$ 72,800.00	$ -	$ 72,800.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Respite	$ 230,000.00	$ -	$ 230,000.00	$ -	$ -	$ -	$ 230,000.00	$ -	$ 230,000.00
Flex Funds	$ 268,837.00	$ -	$ 268,837.00	$ -	$ -	$ -	$ 268,837.00	$ -	$ 268,837.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 923,000.00	$ -	$ 923,000.00	$ -	$ -	$ -	$ 923,000.00	$ -	$ 923,000.00
Indirect As A Percent of Direct		0.0%							

Contractor Initials DS AW

Date 12/15/2020

State of New Hampshire

Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that CATHOLIC MEDICAL CENTER is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on November 07, 1974. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **62116**

Certificate Number: **0005049262**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of December A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Matthew Kfoury, do hereby certify that:

1. I am the duly elected Secretary of Catholic Medical Center, a New Hampshire voluntary corporation ("CMC");

2. Joseph Pepe, M.D. is the duly elected President & CEO of CMC.

3. Alexander J. Walker, is the duly elected Executive Vice President and Chief Operating Officer of CMC.

4. The attached Exhibit A is a true copy of resolutions duly adopted at a meeting of the Board of Trustees of CMC, duly held on October 22, 2020;

5. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of the 1st day of December, 2020 and this authority remains valid for thirty (30) days from the date of this Certificate of Authority; and

6. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence from CMC that I am the Secretary of CMC and that Dr. Pepe and Mr. Walker have the authority to bind CMC. To the extent that there are any limits on the authority of Dr. Pepe, Mr. Walker, or myself to bind CMC in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

I have hereunto set my hand as the Secretary of CMC this 1st day of December 2020.

s/ Matthew Kfoury
Matthew Kfoury, Secretary

Exhibit A

PROPOSED RESOLUTIONS

OF THE

BOARD OF TRUSTEES

OF CATHOLIC MEDICAL CENTER ("CMC")

Authorizing CMC to enter into Contracts with the State of New Hampshire

October 22, 2020

RESOLVED: That CMC be authorize to enter into contracts, amendments, renewals, revisions or modifications thereto, with the State of New Hampshire, including any of its agencies or departments.

RESOLVED: That the Joseph Pepe, M.D., as President & CEO of CMC and Alexander J. Walker, as Executive Vice President and Chief Operating Officer are hereby jointly and severally authorized on behalf of CMC to enter into contracts with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he may deem necessary, desirable, or appropriate.

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/19/2020

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
MARSH USA, INC.
99 HIGH STREET
BOSTON, MA 02110
Attn: Boston.certrequest@Marsh.com Fax: 212-948-4377

CN109021768-ALL-GAWXP-20-21

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Pro Select Insurance Company	
INSURER B : Safety National Casualty Corp.	15105
INSURER C : N/A	N/A
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
CMC HEALTHCARE SYSTEM
100 MCGREGOR STREET
MANCHESTER, NH 03102

COVERAGES **CERTIFICATE NUMBER:** NYC-009552485-14 **REVISION NUMBER:** 11

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			002NH0000016052	10/01/2020	10/01/2021	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	N/A		SP 4063859	10/01/2020	10/01/2021	X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N			*SIR $750,000			E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

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 of Marsh USA Inc.
Manashi Mukherjee Manashi Mukherjee

The heart of Catholic Medical Center is to carry out Christ's healing ministry by offering **health, healing, and hope** to every individual who seeks our care.

CMC

CATHOLIC MEDICAL CENTER

a member of GraniteOne Health

BAKER NEWMAN NOYES

CMC Healthcare System, Inc.

Audited Consolidated Financial Statements and Other Financial Information

Years Ended September 30, 2019 and 2018
With Independent Auditors' Report

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

CMC HEALTHCARE SYSTEM, INC.

AUDITED CONSOLIDATED FINANCIAL STATEMENTS
AND OTHER FINANCIAL INFORMATION

Years Ended September 30, 2019 and 2018

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BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

INDEPENDENT AUDITORS' REPORT

Board of Trustees
CMC Healthcare System, Inc.

We have audited the accompanying consolidated financial statements of CMC Healthcare System, Inc., which comprise the consolidated balance sheets as of September 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.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Board of Trustees
CMC Healthcare System, Inc.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CMC Healthcare System, Inc. as of September 30, 2019 and 2018, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, in 2019, CMC Healthcare System, Inc. adopted the provisions of Financial Accounting Standards Board Accounting Standards Update No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities* and applied the guidance retrospectively for all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED BALANCE SHEETS

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets:		
Cash and cash equivalents	$ 56,249,490	$ 61,849,320
Short-term investments	4,021,270	29,009,260
Accounts receivable, less allowance for doubtful accounts of $20,265,887 in 2019 and $20,526,837 in 2018	79,322,642	55,326,986
Inventories	4,600,802	3,583,228
Other current assets	14,198,223	10,664,957
Total current assets	158,392,427	160,433,751
Property, plant and equipment, net	143,111,363	134,597,894
Other assets:		
Intangible assets and other	18,600,614	17,581,549
Assets whose use is limited:		
Pension and insurance obligations	18,832,810	17,859,458
Board designated and donor restricted investments and restricted grants	129,341,870	127,267,085
Held by trustee under revenue bond agreements	18,845,355	36,660,053
	167,020,035	181,786,596
Total assets	$487,124,439	$494,399,790

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities:		
Accounts payable and accrued expenses	$ 38,985,902	$ 30,789,153
Accrued salaries, wages and related accounts	22,973,478	22,673,489
Amounts payable to third-party payors	11,456,467	14,643,104
Current portion of long-term debt	4,158,079	4,365,199
Total current liabilities	77,573,926	72,470,945
Accrued pension and other liabilities, less current portion	172,049,836	122,463,230
Long-term debt, less current portion	121,883,751	122,913,717
Total liabilities	371,507,513	317,847,892
Net assets:		
Without donor restrictions	104,372,035	166,125,080
With donor restrictions	11,244,891	10,426,818
Total net assets	115,616,926	176,551,898
Total liabilities and net assets	$487,124,439	$494,399,790

See accompanying notes.

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018

	2019	2018
Net patient service revenues, net of contractual allowances and discounts	$465,757,562	$452,510,375
Provision for doubtful accounts	(21,644,644)	(20,334,249)
Net patient service revenues less provision for doubtful accounts	444,112,918	432,176,126
Other revenue	21,610,585	19,454,686
Disproportionate share funding	22,566,094	17,993,289
Total revenues	488,289,597	469,624,101
Expenses:		
Salaries, wages and fringe benefits	284,646,960	266,813,278
Supplies and other	169,119,057	160,290,214
New Hampshire Medicaid enhancement tax	21,382,132	19,968,497
Depreciation and amortization	16,902,437	16,136,984
Interest	4,224,046	4,368,765
Total expenses	496,274,632	467,577,738
(Loss) income from operations	(7,985,035)	2,046,363
Nonoperating gains (losses):		
Investment income, net	4,120,862	6,086,794
Net periodic pension cost, other than service cost	(640,624)	(1,099,092)
Contributions without donor restrictions	834,004	629,198
Development costs	(739,596)	(635,408)
Other nonoperating loss	(3,135,699)	(489,294)
Total nonoperating gains, net	438,947	4,492,198
(Deficiency) excess of revenues and gains over expenses	(7,546,088)	6,538,561
Unrealized appreciation on investments	912,170	2,325,151
Change in fair value of interest rate swap agreement	(482,735)	302,826
Assets released from restriction used for capital	434,010	128,600
Pension-related changes other than net periodic pension cost	(55,070,402)	20,436,931
Change in net assets without donor restrictions	(61,753,045)	29,732,069
Net assets without donor restrictions at beginning of year	166,125,080	136,393,011
Net assets without donor restrictions at end of year	$104,372,035	$166,125,080

See accompanying notes.

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2019 and 2018

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total Net Assets
Balances at September 30, 2017	$136,393,011	$ 9,726,007	$146,119,018
Excess of revenues and gains over expenses	6,538,561	–	6,538,561
Restricted investment income	–	27,373	27,373
Changes in interest in perpetual trust	–	341,439	341,439
Donor restricted contributions	–	646,924	646,924
Unrealized appreciation on investments	2,325,151	61,431	2,386,582
Change in fair value of interest rate swap agreement	302,826	–	302,826
Assets released from restriction used for operations	–	(247,756)	(247,756)
Assets released from restriction used for capital	128,600	(128,600)	–
Pension-related changes other than net periodic pension cost	20,436,931	–	20,436,931
	29,732,069	700,811	30,432,880
Balances at September 30, 2018	166,125,080	10,426,818	176,551,898
Deficiency of revenues and gains over expenses	(7,546,088)	–	(7,546,088)
Restricted investment income	–	31,596	31,596
Changes in interest in perpetual trust	–	(110,168)	(110,168)
Donor restricted contributions	–	1,536,316	1,536,316
Unrealized appreciation on investments	912,170	15,219	927,389
Change in fair value of interest rate swap agreement	(482,735)	–	(482,735)
Assets released from restriction used for operations	–	(220,880)	(220,880)
Assets released from restriction used for capital	434,010	(434,010)	–
Pension-related changes other than net periodic pension cost	(55,070,402)	–	(55,070,402)
	(61,753,045)	818,073	(60,934,972)
Balances at September 30, 2019	$104,372,035	$11,244,891	$115,616,926

See accompanying notes.

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018

	2019	2018
Operating activities:		
Change in net assets	$ (60,934,972)	$ 30,432,880
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities:		
Depreciation and amortization	16,902,437	16,136,984
Pension-related changes other than net periodic pension cost	55,070,402	(20,436,931)
Restricted gifts and investment income	(1,567,912)	(674,297)
Net realized and unrealized gains on investments	(803,714)	(5,304,630)
Change in interest in perpetual trust	110,168	(341,439)
Change in fair value of interest rate swap agreement	482,735	(487,593)
Bond discount/premium and issuance cost amortization	(289,968)	(313,993)
Change in operating assets and liabilities:		
Accounts receivable, net	(23,995,656)	(5,828,809)
Inventories	(1,017,574)	(176,498)
Other current assets	(3,533,266)	1,711,535
Other assets	(1,049,682)	(1,031,639)
Accounts payable and accrued expenses	6,945,059	(5,312,460)
Accrued salaries, wages and related accounts	299,989	2,561,918
Amounts payable to third-party payors	(3,186,637)	291,872
Accrued pension and other liabilities	(5,978,340)	6,039,303
Net cash (used) provided by operating activities	(22,546,931)	17,266,203
Investing activities:		
Purchases of property, plant and equipment	(24,121,790)	(36,812,874)
Net change in assets held by trustee under revenue bond agreements	17,814,698	14,819,012
Proceeds from sales of investments	54,831,303	32,671,019
Purchases of investments	(31,397,904)	(40,605,899)
Net cash provided (used) by investing activities	17,126,307	(29,928,742)
Financing activities:		
Payments on long-term debt	(3,689,000)	(11,509,593)
Proceeds from issuance of long-term debt	3,513,632	8,130,000
Payments on capital leases	(676,199)	(707,299)
Bond issuance costs	(95,551)	(120,118)
Restricted gifts and investment income	767,912	674,297
Net cash used by financing activities	(179,206)	(3,532,713)
Decrease in cash and cash equivalents	(5,599,830)	(16,195,252)
Cash and cash equivalents at beginning of year	61,849,320	78,044,572
Cash and cash equivalents at end of year	$ 56,249,490	$ 61,849,320

Supplemental disclosure:
At September 30, 2019, amounts totaling $1,251,690 related to the purchase of property, plant and equipment were included in accounts payable and accrued expenses.

See accompanying notes.

1. Organization

CMC Healthcare System, Inc. (the System) is a not-for-profit organization formed effective July 1, 2001. The System functioned as the parent company and sole member of Catholic Medical Center (the Medical Center) (until December 31, 2016, as discussed below), Physician Practice Associates, Inc. (PPA), Alliance Enterprises, Inc. (Enterprises), Alliance Resources, Inc. (Resources), Alliance Ambulatory Services, Inc. (AAS), Alliance Health Services, Inc. (AHS), Doctors Medical Association, Inc. (DMA) and St. Peter's Home, Inc.

On December 30, 2016, the System became affiliated with Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, and Monadnock Community Hospital (MCH), a 25-bed critical access hospital in Peterborough, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of HH and MCH and co-member of the Medical Center, along with the System. GraniteOne is governed by a thirteen member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying consolidated financial statements for the years ended September 30, 2019 and 2018 do not include the accounts and activity of GraniteOne, HH and MCH.

On September 30, 2019, GraniteOne, the Medical Center, the System, certain subsidiaries of the System, HH and MCH entered into a Combination Agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. Pursuant to the terms of the Agreement, the parties intend to revise D-HH's corporate name to Dartmouth-Hitchcock Health GraniteOne (D-HH GO), which will continue to serve as the sole corporate member of the existing D-HH System Members (Mary Hitchcock Memorial Health and Dartmouth-Hitchcock Clinic, New London Hospital (NLH), Cheshire Medical Center (Cheshire), Mt. Ascutney Hospital and Health Center (MAHHC), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)), and which will be substituted for GraniteOne as the sole corporate member of HH and MCH and as co-member, of the Medical Center and certain subsidiaries of the System (the Combination). The overarching goal of the Combination is to create a New Hampshire-based, integrated and regionally distributed health care delivery system that better serves its patients and communities. While the System will not be a component of the D-HH GO System, it will continue to serve as the corporate vehicle through which the Bishop of the Diocese of Manchester (the Bishop) ensures the Medical Center's adherence to the Ethical and Religious Directives for Catholic Health Care Services. Neither the System nor the Bishop will have authority over any other D-HH GO System Member, including HH and MCH. Subject to certain rights reserved to the Bishop and the System with respect to the Medical Center and the System's subsidiaries, D-HH GO will reserve to itself certain approval and initiation powers over the governance, financial, programmatic, administrative, and strategic decisions of D-HH GO System Members.

1. Organization (Continued)

On December 30, 2019, GraniteOne, the Medical Center, HH and MCH submitted a Joint Notice of Change of Control to the New Hampshire Attorney General, Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the Combination. If all necessary approvals are obtained and closing conditions satisfied, D-HH GO will consist of a major academic medical center offering tertiary and quaternary services, an acute care community hospital in an urban setting (the Medical Center), an acute care community hospital in a rural setting (Cheshire), five rural critical access hospitals (NLH, MAHHC, APD, HH and MCH), a post-acute home health and hospice provider (VNH), and nearly 1,800 employed and affiliated primary and specialty care physicians. D-HH GO System Members will combine their resources to offer a broader array of inpatient, outpatient and ambulatory services.

2. Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements have been prepared using the accrual basis of accounting.

Principles of Consolidation

The consolidated financial statements include the accounts of the Medical Center, PPA, Enterprises, Resources, AAS, AHS, DMA and St. Peter's Home, Inc. Significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The primary estimates relate to collectibility of receivables from patients and third-party payors, amounts payable to third-party payors, accrued compensation and benefits, conditional asset retirement obligations, and self-insurance reserves.

Income Taxes

The System and all related entities, with the exception of Enterprises and DMA, are not-for-profit corporations as described in Section 501(c)(3) of the Code and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Management evaluated the System's tax positions and concluded the System has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to the consolidated financial statements.

2. Significant Accounting Policies (Continued)

Enterprises and DMA are for-profit organizations and, in accordance with federal and state tax laws, file income tax returns, as applicable. There was no significant provision for income taxes for the years ended September 30, 2019 and 2018. There are no significant deferred tax assets or liabilities. These entities have concluded there are no significant uncertain tax positions requiring disclosure and there is no material liability for unrecognized tax benefits. It is the policy of these entities to recognize interest related to unrecognized tax benefits in interest expense and penalties in income tax expense.

Performance Indicator

(Deficiency) excess of revenues and gains over expenses is comprised of operating revenues and expenses and nonoperating gains and losses. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenue and expenses. Peripheral or incidental transactions are reported as nonoperating gains or losses, which include contributions without donor restrictions, development costs, net investment income (including realized gains and losses on the sales of investments), net periodic pension costs (other than service cost), other nonoperating losses, and contributions to community agencies.

Charity Care

The System has a formal charity care policy under which patient care is provided to patients who meet certain criteria without charge or at amounts less than its established rates. The System does not pursue collection of amounts determined to qualify as charity care; therefore, they are not reported as revenues.

Of the System's $496,274,632 total expenses reported for the year ended September 30, 2019, an estimated $7,700,000 arose from providing services to charity patients. Of the System's $467,577,738 total expenses reported for the year ended September 30, 2018, an estimated $7,500,000 arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the System's total expenses divided by gross patient service revenue.

Concentration of Credit Risk

Financial instruments which subject the System to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the System's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The System's accounts receivable are primarily due from third-party payors and amounts are presented net of expected contractual allowances and uncollectible amounts. The System's investment portfolio consists of diversified investments, which are subject to market risk. Investments that exceeded 10% of investments include the SSGA S&P 500 Tobacco Free Fund and the Dreyfus Treasury Securities Cash Management Fund as of September 30, 2019 and 2018.

2. **Significant Accounting Policies (Continued)**

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit with maturities of three months or less when purchased and investments in overnight deposits at various banks. Cash and cash equivalents exclude amounts whose use is limited by board designation and amounts held by trustees under revenue bond and other agreements. The System maintains approximately $52,000,000 and $60,000,000 at September 30, 2019 and 2018, respectively, of its cash and cash equivalent accounts with a single institution. The System has not experienced any losses associated with deposits at this institution.

Net Patient Service Revenues and Accounts Receivable

The System has agreements with third-party payors that provide for payments at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, per diem payments and fee schedules. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the year the related services are rendered and adjusted in future years as final settlements are determined. Changes in these estimates are reflected in the consolidated financial statements in the year in which they occur.

The System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients, the System provides a discount approximately equal to that of its largest private insurance payors.

The provision for doubtful accounts is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. The System records a provision for doubtful accounts in the year services are provided related to self-pay patients, including both uninsured patients and patients with deductible and copayment balances due for which third-party coverage exists for a portion of their balance.

Periodically, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. Accounts receivable are written off after collection efforts have been followed in accordance with internal policies.

Inventories

Inventories of supplies are stated at the lower of cost (determined by the first-in, first-out method) or net realizable value.

2. **Significant Accounting Policies (Continued)**

Related Party Activity

The Medical Center has engaged in various transactions with GraniteOne, HH and MCH. The Medical Center recognized approximately $3.3 million and $3.4 million in revenue from these related parties for the years ended September 30, 2019 and 2018, respectively, which is reflected within other revenues in the accompanying consolidated statements of operations. The Medical Center also incurred expenses to these related parties of approximately $2.5 million and $399,000 for the years ended September 30, 2019 and 2018, respectively, of which $800,000 and $399,000, respectively, is reflected within operating expenses. Additionally, approximately $1.7 million as of September 30, 2019 is reflected within nonoperating gains (losses) in the accompanying consolidated statement of operations for the year ended September 30, 2019. As of September 30, 2019, the Medical Center had a net amount due from these related parties of approximately $2.6 million, of which $4.4 million is reflected within other current assets and $1.8 million is reflected within accounts payable and accrued expenses in the accompanying 2019 consolidated balance sheet. As of September 30, 2018, the Medical Center has a net amount due from these related parties of approximately $507,000, which is reflected within other current assets in the accompanying 2018 consolidated balance sheet.

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase or fair value at the time of donation, less accumulated depreciation. The System's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. The provisions for depreciation and amortization have been determined using the straight-line method at rates intended to amortize the cost of assets over their estimated useful lives, which range from 2 to 40 years. Assets which have been purchased but not yet placed in service are included in construction in progress and no depreciation expense is recorded.

Conditional Asset Retirement Obligations

The System recognizes the fair value of a liability for legal obligations associated with asset retirements in the year in which the obligation is incurred, in accordance with the Accounting Standards for *Accounting for Asset Retirement Obligations* (ASC 410-20). When the liability is initially recorded, the cost of the asset retirement obligation is capitalized by increasing the carrying amount of the related long lived asset. The liability is accreted to its present value each year, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the consolidated statements of operations.

As of September 30, 2019 and 2018, $1,036,702 and $1,078,784, respectively, of conditional asset retirement obligations are included within accrued pension and other liabilities in the accompanying consolidated balance sheets.

2. **Significant Accounting Policies (Continued)**

Goodwill

The System reviews its goodwill and other long-lived assets annually to determine whether the carrying amount of such assets is impaired. Upon determination that an impairment has occurred, these assets are reduced to fair value. There were no impairments recorded for the years ended September 30, 2019 or 2018. The net carrying value of goodwill is $4,490,154 at September 30, 2019 and 2018 and is reflected within intangible assets and other in the accompanying consolidated balance sheets.

Retirement Benefits

The Catholic Medical Center Pension Plan (the Plan) provides retirement benefits for certain employees of the Medical Center and PPA who have attained age twenty-one and work at least 1,000 hours per year. The Plan consists of a benefit accrued to July 1, 1985, plus 2% of plan year earnings (to legislative maximums) per year. The 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 may be determined to be appropriate from time to time. The Plan is intended to constitute a plan described in Section 414(k) of the Code, under which benefits derived from employer contributions are based on the separate account balances of participants in addition to the defined benefits under the Plan.

Effective January 1, 2008 the Medical Center decided to close participation in the Plan to new participants. As of January 1, 2008, current participants continued to participate in the Plan while new employees receive a higher matching contribution to the tax-sheltered annuity benefit program discussed below.

During 2011, the Board of Trustees voted to freeze the accrual of benefits under the Plan effective December 31, 2011.

The Plan was amended effective as of May 1, 2016 to provide a limited opportunity for certain terminated vested participants to elect an immediate lump sum or annuity distribution option.

The System also maintains tax-sheltered annuity benefit programs in which it matches one half of employee contributions up to 3% of their annual salary, depending on date of hire, plus an additional 3% - 5% based on tenure. The System made matching contributions under the program of $8,462,595 and $7,733,193 for the years ended September 30, 2019 and 2018, respectively.

During 2007, the Medical Center created a nonqualified deferred compensation plan covering certain employees under Section 457(b) of the Code. Under the plan, a participant may elect to defer a portion of their compensation to be held until payment in the future to the participant or his or her beneficiary. Consistent with the requirements of the Code, all amounts of deferred compensation, including but not limited to any investments held and all income attributable to such amounts, property, and rights will remain subject to the claims of the Medical Center's creditors, without being restricted to the payment of deferred compensation, until payment is made to the participant or their beneficiary. No contributions were made by the System for the years ended September 30, 2019 or 2018.

2. **Significant Accounting Policies (Continued)**

The System also provides a noncontributory supplemental executive retirement plan covering certain former executives of the Medical Center, as defined. The System's policy is to accrue costs under this plan using the "Projected Unit Credit Actuarial Cost Method" and to amortize past service costs over a fifteen year period. Benefits under this plan are based on the participant's final average salary, social security benefit, retirement income plan benefit, and total years of service. Certain investments have been designated for payment of benefits under this plan and are included in assets whose use is limited–pension and insurance obligations.

During 2007, the System created a supplemental executive retirement plan covering certain executives of the Medical Center under Section 457(f) of the Code. The System recorded compensation expense of $661,215 and $682,820 for the years ended September 30, 2019 and 2018, respectively, related to this plan.

Employee Fringe Benefits

The System has an "earned time" plan. Under this plan, each qualifying employee "earns" hours of paid leave for each pay period worked. These hours of paid leave may be used for vacations, holidays, or illness. Hours earned but not used are vested with the employee and are paid to the employee upon termination. The System expenses the cost of these benefits as they are earned by the employees.

Debt Issuance Costs/Original Issue Discount or Premium

The debt issuance costs incurred to obtain financing for the System's construction and renovation programs and refinancing of prior bonds and the original issue discount or premium are amortized to interest expense using the effective interest method over the repayment period of the bonds. The original issue discount or premium and debt issuance costs are presented as a component of long-term debt.

Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted include assets held by trustees under indenture agreements, pension and insurance obligations, designated assets set aside by the Board of Trustees, over which the Board retains control and may, at its discretion, subsequently use for other purposes, and donor-restricted investments.

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of the receipt of the promise. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions used for capital purchases (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the System in perpetuity.

2. **Significant Accounting Policies (Continued)**

Except for contributions related to capital purchases, donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions within net assets without donor restrictions in the accompanying consolidated financial statements.

Pledges Receivable

Pledges receivable are recognized as revenue when the unconditional promise to give is made. Pledges expected to be collected within one year are recorded at their net realizable value. Pledges that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The present value of estimated future cash flows is measured utilizing risk-free rates of return adjusted for market and credit risk established at the time a contribution is received.

Investments and Investment Income

Investments are carried at fair value in the accompanying consolidated balance sheets. See Note 8 for further discussion regarding fair value measurements. Investment income (including realized gains and losses on investments and interest and dividends) is included in the (deficiency) excess of revenues and gains over expenses unless the income is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions. Realized gains or losses on the sale of investment securities are determined by the specific identification method and are recorded on the settlement date. Unrealized gains and losses on investments are excluded from the (deficiency) excess of revenues and gains over expenses unless the investments are classified as trading securities or losses are considered other-than-temporary.

Derivative Instruments

Derivatives are recognized as either assets or liabilities in the consolidated balance sheets at fair value regardless of the purpose or intent for holding the instrument. Changes in the fair value of derivatives are recognized either in the (deficiency) excess of revenues and gains over expenses or net assets, depending on whether the derivative is speculative or being used to hedge changes in fair value or cash flows. See also Note 6.

Beneficial Interest in Perpetual Trust

The System is the beneficiary of trust funds administered by trustees or other third parties. Trusts wherein the System has the irrevocable right to receive the income earned on the trust assets in perpetuity are recorded as net assets with donor restrictions at the fair value of the trust at the date of receipt. Income distributions from the trusts are reported as investment income that increase net assets without donor restrictions, unless restricted by the donor. Annual changes in the fair value of the trusts are recorded as increases or decreases to net assets with donor restrictions.

2. **Significant Accounting Policies (Continued)**

Endowment, Investment and Spending Policies

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

Spending policies may be adopted by the System, 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 System currently has a policy allowing interest and dividend income earned on investments to be used for operations with the goal of keeping principal, including its appreciation, intact.

The System's investment policies provide guidance for the prudent and skillful management of invested assets with the objective of preserving capital and maximizing returns. The invested assets include endowment, specific purpose and board designated funds.

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events.

Specific purpose funds are temporary in nature, restricted as to time or purpose as identified by the donor or grantor. These funds have various intermediate/long-term time horizons associated with specific identified spending objectives.

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees.

Management of these assets is designed to maximize total return while preserving the capital values of the funds, protecting the funds from inflation and providing liquidity as needed. The objective is to provide a real rate of return that meets inflation, plus 4% to 5%, over a long-term time horizon.

The System targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

Federal Grant Revenue and Expenditures

Revenues and expenses under federal grant programs are recognized as the related expenditure is incurred.

2. **Significant Accounting Policies (Continued)**

Malpractice Loss Contingencies

The System has a claims-made basis policy for its malpractice insurance coverage. A claims-made basis policy provides specific coverage for claims reported during the policy term. The System has established a reserve to cover professional liability exposure, which may not be covered by insurance. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System. In the event a loss contingency should occur, the System would give it appropriate recognition in its consolidated financial statements in conformity with accounting standards. The System expects to be able to obtain renewal or other coverage in future years.

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2019 and 2018, the System recorded a liability of $13,252,269 and $12,520,618, respectively, related to estimated professional liability losses covered under this policy. At September 30, 2019 and 2018, the System also recorded a receivable of $9,584,019 and $8,829,118, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other liabilities, and intangible assets and other, respectively, on the consolidated balance sheets.

Workers' Compensation

The System maintains workers' compensation insurance under a self-insured plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the System against excessive losses. The System has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $3,069,898 and $3,061,261 at September 30, 2019 and 2018, respectively, have been discounted at 1.25% and, in management's opinion, provide an adequate reserve for loss contingencies. At September 30, 2019, $1,397,510 and $1,672,388 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying consolidated balance sheets. The System has also recorded $258,107 and $408,034 within other current assets and intangible assets and other, respectively, in the accompanying consolidated balance sheets to limit the accrued losses to the retention amount at September 30, 2019. At September 30, 2018, $1,359,646 and $1,701,615 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying consolidated balance sheets. The System has also recorded $248,403 and $408,513 within other current assets and intangible assets and other, respectively, in the accompanying consolidated balance sheets to limit the accrued losses to the retention amount at September 30, 2018.

Health Insurance

The System has a self-funded health insurance plan. The plan is administered by an insurance company and the System has employed independent actuaries to estimate unpaid claims, and those claims incurred but not reported at fiscal year end. The System was insured above a stop-loss amount of $570,000 and $375,000 at September 30, 2019 and 2018, respectively, on individual claims. Estimated unpaid claims, and those claims incurred but not reported, at September 30, 2019 and 2018 of $2,334,000 and $2,849,427, respectively, are reflected in the accompanying consolidated balance sheets within accounts payable and accrued expenses.

2. **Significant Accounting Policies (Continued)**

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in Note 11. Accordingly, costs have been allocated among program services and supporting services benefitted.

Advertising Costs

The System expenses advertising costs as incurred, and such costs totaled approximately $1,298,000 and $1,918,000 for the years ended September 30, 2019 and 2018, respectively.

Recent Accounting Pronouncements

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities.* The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the System for the year ended September 30, 2019. The System has adjusted the presentation of these consolidated financial statements and related disclosures accordingly. ASU 2016-14 has been applied retrospectively to all periods presented. The adoption of ASU 2016-14 had no impact to changes in net assets or total net assets in 2019 or 2018.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the System expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the System on October 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The System is evaluating the impact that ASU 2014-09 will have on its revenue recognition policies, but does not expect the new pronouncement will have a material impact on its consolidated financial statements.

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). The amendments in ASU 2016-01 address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. ASU 2016-01 is effective for the System for the year ended September 30, 2020, with early adoption permitted. The System is currently evaluating the impact that ASU 2016-01 will have on its consolidated financial statements.

2. **Significant Accounting Policies (Continued)**

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the System on October 1, 2021, with early adoption permitted. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the consolidated financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The System is currently evaluating the impact of the pending adoption of ASU 2016-02 on the System's consolidated financial statements.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash (a consensus of the FASB Emerging Issues Task Force)* (ASU 2016-18), which provides guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. ASU 2016-18 will be effective for the System's fiscal year ended September 30, 2020, and early adoption is permitted. ASU 2016-18 must be applied using a retrospective transition method. The System is currently evaluating the impact of the adoption of this guidance on its consolidated 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 System on October 1, 2019, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-08 will have on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement* (ASU 2018-13). The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the System on October 1, 2020, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-13 will have on its consolidated financial statements.

Subsequent Events

Management of the System evaluated events occurring between the end of the System's fiscal year and February 4, 2020, the date the consolidated financial statements were available to be issued.

3. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs, consisted of the following at September 30, 2019:

Cash and cash equivalents	$ 56,249,490
Short-term investments	4,021,270
Accounts receivable	79,322,642
	$139,593,402

To manage liquidity, the System maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the System. In addition, the System has board-designated assets that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2019, the balance in board-designated assets was approximately $110 million.

4. Net Patient Service Revenue

The following summarizes net patient service revenue for the years ended September 30:

	2019	2018
Gross patient service revenue	$1,435,238,995	$1,341,051,947
Less contractual allowances	(969,481,433)	(888,541,572)
Less provision for doubtful accounts	(21,644,644)	(20,334,249)
Net patient service revenue	$ 444,112,918	$ 432,176,126

The System maintains contracts with the Social Security Administration ("Medicare") and the State of New Hampshire Department of Health and Human Services ("Medicaid"). The System is paid a prospectively determined fixed price for each Medicare and Medicaid inpatient acute care service depending on the type of illness or the patient's diagnosis related group classification. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed price. The System receives payment for other Medicaid outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports.

Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known. The percentage of net patient service revenues earned from the Medicare and Medicaid programs was 37% and 5%, respectively, for the year ended September 30, 2019 and 39% and 5%, respectively, for the year ended September 30, 2018.

4. Net Patient Service Revenue (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The System believes that it is in compliance with all applicable laws and regulations; compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs (Note 15).

The System also maintains contracts with certain commercial carriers, health maintenance organizations, preferred provider organizations and state and federal agencies. The basis for payment under these agreements includes prospectively determined rates per discharge and per day, discounts from established charges and fee screens. The System does not currently hold reimbursement contracts which contain financial risk components.

The approximate percentages of patient service revenues, net of contractual allowances and discounts and provision for doubtful accounts for the years ended September 30 from third-party payors and uninsured patients are as follows:

	Third-Party Payors	Uninsured Patients	Total All Payors
2019			
Net patient service revenues, net of contractual allowance and discounts	99.4%	0.6%	100.0%
2018			
Net patient service revenues, net of contractual allowance and discounts	99.6%	0.4%	100.0%

An estimated breakdown of patient service revenues, net of contractual allowances, discounts and provision for doubtful accounts recognized for the years ended September 30 from major payor sources, is as follows:

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2019				
Private payors (includes coinsurance and deductibles)	$ 524,868,968	$(264,786,990)	$ (7,676,695)	$ 252,405,283
Medicaid	151,316,824	(128,250,350)	(332,821)	22,733,653
Medicare	725,090,044	(555,260,823)	(3,439,271)	166,389,950
Self-pay	33,963,159	(21,183,270)	(10,195,857)	2,584,032
	$1,435,238,995	$(969,481,433)	$(21,644,644)	$444,112,918

4. **Net Patient Service Revenue (Continued)**

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2018				
Private payors (includes coinsurance and deductibles)	$ 477,457,407	$(229,413,775)	$ (9,298,563)	$ 238,745,069
Medicaid	137,508,097	(113,364,379)	(651,292)	23,492,426
Medicare	695,141,198	(523,976,071)	(3,140,980)	168,024,147
Self-pay	30,945,245	(21,787,347)	(7,243,414)	1,914,484
	$1,341,051,947	$(888,541,572)	$(20,334,249)	$432,176,126

The System recognizes changes in accounting estimates for net patient service revenues and third-party payor settlements as new events occur or as additional information is obtained. For the year ended September 30, 2019, there were no significant adjustments recorded for changes to prior year estimates. For the year ended September 30, 2018, favorable adjustments recorded for changes to prior year estimates were approximately $1,000,000.

Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of the Medical Center's net patient service revenues with certain exclusions. The amount of tax incurred by the Medical Center for the years ended September 30, 2019 and 2018 was $21,382,132 and $19,968,497, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded in operating revenues and amounted to $22,566,094 and $17,993,289 for the years ended September 30, 2019 and 2018, respectively, net of reserves referenced below.

The Centers for Medicare and Medicaid Services (CMS) has completed audits of the State's program and the disproportionate share payments made by the State from 2011 through 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The System has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions. During 2019, the System reduced the recorded reserves by approximately $4,300,000.

5. Property, Plant and Equipment

The major categories of property, plant and equipment are as follows at September 30:

	Useful Lives	2019	2018
Land and land improvements	2-40 years	$ 4,246,500	$ 3,630,354
Buildings and improvements	2-40 years	137,678,182	128,776,786
Fixed equipment	3-25 years	47,021,894	46,562,689
Movable equipment	3-25 years	154,415,222	138,314,958
Construction in progress		8,565,604	9,269,135
		351,927,402	326,553,922
Less accumulated depreciation and amortization		(208,816,039)	(191,956,028)
Net property, plant and equipment		$ 143,111,363	$ 134,597,894

Depreciation expense amounted to $16,860,011 and $16,092,263 for the years ended September 30, 2019 and 2018, respectively.

The cost of equipment under capital leases was $7,844,527 at September 30, 2019 and 2018. Accumulated amortization of the leased equipment at September 30, 2019 and 2018 was $7,691,462 and $7,059,231, respectively. Amortization of assets under capital leases is included in depreciation and amortization expense.

6. Long-Term Debt and Notes Payable

Long-term debt consists of the following at September 30:

	2019	2018
New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds:		
Series 2012 Bonds with interest ranging from 4.00% to 5.00% per year and principal payable in annual installments ranging from $1,125,000 to $2,755,000 through July 2032	$ 19,800,000	$ 22,450,000
Series 2015A Bonds with interest at a fixed rate of 2.27% per year and principal payable in annual installments ranging from $185,000 to $1,655,000 through July 2040	21,650,000	22,255,000
Series 2015B with variable interest subject to interest rate swap described below and principal payable in annual installments ranging from $195,000 to $665,000 through July 2036	8,060,000	8,260,000

6. Long-Term Debt and Notes Payable (Continued)

	2019	2018
New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds (Continued):		
Series 2017 Bonds with interest ranging from 3.38% to 5.00% per year and principal payable in annual installments ranging from $2,900,000 to $7,545,000 beginning in July 2033 through July 2044	$ 61,115,000	$ 61,115,000
	110,625,000	114,080,000
Construction loan – see below	3,513,632	–
MOB LLC note payable – see below	7,798,500	8,032,500
Capitalized lease obligations	344,079	1,020,278
Unamortized original issue premiums/discounts	5,057,437	5,450,325
Unamortized debt issuance costs	(1,296,818)	(1,304,187)
	126,041,830	127,278,916
Less current portion	(4,158,079)	(4,365,199)
	$121,883,751	$122,913,717

The Authority Revenue Bonds

In December 2012, the Medical Center, in connection with the Authority, issued $35,275,000 of tax-exempt fixed rate revenue bonds (Series 2012). Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. The proceeds of the Series 2012 bond issue were used to advance refund the remaining 2002A Bonds, advance refund certain 2002B Bonds, pay off a short term CAN note and fund certain capital purchases.

On September 3, 2015, the Authority issued $32,720,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2015, consisting of the $24,070,000 aggregate principal amount Series 2015A Bonds and the $8,650,000 aggregate principal amount Series 2015B Bonds sold via direct placement to a financial institution. Although the Series 2015B Bonds were issued, they were not drawn on until July 1, 2016, as discussed below. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Series 2015A Bonds were issued to provide funds for the purpose of (i) advance refunding a portion of the outstanding 2006 Bonds in an amount of $20,655,000 to the first call date of July 1, 2016, (ii) funding certain construction projects and equipment purchases in an amount of approximately $3,824,000, and (iii) paying the costs of issuance related to the Series 2015 Bonds.

6. **Long-Term Debt and Notes Payable (Continued)**

The Series 2015B Bonds were structured as drawdown bonds. On July 1, 2016, the full amount available under the Series 2015B Bonds totaling $8,650,000 was drawn upon and the proceeds in combination with cash contributed by the Medical Center totaling $555,000 were used to currently refund the remaining balance of the Series 2006 Bonds totaling $9,205,000.

On September 1, 2017, the Authority issued $61,115,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2017. The Series 2017 Bonds were issued to fund various construction projects and equipment purchases, as well as pay certain costs of issuance related to the Series 2017 Bonds. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Medical Center has an agreement with the Authority, which provides for the establishment of various funds, the use of which is generally restricted to the payment of debt, as well as a construction fund related to the Series 2017 Bonds. These funds are administered by a trustee, and income earned on certain of these funds is similarly restricted.

Construction Loan

On July 1, 2019, the Medical Center established a nonrevolving line of credit up to $10,000,000 with a bank in order to fund the expansion of the Medical Center as discussed in Note 15. The line of credit bears interest at the LIBOR lending rate plus 0.75% (2.84% at September 30, 2019). Advances from the line of credit are available through July 1, 2021, at which time the then outstanding line of credit balance will automatically convert to a term loan. Upon conversion, the Medical Center shall make monthly payments of principal and interest, assuming a 30-year level monthly principal and interest payment schedule, with a final maturity of July 1, 2029. The bank shall compute the schedule of principal payments based on the interest rate applicable on the conversion date. Payments of interest only are due on a monthly basis until the conversion date. The Medical Center has pledged gross receipts as collateral and is also required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. As of September 30, 2019, the Medical Center has drawn $3,513,632 on this line of credit.

MOB LLC Notes Payable

During 2007, MOB LLC (a subsidiary of Enterprises) established a nonrevolving line of credit for $9,350,000 with a bank in order to fund construction of a medical office building. The line of credit bore interest at the LIBOR lending rate plus 1%. Payments of interest only were due on a monthly basis until the completed construction of the medical office. During 2008, the building construction was completed and the line of credit was converted to a note payable with payments of interest (at the one-month LIBOR rate plus 1.4%) and principal due on a monthly basis, with all payments to be made no later than April 1, 2018.

6. Long-Term Debt and Notes Payable (Continued)

On March 27, 2018, the MOB LLC note payable discussed above was refinanced to a term loan totaling $8,130,000. Interest is fixed at 3.71% and is payable monthly. Principal payments of $19,500 are due in monthly installments beginning May 1, 2018, and continuing until March 27, 2028, at which time the remaining unpaid principal and interest shall be due in full. Under the terms of the loan agreement, the Medical Center and MOB LLC (the Obligated Group) has granted the bank a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center and the System also guarantee the note payable. The Obligated Group is required to maintain a minimum debt service coverage ratio of 1.20. The Obligated Group was in compliance with this covenant as of September 30, 2019.

The aggregate principal payments due on the revenue bonds, capital lease obligations and other debt obligations for each of the five years ending September 30 and thereafter are as follows:

2020	$ 4,158,079
2021	2,650,886
2022	2,779,704
2023	3,001,881
2024	3,094,120
Thereafter	106,596,541
	$122,281,211

Interest paid by the System totaled $4,688,512 (including capitalized interest of $158,155) for the year ended September 30, 2019 and $4,351,405 (including capitalized interest of $251,490) for the year ended September 30, 2018.

The fair value of the System's long-term debt is estimated using discounted cash flow analysis, based on the System's current incremental borrowing rate for similar types of borrowing arrangements. The fair value of the System's long-term debt, excluding capitalized lease obligations, was approximately $128,000,000 and $122,000,000 at September 30, 2019 and 2018, respectively.

Derivatives

The System uses derivative financial instruments principally to manage interest rate risk. During 2007, MOB LLC entered into an interest rate swap agreement with an initial notional amount of $9,350,000 in connection with its line of credit. Under this agreement, MOB LLC paid a fixed rate equal to 5.21%, and received a variable rate of the one-month LIBOR rate. The interest rate swap agreement terminated April 1, 2018. The change in fair value of this interest swap agreement totaled $184,767 during 2018, which amount was included within nonoperating investment income within the 2018 consolidated statements of operations.

6. Long-Term Debt and Notes Payable (Continued)

In January 2016, the Medical Center entered into an interest rate swap agreement with an initial notional amount of $8,650,000 in connection with its Series 2015B Bond issuance. The swap agreement hedges the Medical Center's interest exposure by effectively converting interest payments from variable rates to a fixed rate. The swap agreement is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. Under this agreement, the Medical Center pays a fixed rate equal to 1.482%, and receives a variable rate of 69.75% of the one-month LIBOR rate (1.46% at September 30, 2019). Payments under the swap agreement began August 1, 2016 and the agreement will terminate August 1, 2025.

The fair value of the Medical Center's interest rate swap agreement amounted to a liability of $220,010 as of September 30, 2019, which amount has been recorded within accrued pension and other liabilities in the accompanying consolidated balance sheets. The fair value of the Medical Center's interest rate swap agreement amounted to an asset of $262,725 as of September 30, 2018, which amount has been recorded within intangible assets and other in the accompanying consolidated balance sheets. The (decrease) increase in the fair value of this derivative of $(482,735) and $302,826, respectively, has been included within the consolidated statements of changes in net assets as a change in net assets without donor restrictions for the years ended September 30, 2019 and 2018.

7. Operating Leases

The System has various noncancelable agreements to lease various pieces of medical equipment. The System also has noncancelable leases for office space and its physician practices. Rental expense under all leases for the years ended September 30, 2019 and 2018 was $4,847,292 and $4,857,031, respectively.

Estimated future minimum lease payments under noncancelable operating leases are as follows:

2020	$ 3,180,427
2021	3,151,760
2022	3,178,564
2023	3,155,635
2024	3,048,854
Thereafter	5,620,891
	$21,336,131

8. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited are comprised of the following at September 30:

	2019		2018	
	Fair Value	Cost	Fair Value	Cost
Cash and cash equivalents	$ 16,988,051	$ 16,988,051	$ 16,525,946	$ 16,525,946
U.S. federal treasury obligations	19,045,894	19,043,708	36,950,913	36,957,749
Marketable equity securities	44,292,283	41,130,117	44,031,227	39,959,906
Fixed income securities	38,160,610	38,096,345	57,757,424	58,911,509
Private investment funds	51,796,283	21,653,351	55,530,346	25,886,418
Pledges receivable	758,184	758,184	–	–
	$171,041,305	$137,669,756	$210,795,856	$178,241,528

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. In determining fair value, the use of various valuation approaches, including market, income and cost approaches, is permitted.

A fair value hierarchy has been established based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entity's own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The standard describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the System for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

Level 1 — Observable inputs such as quoted prices in active markets;

Level 2 — Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and

Level 3 — Unobservable inputs in which there is little or no market data.

8. Investments and Assets Whose Use is Limited (Continued)

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques).

In determining the appropriate levels, the System performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2019 and 2018.

The following is a description of the valuation methodologies used:

U.S. Federal Treasury Obligations and Fixed Income Securities

The fair value is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The System holds fixed income mutual funds and exchange traded funds, governmental and federal agency debt instruments, municipal bonds, corporate bonds, and foreign bonds which are primarily classified as Level 1 within the fair value hierarchy.

Marketable Equity Securities

Marketable equity securities are valued based on stated market prices and at the net asset value of shares held by the System at year end, which generally results in classification as Level 1 within the fair value hierarchy.

Private Investment Funds

The System invests in private investment funds that consist primarily of limited partnership interests in investment funds, which, in turn, invest in diversified portfolios predominantly comprised of equity and fixed income securities, as well as options, futures contracts, and some other less liquid investments. Management has approved procedures pursuant to the methods in which the System values these investments, which ordinarily will be the amount equal to the pro-rata interest in the net assets of the limited partnership, as such value is supplied by, or on behalf of, each investment manager from time to time, usually monthly and/or quarterly.

8. Investments and Assets Whose Use is Limited (Continued)

System management is responsible for the fair value measurements of investments reported in the consolidated financial statements. Such amounts are generally determined using audited financial statements of the funds and/or recently settled transactions. Because of inherent uncertainty of valuation of certain private investment funds, the estimate of the fund manager or general partner may differ from actual values, and differences could be significant. Management believes that reported fair values of its private investment funds at the consolidated balance sheet dates are reasonable.

Fair Value on a Recurring Basis

The following table presents information about the System's assets and liabilities measured at fair value on a recurring basis based upon the lowest level of significant input to the valuations at September 30:

2019	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 16,988,051	$ –	$ –	$ 16,988,051
U.S. federated treasury obligations	19,045,894	–	–	19,045,894
Marketable equity securities	44,292,283	–	–	44,292,283
Fixed income securities	38,160,610	–	–	38,160,610
Pledges receivable	–	–	758,184	758,184
	$118,486,838	$ –	$758,184	119,245,022
Investments measured at net asset value:				
Private investment funds				51,796,283
Total assets at fair value				$171,041,305
Liabilities				
Interest rate swap agreement	$ –	$ –	$220,010	$ 220,010
2018				
Assets				
Cash and cash equivalents	$ 16,525,946	$ –	$ –	$ 16,525,946
U.S. federated treasury obligations	36,950,913	–	–	36,950,913
Marketable equity securities	44,031,227	–	–	44,031,227
Fixed income securities	57,757,424	–	–	57,757,424
Interest rate swap agreement	–	–	262,725	262,725
	$155,265,510	$ –	$262,725	155,528,235
Investments measured at net asset value:				
Private investment funds				55,530,346
Total assets at fair value				$211,058,581

8. Investments and Assets Whose Use is Limited (Continued)

The following table presents the assets (liabilities) carried at fair value as of September 30, 2019 and 2018 that are classified within Level 3 of the fair value hierarchy.

	Pledges Receivable
Balance at September 30, 2018	$ –
Net activity	758,184
Balance at September 30, 2019	$758,184

	Interest Rate Swap Agreement
Balance at September 30, 2017	$(224,868)
Unrealized gains	487,593
Balance at September 30, 2018	262,725
Unrealized losses	(482,735)
Balance at September 30, 2019	$(220,010)

There were no significant transfers between Levels 1, 2 or 3 for the years ended September 30, 2019 or 2018.

Net Asset Value Per Share

The following table discloses the fair value and redemption frequency of those assets whose fair value is estimated using the net asset value per share practical expedient at September 30:

Category	Fair Value	Unfunded Commitments	Redemption Frequency	Notice Period
2019				
Private investment funds	$48,155,175	$ –	Daily/monthly	2-30 day notice
Private investment funds	3,641,108	–	Quarterly	30 day notice
2018				
Private investment funds	$52,108,790	$ –	Daily/monthly	2-30 day notice
Private investment funds	3,421,556	–	Quarterly	30 day notice

8. Investments and Assets Whose Use is Limited (Continued)

Investment Strategies

U.S. Federal Treasury Obligations and Fixed Income Securities

The primary purpose of these investments is to provide a highly predictable and dependable source of income, preserve capital, reduce the volatility of the total portfolio, and hedge against the risk of deflation or protracted economic contraction.

Marketable Equity Securities

The primary purpose of equity investments is to provide appreciation of principal and growth of income with the recognition that this requires the assumption of greater market volatility and risk of loss. The total equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics, including style and capitalization. The System may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

Private Investment Funds

The primary purpose of private investment funds is to provide further portfolio diversification and to reduce overall portfolio volatility by investing in strategies that are less correlated with traditional equity and fixed income investments. Private investment funds may provide access to strategies otherwise not accessible through traditional equities and fixed income such as derivative instruments, real estate, distressed debt and private equity and debt.

Fair Value of Other Financial Instruments

Other financial instruments consist of accounts receivable, accounts payable and accrued expenses, amounts payable to third-party payors and long-term debt. The fair value of all financial instruments other than long-term debt approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value. See Note 6 for disclosure of the fair value of long-term debt.

9. Retirement Benefits

A reconciliation of the changes in the Catholic Medical Center Pension Plan, the Medical Center's Supplemental Executive Retirement Plan and the New Hampshire Medical Laboratories Retirement Income Plan projected benefit obligations and the fair value of assets for the years ended September 30, 2019 and 2018, and a statement of funded status of the plans for both years is as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Changes in benefit obligations:						
Projected benefit obligations at beginning of year	$ (270,114,507)	$(284,200,778)	$(4,140,755)	$(4,567,286)	$(2,829,963)	$(3,062,398)
Service cost	(1,500,000)	(1,500,000)	–	–	(25,000)	(25,000)
Interest cost	(11,301,910)	(10,628,197)	(154,744)	(140,414)	(114,026)	(104,714)
Benefits paid	7,935,050	7,117,759	408,853	411,692	173,921	171,828
Actuarial (loss) gain	(48,841,695)	17,666,264	(174,264)	155,253	(372,806)	173,565
Expenses paid	1,468,125	1,430,445	–	–	16,623	16,756
Projected benefit obligations at end of year	(322,354,937)	(270,114,507)	(4,060,910)	(4,140,755)	(3,151,251)	(2,829,963)
Changes in plan assets:						
Fair value of plan assets at beginning of year	185,414,590	181,485,201	–	–	2,140,827	2,144,861
Actual return on plan assets	5,194,931	12,074,468	–	–	56,327	141,614
Employer contributions	8,141,191	403,125	408,853	411,692	120,167	42,936
Benefits paid	(7,935,050)	(7,117,759)	(408,853)	(411,692)	(173,921)	(171,828)
Expenses paid	(1,468,125)	(1,430,445)	–	–	(16,623)	(16,756)
Fair value of plan assets at end of year	189,347,537	185,414,590	–	–	2,126,777	2,140,827
Funded status of plan at September 30	$(133,007,400)	$ (84,699,917)	$(4,060,910)	$(4,140,755)	$(1,024,474)	$ (689,136)
Amounts recognized in the balance sheets consist of:						
Current liability	$ –	$ –	$ (391,100)	$ (398,750)	$ –	$ –
Noncurrent liability	(133,007,400)	(84,699,917)	(3,669,810)	(3,742,005)	(1,024,474)	(689,136)
	$(133,007,400)	$ (84,699,917)	$(4,060,910)	$(4,140,755)	$(1,024,474)	$ (689,136)

The net loss for the defined benefit pension plans that will be amortized from net assets without donor restrictions into net periodic benefit cost over the next fiscal year is $4,686,885.

The current portion of accrued pension costs included in the above amounts for the System amounted to $391,100 and $398,750 at September 30, 2019 and 2018, respectively, and has been included in accounts payable and accrued expenses in the accompanying balance sheets.

The amounts recognized in net assets without donor restrictions for the years ended September 30 consist of:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Amounts recognized in the balance sheets – total plan:						
Net assets without donor restrictions:						
Net loss	$(160,478,700)	$(105,860,712)	$(2,141,585)	$(2,102,034)	$(1,902,167)	$(1,492,143)
Net amount recognized	$(160,478,700)	$(105,860,712)	$(2,141,585)	$(2,102,034)	$(1,902,167)	$(1,492,143)

9. Retirement Benefits (Continued)

Net periodic pension cost includes the following components for the years ended September 30:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Service cost	$ 1,500,000	$ 1,500,000	$ –	$ –	$ 25,000	$ 25,000
Interest cost	11,301,910	10,628,197	154,744	140,414	114,026	104,714
Expected return on plan assets	(13,738,629)	(13,110,637)	–	–	(155,594)	(153,960)
Amortization of actuarial loss	2,767,405	3,275,000	134,713	147,466	62,049	67,898
Net periodic pension cost	$ 1,830,686	$ 2,292,560	$ 289,457	$ 287,880	$ 45,481	$ 43,652

Other changes in plan assets and benefit obligations recognized in net assets without donor restrictions for the years ended September 30, 2019 and 2018 consist of:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Net loss (gain)	$ 57,388,232	$ (16,630,095)	$ 174,264	$ (155,253)	$ 472,073	$ (161,219)
Amortization of actuarial loss	(2,767,405)	(3,275,000)	(134,713)	(147,466)	(62,049)	(67,898)
Net amount recognized	$ 54,620,827	$ (19,905,095)	$ 39,551	$ (302,719)	$ 410,024	$ (229,117)

The investments of the plans are comprised of the following at September 30:

	Target Allocation		Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018	2019	2018
Cash and cash equivalents	5.0%	0.0%	3.5%	1.1%	0.0%	0.0%	3.5%	1.1%
Equity securities	65.0	70.0	68.5	66.2	0.0	0.0	68.5	66.2
Fixed income securities	20.0	20.0	24.6	23.7	0.0	0.0	24.6	23.7
Other	10.0	10.0	3.4	9.0	0.0	0.0	3.4	9.0
	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%

The assumption for the long-term rate of return on plan assets has been determined by reflecting expectations regarding future rates of return for the investment portfolio, with consideration given to the distribution of investments by asset class and historical rates of return for each individual asset class.

The weighted-average assumptions used to determine the defined benefit pension plan obligations at September 30 are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Discount rate	3.12%	4.23%	2.70%	3.93%	2.93%	4.10%
Rate of compensation increase	N/A	N/A	N/A	N/A	N/A	N/A

9. Retirement Benefits (Continued)

The weighted-average assumptions used to determine the defined benefit pension plan net periodic benefit costs for the years ended September 30 are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Discount rate	4.23%	3.79%	3.93%	3.22%	4.10%	3.52%
Rate of compensation increase	N/A	N/A	N/A	N/A	N/A	N/A
Expected long-term return on plan assets	7.30 %	7.30%	N/A	N/A	7.30%	7.30%

The System expects to make employer contributions totaling $6,500,000 to the Catholic Medical Center Pension Plan for the fiscal year ending September 30, 2020. Expected employer contributions to the Pre-1987 Supplemental Executive Retirement Plan and New Hampshire Medical Laboratories Retirement Income Plan for the fiscal year ending September 30, 2020 are not expected to be significant.

The benefits, which reflect expected future service, as appropriate, expected to be paid for the years ending September 30 are as follows:

	Catholic Medical Center Pension Plan	Pre-1987 Supplemental Executive Retirement Plan	New Hampshire Medical Laboratories Retirement Income Plan
2020	$ 9,243,136	$ 396,345	$194,433
2021	9,993,328	381,634	200,720
2022	10,827,746	366,382	200,423
2023	11,705,953	350,590	200,594
2024	12,473,696	334,272	197,969
2025 - 2029	72,831,683	1,409,626	947,912

The System contributed $8,141,191, $408,853 and $120,167 to the Catholic Medical Center Pension Plan, the Pre-1987 Supplemental Executive Retirement Plan and New Hampshire Medical Laboratories Retirement Income Plan, respectively, for the year ended September 30, 2019. The System contributed $403,125, $411,692 and $42,936 to the Catholic Medical Center Pension Plan, Pre-1987 Supplemental Executive Retirement Plan and the New Hampshire Medical Laboratories Retirement Income Plan, respectively, for the year ended September 30, 2018. The System plans to make any necessary contributions during the upcoming fiscal 2020 year to ensure the plans continue to be adequately funded given the current market conditions.

9. Retirement Benefits (Continued)

The following fair value hierarchy table presents information about the financial assets of the above plans measured at fair value on a recurring basis based upon the lowest level of significant input valuation as of September 30:

	Level 1	Level 2	Level 3	Total
2019				
Cash and cash equivalents	$ 6,607,245	$ –	$ –	$ 6,607,245
Marketable equity securities	48,731,127	–	–	48,731,127
Fixed income securities	47,028,757	–	–	47,028,757
	$102,367,129	$ –	$ –	102,367,129
Investments measured at net asset value:				
Private investment funds				89,107,185
Total assets at fair value				$191,474,314
2018				
Cash and cash equivalents	$ 2,160,634	$ –	$ –	$ 2,160,634
Marketable equity securities	39,221,636	–	–	39,221,636
Fixed income securities	44,497,162	–	–	44,497,162
	$ 85,879,432	$ –	$ –	85,879,432
Investments measured at net asset value:				
Private investment funds				101,675,985
Total assets at fair value				$187,555,417

10. Community Benefits

The System rendered charity care in accordance with its formal charity care policy, which, at established charges, amounted to $22,670,908 and $21,671,846 for the years ended September 30, 2019 and 2018, respectively. Also, the System provides community service programs, without charge, such as the Medication Assistance Program, Community Education and Wellness, Patient Transport, and the Parish Nurse Program. The costs of providing these programs amounted to $977,697 and $983,861 for the years ended September 30, 2019 and 2018, respectively.

11. Functional Expenses

The System provides general health care services to residents within its geographic location including inpatient, outpatient and emergency care. Expenses related to providing these services are as follows at September 30, 2019:

	Healthcare Services	General and Administrative	Total
Salaries, wages and fringe benefits	$241,819,757	$42,827,203	$284,646,960
Supplies and other	132,091,040	37,028,017	169,119,057
New Hampshire Medicaid enhancement tax	21,382,132	–	21,382,132
Depreciation and amortization	10,590,235	6,312,202	16,902,437
Interest	3,178,047	1,045,999	4,224,046
	$409,061,211	$87,213,421	$496,274,632

For the year ended September 30, 2018, the System provided $367,226,914 in health services expenses and $100,350,824 in general and administrative expenses.

The consolidated financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits are allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

12. Concentration of Credit Risk

The System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors is as follows at September 30:

	2019	2018
Medicare	45%	44%
Medicaid	12	12
Commercial insurance and other	24	23
Patients (self pay)	5	8
Anthem Blue Cross	14	13
	100%	100%

13. Endowments and Net Assets With Donor Restrictions

Endowments

In July 2008, the State of New Hampshire enacted a version of UPMIFA (the Act). The new law, which had an effective date of July 1, 2008, eliminates the historical dollar threshold and establishes prudent spending guidelines that consider both the duration and preservation of the fund. As a result of this enactment, subject to the donor's intent as expressed in a gift agreement or similar document, a New Hampshire charitable organization may now spend the principal and income of an endowment fund, even from an underwater fund, after considering the factors listed in the Act.

Endowment net assets consist of the following at September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
2019			
Board-designated endowment funds	$110,175,169	$ –	$110,175,169
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	7,342,731	7,342,731
Accumulated investment gains	–	2,902,160	2,902,160
Total endowment net assets	$110,175,169	$10,244,891	$120,420,060
2018			
Board-designated endowment funds	$107,832,023	$ –	$107,832,023
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	7,342,731	7,342,731
Accumulated investment gains	–	3,084,087	3,084,087
Total endowment net assets	$107,832,023	$10,426,818	$118,258,841

13. Endowments and Net Assets With Donor Restrictions (Continued)

Changes in endowment net assets consisted of the following for the years ended September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
Balance at September 30, 2017	$102,045,292	$ 9,726,007	$111,771,299
Investment return, net	5,658,131	430,243	6,088,374
Contributions	–	646,924	646,924
Appropriation for operations	–	(247,756)	(247,756)
Appropriation for capital	128,600	(128,600)	–
Balance at September 30, 2018	107,832,023	10,426,818	118,258,841
Investment return (loss), net	1,909,136	(63,353)	1,845,783
Contributions	–	536,316	536,316
Appropriation for operations	–	(220,880)	(220,880)
Appropriation for capital	434,010	(434,010)	–
Balance at September 30, 2019	$110,175,169	$10,244,891	$120,420,060

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Medical Center to retain as a fund of perpetual duration. There were no such deficiencies as of September 30, 2019 or 2018.

Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at September 30:

	2019	2018
Funds subject to use or time restrictions:		
Capital acquisitions	$ 258,494	$ 37,941
Health education	909,765	899,288
Indigent care	168,437	253,492
Pledges receivable	758,184	–
	2,094,880	1,190,721
Funds of perpetual duration	9,150,011	9,236,097
	$11,244,891	$10,426,818

14. Investments in Joint Ventures

AAS has a 44% ownership interest in the Bedford Ambulatory Surgical Center. AAS accounts for its investment in this joint venture under the equity method.

AAS has a 50% ownership interest in the Alliance Urgent Care Services, LLC. AAS accounts for its investment in this joint venture under the equity method.

The Medical Center, along with four other participating hospitals and Tufts Health Plan, formed Tufts Health Freedom Plan (THFP), a joint venture. THFP is a health insurance company which began operations as of January 1, 2016. The Medical Center has an approximate 12% ownership interest in this joint venture. Selected financial information relating to the above entities for the years ended September 30, 2019 and 2018 is not shown as such amounts are not significant to the consolidated financial statements.

15. Commitments and Contingencies

Litigation

Various legal claims, generally incidental to the conduct of normal business, are pending or have been threatened against the System. The System intends to defend vigorously against these claims. While ultimate liability, if any, arising from any such claim is presently indeterminable, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the financial condition of the System.

Regulatory

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Government activity continues with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Compliance with such laws and regulations are subject to government review and interpretations as well as regulatory actions unknown or unasserted at this time.

Development Agreement

During fiscal year 2019, the Medical Center entered into a development agreement with PJC Manchester Realty, LLC ("Rite Aid") in regards to the Medical Center's acquisition of certain property owned by Rite Aid. Under the development agreement, the Medical Center acquired the property from Rite Aid for approximately $6.9 million, inclusive of certain costs expected to be incurred to construct a new building that Rite Aid will own and occupy at a separate location. The purchase of the property from Rite Aid allows the Medical Center to expand its campus. As the Medical Center retains title to the project until such time of the second closing, as defined within the development agreement, amounts paid under the development agreement are recorded by the Medical Center as land acquisition costs, and totaled approximately $4.6 million as of September 30, 2019.

The Medical Center has outstanding construction commitments related to this project totaling approximately $8.1 million at September 30, 2019.

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INDEPENDENT AUDITORS' REPORT ON OTHER FINANCIAL INFORMATION

Board of Trustees
CMC Healthcare System, Inc.

We have audited the consolidated financial statements of CMC Healthcare System, Inc. (the System) as of and for the years ended September 30, 2019 and 2018, and have issued our report thereon, which contains an unmodified opinion on those consolidated financial statements. See page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations and cash flows of the individual entities and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING BALANCE SHEET

September 30, 2019

ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current assets:										
Cash and cash equivalents	$ 47,897,010	$ 2,391,045	$ 3,445,644	$ 705,932	$ 603,153	$ 222,020	$ 75,443	$ 909,243	$ –	$ 56,249,490
Short-term investments	4,021,270	–	–	–	–	–	–	–	–	4,021,270
Accounts receivable, net	78,067,491	–	(3,076)	–	–	1,258,227	–	–	–	79,322,642
Inventories	4,600,802	–	–	–	–	–	–	–	–	4,600,802
Other current assets	12,780,425	(22,443)	14,433	65,943	–	1,335,176	–	24,689	–	14,198,223
Total current assets	147,366,998	2,368,602	3,457,001	771,875	603,153	2,815,423	75,443	933,932	–	158,392,427
Property, plant and equipment, net	118,690,076	–	8,550,580	14,715,075	–	76,528	–	1,079,104	–	143,111,363
Other assets:										
Intangible assets and other	11,869,524	–	–	–	6,731,090	–	–	–	–	18,600,614
Assets whose use is limited:										
Pension and insurance obligations	18,832,810	–	–	–	–	–	–	–	–	18,832,810
Board designated and donor restricted investments and restricted grants	122,116,666	–	–	–	–	–	–	7,225,204	–	129,341,870
Held by trustee under revenue bond agreements	18,845,355	–	–	–	–	–	–	–	–	18,845,355
	159,794,831	–	–	–	–	–	–	7,225,204	–	167,020,035
Total assets	$437,721,429	$ 2,368,602	$12,007,581	$15,486,950	$7,334,243	$2,891,951	$ 75,443	$9,238,240	$ –	$487,124,439

LIABILITIES AND NET ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current liabilities:										
Accounts payable and accrued expenses	$ 36,870,043	$ 101,896	$ 116,826	$ 14,945	$ –	$1,557,916	$ 9,312	$ 314,964	$ –	$ 38,985,902
Accrued salaries, wages and related accounts	18,604,407	4,256,637	–	–	–	–	–	112,434	–	22,973,478
Amounts payable to third-party payors	11,456,467	–	–	–	–	–	–	–	–	11,456,467
Due to (from) affiliates	991,062	(876,484)	33,830	(112,489)	–	(17,750)	(16,141)	(2,028)	–	–
Current portion of long-term debt	3,924,079	–	234,000	–	–	–	–	–	–	4,158,079
Total current liabilities	71,846,058	3,482,049	384,656	(97,544)	–	1,540,166	(6,829)	425,370	–	77,573,926
Accrued pension and other liabilities, less current portion	160,696,816	9,869,149	1,041,879	69,526	–	372,466	–	–	–	172,049,836
Long-term debt, less current portion	114,421,351	–	7,462,400	–	–	–	–	–	–	121,883,751
Total liabilities	346,964,225	13,351,198	8,888,935	(28,018)	–	1,912,632	(6,829)	425,370	–	371,507,513
Net assets (deficit):										
Without donor restrictions	79,512,313	(10,982,596)	3,118,646	15,514,968	7,334,243	979,319	82,272	8,812,870	–	104,372,035
With donor restrictions	11,244,891	–	–	–	–	–	–	–	–	11,244,891
Total net assets (deficit)	90,757,204	(10,982,596)	3,118,646	15,514,968	7,334,243	979,319	82,272	8,812,870	–	115,616,926
Total liabilities and net assets	$437,721,429	$ 2,368,602	$12,007,581	$15,486,950	$7,334,243	$2,891,951	$ 75,443	$9,238,240	$ –	$487,124,439

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended September 30, 2019

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Eliminations	Consolidated
Net patient service revenues, net of contractual allowances and discounts	$449,484,087	$ –	$ –	$ –	$ –	$16,273,475	$ –	$ –	$ –	$465,757,562
Provision for doubtful accounts	(20,972,163)	–	–	–	–	(672,481)	–	–	–	(21,644,644)
Net patient service revenues less provision for doubtful accounts	428,511,924	–	–	–	–	15,600,994	–	–	–	444,112,918
Other revenue	14,687,063	21,730,371	2,029,569	1,348,691	2,450,518	589,283	114,787	3,296,789	(24,636,486)	21,610,585
Disproportionate share funding	22,566,094	–	–	–	–	–	–	–	–	22,566,094
Total revenues	465,765,081	21,730,371	2,029,569	1,348,691	2,450,518	16,190,277	114,787	3,296,789	(24,636,486)	488,289,597
Expenses:										
Salaries, wages and fringe benefits	227,559,475	59,819,529	25,000	–	–	15,345,730	–	3,293,166	(21,395,940)	284,646,960
Supplies and other	161,282,151	2,859,148	829,215	886,058	–	6,095,729	129,091	278,211	(3,240,546)	169,119,057
New Hampshire Medicaid enhancement tax	21,382,132	–	–	–	–	–	–	–	–	21,382,132
Depreciation and amortization	15,741,819	–	310,579	613,839	–	34,602	–	201,598	–	16,902,437
Interest	3,913,935	–	310,111	–	–	–	–	–	–	4,224,046
Total expenses	429,879,512	62,678,677	1,474,905	1,499,897	–	21,476,061	129,091	3,772,975	(24,636,486)	496,274,632
Income (loss) from operations	35,885,569	(40,948,306)	554,664	(151,206)	2,450,518	(5,285,784)	(14,304)	(476,186)	–	(7,985,035)
Nonoperating gains (losses):										
Investment income	3,875,387	–	–	–	14,106	–	–	231,369	–	4,120,862
Net periodic pension cost, other than service cost	(595,606)	(24,537)	(20,481)	–	–	–	–	–	–	(640,624)
Contributions without donor restrictions	834,004	–	–	–	–	–	–	–	–	834,004
Development costs	(739,596)	–	–	–	–	–	–	–	–	(739,596)
Other nonoperating (loss) gain	(3,153,699)	–	–	–	–	–	–	18,000	–	(3,135,699)
Total nonoperating gains, net	220,490	(24,537)	(20,481)	–	14,106	–	–	249,369	–	438,947
Excess (deficiency) of revenues over expenses	36,106,059	(40,972,843)	534,183	(151,206)	2,464,624	(5,285,784)	(14,304)	(226,817)	–	(7,546,088)
Unrealized appreciation (depreciation) on investments	1,026,222	–	–	–	–	–	–	(114,052)	–	912,170
Change in fair value of interest rate swap agreement	(482,735)	–	–	–	–	–	–	–	–	(482,735)
Assets released from restriction used for capital	434,010	–	–	–	–	–	–	–	–	434,010
Pension-related changes other than net periodic pension cost	(51,110,160)	(3,550,218)	(410,024)	–	–	–	–	–	–	(55,070,402)
Net transfers (to) from affiliates	(46,133,644)	42,163,000	120,167	700,000	(2,500,000)	5,650,000	–	477	–	–
Change in net assets without donor restrictions	$(60,160,248)	$ (2,360,061)	$ 244,326	$ 548,794	$ (35,376)	$ 364,216	$ (14,304)	$ (340,392)	$ –	$(61,753,045)

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING BALANCE SHEET

September 30, 2018

ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current assets:										
Cash and cash equivalents	$ 57,668,500	$ 22,273	$ 2,745,448	$ 332,128	$ 376,706	$ 166,645	$ 76,949	$ 460,671	$ –	$ 61,849,320
Short-term investments	29,009,260	–	–	–	–	–	–	–	–	29,009,260
Accounts receivable, net	54,074,988	–	–	–	–	1,251,998	–	–	–	55,326,986
Inventories	3,583,228	–	–	–	–	–	–	–	–	3,583,228
Other current assets	9,150,610	3,750	2,537	57,365	286,666	1,139,687	1,608	22,734	–	10,664,957
Total current assets	153,486,586	26,023	2,747,985	389,493	663,372	2,558,330	78,557	483,405	–	160,433,751
Property, plant and equipment, net	109,898,233	–	8,858,160	14,585,192	–	111,130	–	1,145,179	–	134,597,894
Other assets:										
Intangible assets and other	10,875,302	–	–	–	6,706,247	–	–	–	–	17,581,549
Assets whose use is limited:										
Pension and insurance obligations	17,859,458	–	–	–	–	–	–	–	–	17,859,458
Board designated and donor restricted investments and restricted grants	119,411,378	1,488	–	–	–	–	–	7,854,219	–	127,267,085
Held by trustee under revenue bond agreements	36,660,053	–	–	–	–	–	–	–	–	36,660,053
	173,930,889	1,488	–	–	–	–	–	7,854,219	–	181,786,596
Total assets	$448,191,010	$ 27,511	$11,606,145	$14,974,685	$7,369,619	$2,669,460	$ 78,557	$9,482,803	$ –	$494,399,790

LIABILITIES AND NET ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current liabilities:										
Accounts payable and accrued expenses	$ 28,743,870	$ 68,143	$ 90,029	$ 17,169	$ –	$1,660,520	$ 5,590	$ 203,832	$ –	$ 30,789,153
Accrued salaries, wages and related accounts	18,755,583	3,791,797	–	–	–	–	–	126,109	–	22,673,489
Amounts payable to third-party payors	14,643,104	–	–	–	–	–	–	–	–	14,643,104
Due to (from) affiliates	1,477,267	(1,392,988)	16,867	(80,123)	–	2,986	(23,609)	(400)	–	–
Current portion of long-term debt	4,131,199	–	234,000	–	–	–	–	–	–	4,365,199
Total current liabilities	67,751,023	2,466,952	340,896	(62,954)	–	1,663,506	(18,019)	329,541	–	72,470,945
Accrued pension and other liabilities, less current portion	115,111,279	6,183,094	706,541	71,465	–	390,851	–	–	–	122,463,230
Long-term debt, less current portion	115,229,329	–	7,684,388	–	–	–	–	–	–	122,913,717
Total liabilities	298,091,631	8,650,046	8,731,825	8,511	–	2,054,357	(18,019)	329,541	–	317,847,892
Net assets (deficit):										
Without donor restrictions	139,672,561	(8,622,535)	2,874,320	14,966,174	7,369,619	615,103	96,576	9,153,262	–	166,125,080
With donor restrictions	10,426,818	–	–	–	–	–	–	–	–	10,426,818
Total net assets (deficit)	150,099,379	(8,622,535)	2,874,320	14,966,174	7,369,619	615,103	96,576	9,153,262	–	176,551,898
Total liabilities and net assets	$448,191,010	$ 27,511	$11,606,145	$14,974,685	$7,369,619	$2,669,460	$ 78,557	$9,482,803	$ –	$494,399,790

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended September 30, 2018

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Eliminations	Consolidated
Net patient service revenues, net of contractual allowances and discounts	$436,357,697	$ –	$ –	$ –	$ –	$16,152,678	$ –	$ –	$ –	$452,510,375
Provision for doubtful accounts	(19,593,714)	–	–	–	–	(740,535)	–	–	–	(20,334,249)
Net patient service revenues less provision for doubtful accounts	416,763,983	–	–	–	–	15,412,143	–	–	–	432,176,126
Other revenue	12,515,169	24,664,782	2,026,051	1,306,175	2,685,142	572,119	131,102	3,090,287	(27,536,141)	19,454,686
Disproportionate share funding	17,993,289	–	–	–	–	–	–	–	–	17,993,289
Total revenues	447,272,441	24,664,782	2,026,051	1,306,175	2,685,142	15,984,262	131,102	3,090,287	(27,536,141)	469,624,101
Expenses:										
Salaries, wages and fringe benefits	217,868,046	55,518,048	25,000	–	–	14,377,316	–	3,020,016	(23,995,148)	266,813,278
Supplies and other	153,527,155	2,191,509	752,790	1,016,430	–	5,867,844	142,023	333,456	(3,540,993)	160,290,214
New Hampshire Medicaid enhancement tax	19,968,497	–	–	–	–	–	–	–	–	19,968,497
Depreciation and amortization	14,972,724	–	333,910	594,149	–	41,518	–	194,683	–	16,136,984
Interest	3,933,617	–	435,148	–	–	–	–	–	–	4,368,765
Total expenses	410,270,039	57,709,557	1,546,848	1,610,579	–	20,286,678	142,023	3,548,155	(27,536,141)	467,577,738
Income (loss) from operations	37,002,402	(33,044,775)	479,203	(304,404)	2,685,142	(4,302,416)	(10,921)	(457,868)	–	2,046,363
Nonoperating gains (losses):										
Investment income	5,699,700	–	158,797	6	3,429	–	–	224,862	–	6,086,794
Net periodic pension cost, other than service cost	(1,023,371)	(57,068)	(18,653)	–	–	–	–	–	–	(1,099,092)
Contributions without donor restrictions	629,198	–	–	–	–	–	–	–	–	629,198
Development costs	(635,408)	–	–	–	–	–	–	–	–	(635,408)
Other nonoperating (loss) gain	(511,679)	–	8,285	–	–	–	–	14,100	–	(489,294)
Total nonoperating gains (losses), net	4,158,440	(57,068)	148,429	6	3,429	–	–	238,962	–	4,492,198
Excess (deficiency) of revenues over expenses	41,160,842	(33,101,843)	627,632	(304,398)	2,688,571	(4,302,416)	(10,921)	(218,906)	–	6,538,561
Unrealized appreciation on investments	2,184,604	–	–	–	–	–	–	140,547	–	2,325,151
Change in fair value of interest rate swap agreement	302,826	–	–	–	–	–	–	–	–	302,826
Assets released from restriction used for capital	128,600	–	–	–	–	–	–	–	–	128,600
Pension-related changes other than net periodic pension cost	18,843,760	1,364,053	229,118	–	–	–	–	–	–	20,436,931
Net transfers (to) from affiliates	(35,782,824)	31,967,000	223,054	1,112,760	(1,650,000)	4,130,000	–	10	–	–
Change in net assets without donor restrictions	$ 26,837,808	$ 229,210	$1,079,804	$ 808,362	$ 1,038,571	$ (172,416)	$(10,921)	$ (78,349)	$ –	$ 29,732,069

Catholic Medical Center
Board of Trustees – 2020

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Carrie Perry, Sr. Executive Assistant / Board Liaison
603-663-6552 / carrie.perry@cmc-nh.org

Nicolette Desgagne

SUMMARY OF QUALIFICATIONS

- Registered nurse with over 4 years of administrative and management experience
- Energetic and highly motivated, able to prioritize daily tasks, learn quickly, multi-task effectively, with strong attention to detail
- Enthusiastic team player, excellent customer service & organizational skills
- Skilled at tactful and diplomatic interpersonal communication and conflict resolution
- Ability to adapt to changing environments and assist others as needed

EDUCATION

Master of Science, Nursing, Psychiatric Mental Health Nurse Practitioner — Expected 2023
Walden University, Minneapolis, MN

Bachelor of Science, Nursing — 2016
Rivier University, Nashua, NH

Associate of Science, Nursing — 2013
Nashua Community College, Nashua, NH

LICENSES AND CERTIFICATIONS

Registered Nurse, State of New Hampshire compact, Licensure	Active: 067828-21
Registered Nurse, State of Massachusetts, Licensure	Active: RN2327413
American Heart Association BLS/CPR Certification	Current

EXPERIENCE

Practice Manager — **2020-present**
The Doorway of Greater Manchester, Manchester NH

- Collaborates with Sr Executive Director regularly on budget development, community involvement and program details
- Ensures staff are trained and fulfilling grant requirements for scope of work
- Participates in the recruiting of staff and preemptively foresees new position opportunities based on program trajectory
- Works in partnership and at the direction of the State of New Hampshire regarding the program and its guidelines.
- Creates policies and procedures to outline and give protocol to the program

Clinical Operations Manager — **2019-2019**
Southern New Hampshire Internal Medicine, Derry NH

- Managed day to day operations of clinical practice throughout 3 internal medicine office locations, including 25 clinical support team members & 20 providers
- Coordinated staff and provider schedules, ensuring optimal coverage was met
- Processed payroll duties in a timely fashion
- Provided oversight and leadership to team leads, conducting regular staff and lead meetings
- Responsible for all aspects of staff recruitment, retention, and performance improvement
- Collaborated with the senior leadership team to determine best practices, desired outcomes, and best method of achieving outcomes
- Implemented initiatives to improve patient outcomes and quality metrics
- Served as principal resource for all operational matters, acting as a liaison between vendors and staff

Massachusetts Regional Manager — **2018-2019**
ConvenientMD Urgent Care, Eastern Massachusetts

- Promoted to Regional Manager position to oversee growth of new clinics into Massachusetts

- Successfully coordinated the opening of 6 new clinics in the Massachusetts region (from Falmouth to Newburyport).
- Provided oversight of all operational aspects of the region including, budget (management and forecasting), vendor management, payroll, recruiting, staffing etc.
- Lead clinic opening conference calls weekly to monitor multi-departmental progress to ensure project remained on track for grand opening date.
- Responsible for preparing every new location for all pre-opening inspections from DPH & CLIA/Laboratory, meeting all necessary state regulations for operation.
- Collaborated with Practice Managers for semi-annual & annual CLIA and/or DPH inspections to ensure compliance.
- Coached and counseled a diverse staff comprised of over 100 clinic team members and 5 practice managers.
- Worked closely with Chief Operating Officer, Director of Compliance, Chief Medical Officer and Regional Medical Directors to drive clinic volume, quality and patient/team satisfaction.
- Prepared a monthly dashboard report to include all metrics aligning with company strategic goals (NPS, D2D, OT, staffing etc), noting key areas of improvement.
- Assisted in the implementation of new patient on-line check-in process across all locations.

Practice Manager **2016-2018**

ConvenientMD Urgent Care, Nashua, NH

- Provided oversight of the day-to-day operations, both in business and clinically, to the Urgent Care Clinic.
- Effectively managed a team of over 25 staff, including Medical Receptionists, Nurses; Paramedics, Radiology Techs, Medical Assistants & Providers (MD's, DO's, PA-C's & NP's).
- Promoted teamwork and helped ensure a positive and productive work environment, increasing employee engagement scores quarterly.
- Assured the clinic was open and appropriately staffed during regularly scheduled hours and special events and that all facilities and equipment are available, operational, safe, and clean.
- Developed the monthly staff schedule, reviewed timecards, and provided input to payroll calculation.
- Conducted all aspects of the recruitment of clinic team.
- Participated in the training/competency (business/clinical) and facilitated orientation of new employees.
- Conducted performance evaluations.
- Addressed performance and disciplinary issues resulting in increased staff morale and performance.
- Provided oversight of Clinical Lead & Administrative Lead in the management of all laboratory and clinical equipment and front desk processes & troubleshooting.
- Reviewed all clinical devices, logs, & QA/QC and compliance statistics as needed.
- Ensured compliance with all company, State and Federal regulations, OSHA, DHHS and Human Resource directives to include patient privacy initiatives as well as employee safety.
- Audit records to ensure compliance with company policies and procedures.
- Facilitated the annual DHHS licensing audit and attended all facility audits and inspections as applicable, including clinical inspections (CLIA etc)
- Gathered reports from multiple sources and prepared a monthly operational dashboard to submit to senior leadership, displaying clinic metrics.
- Participated in several marketing events, including arranging involvement in a multi-day event with over 40,000 attendees.
- Also responsible for many sales leads, event ideas, tours of the clinic, and more in partnership with our local Director of Community & Business Relations.
- Participated on several committees, including Clinical Education, Clinical Operations/Quality Improvement and was the Chair of the DocuTap (EMR) SuperUser Committee.

Amherst Family Practice, Amherst NH **June 2013-present**

Embedded Care Coordinator, Clinical Lead

- Managed care for the non-complex patients of the primary care practice to promote effective education, self- management support, and timely health care delivery while collaborating with the interdisciplinary team to ensure the highest quality of care for the patient using the Patient Centered Medical Home model.
- Participated in NCQA Accreditation for which the practice received Level III Accreditation.
- Developed an MAT program (Vivitrol) in conjunction with BH NP, Primary Care and IT to provide additional access to addiction services for established patients.
- Collaborated with Behavioral Health NP to manage her panel of patients to assist with additional psychiatric services, triage, and scheduling
- Performed independent telephone triage to support a busy 5 provider family practice including, interview, assessment and disposition for the pediatric, adult and geriatric population while also supporting providers by completing all nurse visits, checking vital signs, conducting EKGs and providing face-to-face counseling for patients and families.
- Responsible for ordering vaccines, maintaining records and education of all staff on vaccines.
- Assisted in the coordination and management of patients currently on anti-coagulation therapy in compliance with current recommendations.

VOLUNTEER EXPERIENCE

Registered Nurse, Team Member — 2015 & 2016
Medical Tent, Gate City Marathon, SNHHS
Tended to runners needing assistance with injuries or dehydration at event.

Caregiver — 2014
Global Volunteers, Barlad, Romania
Spent 2 weeks in Romania in a children's hospital assisting with caring for the children. All the children we worked with were orphaned and had some aspect of disability (cognitive or physical). We were able to teach them new ways to do things, like color, eat or help them mobilize.

REFERENCES AVAILABLE UPON REQUEST

TIMOTHY M. SOUCY, MPH

SUMMARY OF QUALIFICATIONS

- Senior Leadership Team Member, Catholic Medical Center
- 28-Year Manchester Health Department Employee, 12-Years as Public Health Director
- Recognized Public Health Leader in the City of Manchester and State of New Hampshire
- Experienced in Managing Employees, Budgets and Community Collaborations
- Lifelong Manchester, New Hampshire Resident

EDUCATION

▪ Master of Public Health Degree Boston, Massachusetts	May 1998	Boston University School of Public Health Concentration: Environmental Health
▪ Bachelor of Science Degree Burlington, Vermont	May 1989	University of Vermont Major: Biology

PROFESSIONAL EXPERIENCE

8/20 – Present: Senior Executive Director – Support Services & Mission, Catholic Medical Center

Catholic Medical Center (CMC) is a nonprofit 330-bed acute-care hospital and regional health system based in Manchester, New Hampshire. The Senior Executive Director of Support Services and Mission oversees the delivery of CMC Support Services including Security, Telecommunications, Patient Transport, Food and Nutrition Services, Environmental Services, Facilities, Safety Officer, as well as Emergency Management and Project Management. In addition, the Senior Executive Director performs the duties of the Executive Director of Community Health & Mission as outlined below.

9/18 – 7/20: Executive Director - Community Health & Mission, Catholic Medical Center

The Executive Director of Community Health & Mission is responsible assessing, evaluating and prioritizing community needs and identifying CMC's role in meeting these needs through the completion on the annual Community Benefit Report and the Community Health Implementation Plan. In addition, the Executive Director manages the delivery of CMC's Community Health Services including Healthcare for the Homeless, Poisson Dental Facility, Medication Assistance Program, Breast and Cervical Cancer Screening Program, Veteran's Care Coordination, 1115 Waiver -Integrated Delivery Network, The Doorway of Greater Manchester, Women's Wellness and Fertility Clinic and the Office of Catholic Identity. The Executive Director rotates as the Administrator on Call for the hospital, serves on multiple hospital committees and acts as a liaison between the hospital and the Community.

12/06 – 8/18: Public Health Director, City of Manchester

The Public Health Director serves as the Chief Administrative Officer for the Manchester Health Department providing administrative oversight to all operations and activities including exclusive personnel responsibility, supervisory authority and budgetary authority. The Public Health Director oversees the routine assessment of the health of the community and recommends appropriate policies, ordinances and programs to improve the health of the community. The Public Health Director oversees

investigations, communicable disease control, environmental inspections and investigations necessary to protect the public health and is also responsible for the provision of school health services in Manchester. The Public Health Director serves as the CEO of the Manchester Health Care for the Homeless Program (330-h) and has overseen the AmeriCorps VISTA Program and Weed & Seed Strategy.

11/02 – 12/06: Public Health Preparedness Administrator, City of Manchester

In addition to carrying out all of the functions as the Chief of Environmental Health, the Public Health Preparedness Administrator planned, directed and supervised all activities to assure local readiness, interagency collaboration, and preparedness for bioterrorism, outbreaks of infectious disease, and other public health emergencies. The Public Health Preparedness Administrator routinely participated in City Emergency Operations Center activations, sheltering operations and hospital preparedness activities.

08/94 – 11/02: Chief, Division of Environmental Health, City of Manchester

The Chief of Environmental Health planned, directed and supervised all environmental health activities carried out within the City. Evaluated and recommended public health standards, ordinances and legislation. Advised governmental leaders, community representatives, and the general public on environmental health issues. Planned and conducted professional public health training programs. Coordinated epidemiological investigations for specific disease outbreaks. Supervised division staff and evaluated personnel performance.

02/90 - 08/94: Environmental Health Specialist / Sanitarian, City of Manchester

The Environmental Health Specialist / Sanitarian performed duties related to a comprehensive environmental health program, including, but not limited to inspection of food service facilities, investigation of foodborne illnesses, inspection of institutional facilities, swimming pool inspections, indoor air quality investigations, inspections of septic systems, investigation of public health nuisances, and investigation of childhood lead poisoning cases.

HONORS, RECOGNITIONS, APPOINTMENTS AND PRESENTATIONS

- Timothy M. Soucy Day in the City of Manchester, August 31, 2018
- Fellow, Kresge Foundation, Emerging Leader in Public Health, 2017-2018
- Robert Wood Johnson Foundation, Culture of Health Prize Award – City of Manchester, 2016
- Appointee, Network4Health Steering Committee, 2016 –Present
- Appointee, Governor's Advisory Board, State Innovation Model, 2015 –2017
- Graduate, Leadership Greater Manchester, Greater Manchester Chamber of Commerce, 2016
- Friend of Public Health Award, New Hampshire Public Health Association, 2015
- Presenter, NACCHO Survive and Thrive Leadership Graduation, 2013
- Appointee, New Hampshire Health Exchange Advisory Board, 2012 - 2016
- Poster Session, NACCHO Annual Conference, 2010
- Presenter, NALBOH Annual Conference, 2009
- Presented with Key to the City, Honorable Mayor Frank C. Guinta, 2009

TIMOTHY M. SOUCY, MPH

- Vice-Chair, Survive & Thrive Workgroup, NACCHO, 2009 – 2013
- Fellow, Survive & Thrive, National Association of County & City Health Officials, 2008 – 2009
- Guest Lecturer, University of New Hampshire, MPH Program, Law School and Undergraduate Programs, 2006- Present
- Associate, Leadership New Hampshire, Class of 2005
- 40 Under Forty, The Union Leader & Business and Industry Association of NH, Class of 2004
- Appointee, Legislative Study Committee for Public Health and the Environment, 2000-2003
- Inductee, Delta Omega Honor Society, Boston University School of Public Health 1998

COMMUNITY and VOLUNTEER ACTIVITIES

- Member, New Hampshire Guild of Catholic Healthcare Professionals, 2019 - Present
- New Hampshire Charitable Foundation, Manchester Regional Advisory Board , 2019 – Present
- City of Manchester Homeless Task Force, 2019
- Decade Knight, West High School Blue Knight Foundation, 2016 – Present
- Member, Manchester Historic Association, 2016 – Present
- Leadership Greater Manchester Steering Committee, Greater Manchester Chamber of Commerce, 2008 – Present
- Member, 100 Club of New Hampshire, 2008- Present
- Member, Board of Directors, Families in Transition, Housing Benefits, Inc., 2010 – 2019
- Volunteer, Dance Visions Network, 2007 - Present
- Health Department Campaign Coordinator & Leadership Donor, Granite United Way, 2008 – 18
- Member, Greater Manchester Mental Health Center CEO Search Committee, 2015
- Member, Manchester Community Health Center CEO Search Committee, 2013
- Member, Management Team, Manchester Homeless Day Center, 2012 - 2015
- Member, Board of Directors, Mental Health Center of Greater Manchester, 2008 – 2015 (Board Chair 2012-2014)
- Member, Seniors Count Collaborating Council, Easter Seals of New Hampshire, 2006 - 2014
- Member, Board of Directors, New Horizons for New Hampshire, 2004 – 2010 (Board President 2007-2009)
- Coach, Parker Varney Girls Basketball Team, 2004-2005
- Assistant Coach, Rising Stars Recreation Soccer League, 2002
- Assistant Coach, Manchester Angels Recreation Soccer League, 2001-2003
- Member, Advisory Council, Endowment for Health, Inc. 2000-2003
- Assistant Coach, Manchester West Junior Soccer League, 2000-2003
- Assistant Coach, Manchester West Junior Deb Softball League, 2000
- Member, Allocations Committee, United Way of Greater Manchester, 1998-2003

TIMOTHY M. SOUCY, MPH

CITY OF MANCHESTER ACTIVITIES

- Acting Director, City of Manchester Welfare Department, 2018
- Co-Chair, Mayor's Opioid Task Force, 2018
- Mentor, City of Manchester Leadership Academy, 2016 - 2018
- Appointee, City of Manchester 911 Ambulance Review Committee, 2013 - 2018
- Appointee, City of Manchester Enterprise Resource Planning Committee, 2012 – 2018
- Appointee, City of Manchester Labor / Management Committee, 2011 – 2018
- Appointee, City of Manchester Local Emergency Planning Committee, 2011 – 2018
- Appointee, City of Manchester Refugee and Immigrant Integration Task Force, 2010 - 2018
- Appointee, City of Manchester 10-Year Plan to End Homelessness, 2010 - 2018
- Appointee, City of Manchester Quality Council, 2008 – 2018
- Appointee, City of Manchester AFSCME Sick Leave Bank, 2006 - 2018

CATHOLIC MEDICAL CENTER ACTIVITIES

- Millworks Condominium Association 2019 – Present (President 2020 – Present)
- Human Trafficking Committee, 2019- Present
- Behavioral Health Clinical Learning Collaborative, 2019 – Present
- CMC / DH Behavioral Health Integration Committee, 2019 – Present
- CMC Board of Directors, Ethics & Mission Committee, 2018 – Present
- Environment of Care Committee, 2018 – Present
- Cancer Committee, 2018 – Present
- Emergency Management Committee, 2018- Present
- Substance Use Disorder Strategy Group, 2018 – Present
- Wilson Street Condominium Association Board Member, 2018 – Present
- Lung Cancer Steering Committee, 2018 – Present
- POLST Advisory Committee, 2018 – Present
- Preventative Food Pantry Advisory Committee, 2018 – Present
- Ethics Consultative Committee, 2018- Present
- Gift of Heart Campaign 2018 -Present
- Holiday Turkey Distribution 2018 – Present

CONTINUING EDUCATION

- National League of Cities - Mayor's Institute on Opioids, Boston, MA 2018
- CMC's Annual Summit on the Treatment of Opioid-dependent Patients and Pain, 2017, 2018
- 500 Cities: Local Data for Better Health, CDC Foundation, RWJ Foundation, 2016
- Culture of Health Prize Award Learning Event, Robert Wood Johnson Foundation, 2016
- Government Leaders Development Program, Tuck Executive Education at Dartmouth, 2016
- Roadmaps to Health Action Awards Convening, Robert Wood Johnson Foundation, 2016
- New Hampshire Department of Environmental Services, Educational Seminars, 2010 - 2016
- Avoid, Deny, Defend Training, City of Manchester Police Department, 2016

TIMOTHY M. SOUCY, MPH

- Culture and Cultural Effectiveness, Southern New Hampshire AHEC, 2015
- American Public Health Association Annual Meeting, Boston, MA, 2013
- Reasonable Suspicion Supervisory Training, City of Manchester Human Resources, 2010
- ICS 300, MGT 313, Incident Management/Unified Command, Texas A&M, 2008
- MGT -100 WMD Incident Management/Unified Command Concept, Texas A&M, 2008
- ICS 100, ICS 200, US Department of Homeland Security, 2008
- Bi-State Primary Care Association, Primary Care Conference, 2007
- Public Health Preparedness Summit, National Association of City & County Health Officials, 2006
- National Incident Management Systems (NIMS), US Department of Homeland Security, 2005
- Healthcare Leadership & Administrative Decision-Making in Response to Weapons of Mass Destruction (WMD) Incidents, US Federal Emergency Management Agency, 2004
- Forensic Epidemiology, US Department of Justice & US Centers for Disease Control, 2003
- BioDefense Mobilization Conference, University of Washington, School of Public Health, 2002
- Emergency Response to Domestic Biological Incidents, US Department of Justice & LSU, 2001
- Financial Skills for Non-Financial Managers, University of New Hampshire, 2001
- National Environmental Health Association Annual Education Conference, NEHA, 2000
- Management Perspectives for Public Health Practitioners, US Centers for Disease Control, 2000
- Investigating Foodborne Illnesses, US Food & Drug Administration, 1999
- Environmental Health Risks to Children, US Environmental Protection Agency, 1998
- Food Microbiological Control, US Food & Drug Administration, 1998
- Computer Assisted Modeling for Emergency Operations, Harvard School of Public Health, 1997
- Local Radon Coordinators Network Training, NACCHO, 1996
- Introduction to Indoor Air Quality, US EPA & Harvard University, 1995
- Hazard Analysis & Critical Control Point (HACCP), US Food & Drug Administration, 1995
- Safety Measurement, Bloodborne Pathogens, Confined Space Entry, UNH, 1994
- Environmental Health Sciences, US Centers for Disease Control & Prevention, 1992
- Field Description of Soils, University of New Hampshire, 1992
- Kentucky Lead Training Workshop, Jefferson County Health Department, 1991
- Foodborne Disease Control, US Centers for Disease Control & Prevention, 1991
- Lead Paint Inspectors Course, PCG PRO-Tech Services, Massachusetts, 1990

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Nicolette Desgagne	Practice Manager	$72,000	100	$72,000
Timothy Soucy	Sr. Executive Director	$157,000	0	0

JUN 12 '20 3 | mac

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH

Lori A. Shibinette
Commissioner

Katja S. Fox
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

June 2, 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 for Behavioral Health, to amend existing **Sole Source** contracts with the vendors listed below, except for Granite Pathways, that provide a statewide network of Doorways for substance use disorder treatment and recovery support services access, by adding budgets for State Fiscal Year 2021, with no change to the price limitation of $23,606,657 and no change to the contract completion dates of September 29, 2020 effective upon Governor and Council approval.

The contracts were approved by the Governor and Executive Council as indicated in the table below.

Vendor Name	Vendor Code	Area Served	Current Amount	Increase/ (Decrease)	New Amount	G&C Approval
Androscoggin Valley Hospital, Inc., Berlin, NH	TBD	Berlin	$1,670,051	$0	$1,670,051	O: 10/31/18 Item #17A A1: 8/28/19 (Item #10)
Concord Hospital, Inc., Concord, NH	177653-B003	Concord	$2,272,793	$0	$2,272,793	O: 10/31/18 Item #17A A1: 8/28/19 (Item #10)
Granite Pathways, Concord, NH	228900-B001	N/A	$6,895,879	$0	$6,895,879	O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)
Littleton Regional Hospital, Littleton, NH	TBD	Littleton	$1,713,805	$0	$1,713,805	O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)
LRGHealthcare, Laconia, NH	TBD	Laconia	$1,987,673	$0	$1,987,673	O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)

Mary Hitchcock Memorial Hospital, Lebanon, NH	177651-B001	Lebanon	$4,349,314	$0	$4,349,314	O: 10/31/18 Item #17A A1: 11/14/18 (Item #11) A2: O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)
The Cheshire Medical Center, Keene, NH	155405-B001	Keene	$1,947,690	$0	$1,947,690	O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)
Wentworth-Douglass, Hospital, Dover, NH	TBD	Dover	$2,769,452	$0	$2,769,452	O: 10/31/18 (Item #17A) A1: 9/18/19, (Item #20)
		Total	**$23,606,657**	**$0**	**$23,606,657**	

Funds are available in the following accounts for State Fiscal Year 2021 with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

See attached fiscal details

EXPLANATION

This request is **Sole Source** because the contracts were originally approved as sole source and MOP 150 requires any subsequent amendments to be labelled as sole source. Upon the initial award of State Opioid Response funding from the federal Substance Abuse and Mental Health Services Administration, the Department restructured the State's service delivery system to provide individuals a more streamlined process to access substance use disorder and opioid use disorder services. The vendors above were identified as organizations for this scope of work based on their existing roles as critical access points for other health services, existing partnerships with key community-based providers, and the administrative infrastructure necessary to meet the Department's expectations for the restructured system. As part of the ongoing improvement of the Doorway system, Granite Pathways has been replaced as the Doorway provider in Manchester (Catholic Medical Center) and Nashua (Southern New Hampshire Medical Center). This action was approved by Governor and Executive Council on March 11, 2020, item 9A.

The purpose of this request is add budgets to the contracts for State Fiscal Year 2021. In accordance with the terms of Exhibit B Method and Conditions Precedent to Payment, the budgets are to be submitted to Governor and Executive Council for approval no later than June 30, 2020. State Fiscal Year 2019 budgets are being reduced by a total amount of $2,271,726 which is identified as unspent funding that is being carried forward to fund activities in the contract for State Fiscal Year 2021, specifically July 1, 2020 through September 29, 2020. The new Manchester and Nashua Doorway contracts already include budgets for July 1, 2020 through September 29, 2020.

Approximately 2,000 individuals will be served from July 1, 2020 to September 30, 2020.

These contractors provide a network of Doorways to ensure that every resident in NH has access to substance use disorder treatment and recovery services in person during the week, along with 24/7 telephonic services for screening, assessment, and evaluations for substance use disorders, in order to ensure no one in NH has to travel more than sixty (60) minutes to access services. The Doorways increase and standardize services for individuals with opioid use disorders; strengthen existing prevention, treatment, and recovery programs; ensure access to critical services to decrease the number of opioid-related deaths in NH; and promote engagement in the recovery process. Because no one will be turned away from the Doorway, individuals outside of opioid use disorders are also being seen and referred to the appropriate services.

The Department has been monitoring the contracted services using the following performance measures:

- Monthly de-identified, aggregate data reports
- Weekly and biweekly Doorway program calls
- Monthly Community of Practice meetings
- Regular review and monitoring of Government Performance and Results Act (GPRA) interviews and follow-ups through the Web Information Technology System (WITS) database.

As referenced in Exhibit C-1 Revisions to Standard Contract Language of the original contracts, the parties have the option to extend the agreements for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval. The Department is not exercising its option to renew at this time.

Should the Governor and Council not authorize this request, the Department may not have the ability to ensure proper billing and proper use of funding by the vendors.

Area served: Statewide

Respectfully submitted,

Lori A. Shibinette
Commissioner

05-95-92-920510-7040 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: BEHAVIORAL HEALTH DIV OF, BUREAU OF DRUG & ALCOHOL SERVICES, STATE OPIOID RESPONSE GRANT					
100% Federal Funds CFDA #93.788 FAIN TI081685					
Activity Code: 92057040					
Androscoggin Valley					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 821,133.00	$ (201,283.00)	$ 619,850.00
2020	Contracts for Prog Svs	102-500731	$ 848,918.00		$ 848,918.00
2021	Contracts for Prog Svs	102-500731		$ 201,283.00	$ 201,283.00
Subtotal			$ 1,670,051.00	$ -	$ 1,670,051.00
Concord					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 947,662.00	$ (236,916.00)	$ 710,746.00
2020	Contracts for Prog Svs	102-500731	$ 1,325,131.00		$ 1,325,131.00
2021	Contracts for Prog Svs	102-500731		$ 236,916.00	$ 236,916.00
Subtotal			$ 2,272,793.00	$ -	$ 2,272,793.00
Cheshire					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 820,133.00	$ (205,033.00)	$ 615,100.00
2020	Contracts for Prog Svs	102-500731	$ 1,127,557.00		$ 1,127,557.00
2021	Contracts for Prog Svs	102-500731		$ 205,033.00	$ 205,033.00
Subtotal			$ 1,947,690.00	$ -	$ 1,947,690.00
Mary Hitchcock					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 1,774,205.00	$ (383,958.00)	$ 1,390,247.00
2020	Contracts for Prog Svs	102-500731	$ 2,575,109.00		$ 2,575,109.00
2021	Contracts for Prog Svs	102-500731		$ 383,958.00	$ 383,958.00
Subtotal			$ 4,349,314.00	$ -	$ 4,349,314.00
LRGHealthcare					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 820,000.00	$ (205,000.00)	$ 615,000.00
2020	Contracts for Prog Svs	102-500731	$ 1,167,673.00		$ 1,167,673.00
2021	Contracts for Prog Svs	102-500731		$ 205,000.00	$ 205,000.00
Subtotal			$ 1,987,673.00	$ -	$ 1,987,673.00

Granite Pathways Manchester					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 1,331,471.00		$ 1,331,471.00
2020	Contracts for Prog Svs	102-500731	$ 2,349,699.00		$ 2,349,699.00
2021	Contracts for Prog Svs	102-500731			$ -
Subtotal			$ 3,681,170.00	$ -	$ 3,681,170.00
Granite Pathways Nashua					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 1,348,973.00		$ 1,348,973.00
2020	Contracts for Prog Svs	102-500731	$ 1,865,736.00		$ 1,865,736.00
2021	Contracts for Prog Svs	102-500731			$ -
Subtotal			$ 3,214,709.00	$ -	$ 3,214,709.00
Provider name here					
Littleton Regional					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 831,000.00	$ (203,750.00)	$ 627,250.00
2020	Contracts for Prog Svs	102-500731	$ 882,805.00		$ 882,805.00
2021	Contracts for Prog Svs	102-500731		$ 203,750.00	$ 203,750.00
Subtotal			$ 1,713,805.00	$ -	$ 1,713,805.00
Wentworth Douglass					
State Fiscal Year	Class Title	Class Account	Current Budget	Increase (Decrease) Budget	Modified Budget
2019	Contracts for Prog Svs	102-500731	$ 962,700.00	$ (240,675.00)	$ 722,025.00
2020	Contracts for Prog Svs	102-500731	$ 1,806,752.00		$ 1,806,752.00
2021	Contracts for Prog Svs	102-500731		$ 240,675.00	$ 240,675.00
Subtotal			$ 2,769,452.00	$ -	$ 2,769,452.00
Subtotal			$ 23,606,657.00	$ -	$ 23,606,657.00

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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION FOR BEHAVIORAL HEALTH

BUREAU OF DRUG AND ALCOHOL SERVICES

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

105 PLEASANT STREET, CONCORD, NH 03301
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August 13, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, to amend existing **sole source** agreements with the two (2) vendors listed in bold below, to implement and operationalize a statewide network of Doorways for substance use disorder treatment and recovery support services access, by increasing the total price limitation by $537,976 from $19,106,657 to $19,644,633, with no change to the completion date of September 29, 2020, effective upon Governor and Executive Council approval. 100% Federal Funds.

These agreements were originally approved by the Governor and Executive Council on October 31, 2018 (Item #17A) and Mary Hitchcock Memorial Hospital amended on November 14, 2018 (Item #11).

Vendor Name	Vendor ID	Vendor Address	Current Budget	Increase/ (Decrease)	Updated Budget
Androscoggin Valley Hospital, Inc.	**TBD**	**59 Page Hill Rd. Berlin, NH 03570**	**$1,559,611**	**$110,440**	**$1,670,051**
Concord Hospital, Inc.	**177653-B003**	**250 Pleasant St. Concord, NH, 03301**	**$1,845,257**	**$427,536**	**$2,272,793**
Granite Pathways	228900-B001	10 Ferry St, Ste. 308, Concord, NH, 03301	$5,008,703	$0	$5,008,703
Littleton Regional Hospital	TBD	600 St. Johnsbury Road, Littleton, NH 03561	$1,572,101	$0	$1,572,101
LRGHealthcare	TBD	80 Highland St. Laconia, NH 003246	$1,593,000	$0	$1,593,000
Mary Hitchcock Memorial Hospital	177651-B001	One Medical Center Drive Lebanon, NH 03756	$4,043,958	$0	$4,043,958
The Cheshire Medical Center	155405-B001	580 Court St. Keene, NH 03431	$1,593,611	$0	$1,593,611
Wentworth-Douglass Hospital	TBD	789 Central Ave. Dover, NH 03820	$1,890,416	$0	$1,890,416
		Total	$19,106,657	$537,976	$19,644,633

Funds to support this request are anticipated to be available in the following accounts for State Fiscal Years 2020 and 2021 upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

will align evidence-based methods to expand treatment, recovery, and prevention services to individuals with OUD in NH. During the first six (6) months of implementation, the Department identified these factors as inhibitors to the long-term success of the program. The outcomes from this amendment align with the original contract to connect individuals with needed services to lower the deaths from OUD in NH and increase the use of Medication Assisted Treatment.

Approximately 9,700 individuals are expected to be served from August 1, 2019 through June 30, 2020. During the first six (6) months of service, the vendors completed 1,571 clinical evaluations, conducted 2,219 treatment referrals, and served 3,239 individuals.

These contracts will allow the Doorways to continue to ensure that every resident in NH has access to SUD treatment and recovery services in person during the week, along with 24/7 telephonic services for screening, assessment, and evaluations for SUD, in order to ensure no one in NH has to travel more than sixty (60) minutes to access services. The Doorways increase and standardize services for individuals with OUD; strengthen existing prevention, treatment, and recovery programs; ensure access to critical services to decrease the number of opioid-related deaths in NH; and promote engagement in the recovery process. Because no one will be turned away from the Doorway, individuals outside of OUD are also being seen and referred to the appropriate services.

The Department will monitor the effectiveness and the delivery of services required under this agreement using the following performance measures:

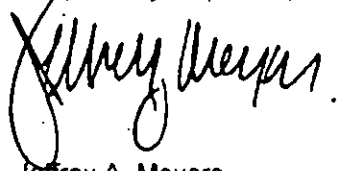
- Monthly de-identified, aggregate data reports
- Weekly and biweekly Doorway program calls
- Monthly Community of Practice meetings
- Regular review and monitoring of Government Performance and Results Act (GPRA) interviews and follow ups through the Web Information Technology System (WITS) database.

Should Governor and Executive Council not authorize this request, individuals seeking help for OUD in NH may experience difficulty navigating a complex system, may not receive the supports and clinical services they need, and may experience delays in receiving care.

Area served: Statewide

Source of Funds: 100% Federal Funds from the Substance Abuse and Mental Health Services Administration. CFDA # 93.788, FAIN #H79TI081685 and FAIN #TI080246.

Respectfully submitted,



Jeffrey A. Meyers
Commissioner

05-95-92-920510-7040 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SERVICES, STATE OPIOID RESPONSE GRANT

State Fiscal Year	Class/ Account	Class Title	Job Number	Current Funding	Increase/ (Decrease)	Updated Funding
2019	102-500731	Contracts for Prog Svc	92057040	$9,325,277	$0	$9,325,277
2020	102-500731	Contracts for Prog Svc	92057040	$9,449,380	$537,976	$9,987,356
2021	102-500731	Contracts for Prog Svc	92057040	$0	$0	$0
			Sub-Total	***$18,774,657***	***$537,976***	***$19,312,633***

05-95-92-920510-2559 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SERVICES, OPIOID STR GRANT

State Fiscal Year	Class/ Account	Class Title	Job Number	Current Funding	Increase/ (Decrease)	Updated Funding
2019	102-500731	Contracts for Prog Svc	92052561	$332,000	$0	$332,000
2020	102-500731	Contracts for Prog Svc	92052561	$0	$0	$0
2021	102-500731	Contracts for Prog Svc	92052561	$0	$0	$0
			Sub-Total	***$332,000***	***$0***	***$332,000***
			Grand Total	$19,106,657	$537,976	$19,644,633

EXPLANATION

This request is sole source because upon the intitial award of State Opioid Response (SOR) funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Department restructured the State's service delivery system to provide individuals a more streamlined process to access substance use disorder (SUD) and Opioid Use Disorder (OUD) services. The vendors above were identified as organizations for this scope of work based on their existing roles as critical access points for other health services, existing partnerships with key community-based providers, and the administrative infrastructure necessary to meet the Department's expectations for the restructured system.

The purpose of this request is to add funding for: Naloxone kits to distribute to individuals and community partners; additional flexible funds to address barriers to care such as transportation and childcare; and respite shelter vouchers to assist in accessing short-term, temporary housing. This action

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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION FOR BEHAVIORAL HEALTH

BUREAU OF DRUG AND ALCOHOL SERVICES

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

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October 17, 2018

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, Bureau of Drug and Alcohol Services, to enter into sole source agreements with the eight (8) vendors listed below, in an amount not to exceed $16,606,487, to develop, implement and operationalize a statewide network of Regional Hubs for opioid use disorder treatment and recovery support services, effective upon date of Governor and Council approval, through September 29, 2020. Federal Funds 100%.

Vendor Name	Vendor ID	Vendor Address	Amount
Androscoggin Valley Hospital, Inc.	TBD	59 Page Hill Rd. Berlin, NH 03570	$1,559,611
Concord Hospital, Inc.	177653-B003	250 Pleasant St. Concord, NH, 03301	$1,845,257
Granite Pathways	228900-B001	10 Ferry St, Ste. 308, Concord, NH, 03301	$5,008,703
Littleton Regional Hospital	TBD	600 St. Johnsbury Road Littleton, NH 03561	$1,572,101
LRGHealthcare	TBD	80 Highland St. Laconia, NH 003246	$1,593,000
Mary Hitchcock Memorial Hospital	177651-B001	One Medical Center Drive Lebanon, NH 03756	$1,543,788
The Cheshire Medical Center	155405-B001	580 Court St. Keene, NH 03431	$1,593,611
Wentworth-Douglass Hospital	TBD	789 Central Ave. Dover, NH 03820	$1,890,416
		Total	**$16,606,487**

Funds are available in the following account(s) for State Fiscal Year (SFY) 2019, and are anticipated to be available in SFY 2020 and SFY 2021, upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval from the Governor and Executive Council.

05-95-92-920510-7040 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SERVICES, STATE OPIOID RESPONSE GRANT

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2019	102-500731	Contracts for Prog Svc	92057040	$8,281,704
SFY 2020	102-500731	Contracts for Prog Svc	92057040	$7,992,783
SFY 2021	102-500731	Contracts for Prog Svc	92057040	$0
			Sub-Total	***$16,274,487***

05-95-92-920510-2659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SERVICES, OPIOID STR GRANT

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2019	102-500731	Contracts for Prog Svc	92052561	$332,000
SFY 2020	102-500731	Contracts for Prog Svc	92052561	$0
SFY 2021	102-500731	Contracts for Prog Svc	92052561	$0
			Sub-Total	***$332,000***
			Grand Total	**$16,606,487**

EXPLANATION

This request is sole source because the Department is seeking to restructure its service delivery system in order for individuals to have more rapid access to opioid use disorder (OUD) services. The vendors above have been identified as organizations for this scope of work based on their existing roles as critical access points for other health services, existing partnerships with key community-based providers, and the administrative infrastructure necessary to meet the Department's expectations for the service restructure. Presently, the Department funds a separate contract with Granite Pathways through December 31, 2018 for Regional Access Points, which provide screening and referral services to individuals seeking help with substance use disorders. The Department is seeking to re-align this service into a streamlined and standardized approach as part of the State Opioid Response (SOR) grant, as awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA). With this funding opportunity, New Hampshire will use evidence-based methods to expand treatment, recovery, and prevention services to individuals with OUD in NH. The establishment of nine (9) Regional Hubs (hereafter referred to as Hubs) is critical to the Department's plan.

The Hubs will ensure that every resident in NH has access to SUD treatment and recovery services in person during the week, along with 24/7 telephonic services for screening, assessment, and evaluations for substance use disorders. The statewide telephone coverage will be accomplished

evaluations for substance use disorders. The statewide telephone coverage will be accomplished through a collaborative effort among all of the Hubs for overnight and weekend access to a clinician, which will be presented to the Governor and Executive Council at the November meeting. The Hubs will be situated to ensure that no one in NH has to travel more than sixty (60) minutes to access their Hub and initiate services. The vendors will be responsible for providing screening, evaluation, closed loop referrals, and care coordination for clients along the continuum of care.

In the cities of Manchester and Nashua, given the maturity of the Safe Stations programs as access points in those regions, Granite Pathways, the existing Regional Access Point contractor, was selected to operate the Hubs in those areas to ensure alignment with models consistent with ongoing Safe Station's operations. To maintain fidelity to existing Safe Stations operations, Granite Pathways will have extended hours of on-site coverage from 8am-11pm on weekdays and 11am-11pm on weekends.

The Hubs will receive referrals for OUD services through a new contract with the crisis call center (2-1-1 NH) operated by Granite United Way and through existing referral networks. Consumers and providers will also be able to directly contact their local Hub for services. The Hubs will refer clients to services for all American Society of Addiction Medicine (ASAM) levels of care. This approach eliminates consumer confusion caused by multiple access points to services and ensures that individuals who present for help with OUD are receiving assistance immediately.

Funds for each Hub were determined based on a variety of factors, including historical client data from Medicaid claims and State-funded treatment services based on client address, naloxone administration and distribution data, and hospital admissions for overdose events. Funds in these agreements will be used to establish the necessary infrastructure for Statewide Hub access and to pay for naloxone purchase and distribution. The vendors will also have a flexible needs fund for providers to access for OUD clients in need of financial assistance for services and items such as transportation, childcare, or medication co-pays not otherwise covered by another payer.

Unique to this service redesign is a robust level of client-specific data that will be available. The SOR grant requires that all individual served receive a comprehensive assessment at several time intervals, specifically at intake, three (3) months, six (6) months and upon discharge. Through care coordination efforts, the Regional Hubs will be responsible for gathering data on items including, but not limited to recovery status, criminal justice involvement, employment, and housing needs at the time intervals listed above. This data will enable the Department to measure short and long-term outcomes associated with SOR-funded initiatives and to determine which programs are generating the best results for the clients served.

As referenced in Exhibit C-1 of this contract, the Department has the option to extend contracted services for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Council.

Notwithstanding any other provision of the Contract to the contrary, no services shall continue after June 30, 2019, and the Department shall not be liable for any payments for services provided after June 30, 2019, unless and until an appropriation for these services has been received from the state legislature and funds encumbered for the SFY 2020-2021 and SFY 2022-2023 biennia.

Should Governor and Executive Council not authorize this request, individuals seeking help for OUD in NH may experience difficulty navigating a complex system, may not receive the supports and clinical services they need, and may experience delays in receiving care.

Area served: Statewide

Source of Funds: 100% Federal Funds from the Substance Abuse and Mental Health Services Administration. CFDA # 93.788, FAIN #H79TI081685 and FAIN #TI080246.

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Katja S. Fox
Director

Approved by:

Jeffrey A. Meyers
Commissioner

05-95-92-920510-7040 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: BEHAVIORAL HEALTH DIV OF, BUREAU OF DRUG & ALCOHOL SERVICES, STATE OPIOID RESPONSE GRANT			
100% Federal Funds			
Activity Code: 92057040			
Androscoggin Valley Hospital, Inc			
Vendor # TBD			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 805,133.00
2020	Contracts for Prog Svs	102-500731	$ 738,478.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,543,611.00**
Concord Hospital, Inc			
Vendor # 177653-B003			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 947,662.00
2020	Contracts for Prog Svs	102-500731	$ 897,595.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,845,257.00**
Granite Pathways			
Vendor # 228900-B001			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 2,380,444.00
2020	Contracts for Prog Svs	102-500731	$ 2,328,259.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 4,708,703.00**
Littleton Regional Hospital			
Vendor # TBD			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 815,000.00
2020	Contracts for Prog Svs	102-500731	$ 741,101.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,556,101.00**
LRGHealthcare			
Vendor # TBD			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 820,000.00
2020	Contracts for Prog Svs	102-500731	$ 773,000.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,593,000.00**

Mary Hitchcock Memorial Hospital			
Vendor # 177651-B001			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 730,632.00
2020	Contracts for Prog Svs	102-500731	$ 813,156.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,543,788.00**
The Cheshire Medical Center			
Vendor # 155405-B001			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 820,133.00
2020	Contracts for Prog Svs	102-500731	$ 773,478.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,593,611.00**
Wentworth-Douglas Hospital			
Vendor # 157797			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 962,700.00
2020	Contracts for Prog Svs	102-500731	$ 927,716.00
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 1,890,416.00**

SUB TOTAL			**$ 16,274,487.00**

05-95-92-920510-2559 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: BEHAVIORAL HEALTH DIV OF, BUREAU OF DRUG & ALCOHOL SERVICES, OPIOID STR GRANT			
100% Federal Funds			
Activity Code: 92052561			
Androscoggin Valley Hospital, Inc			
Vendor # TBD			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ 16,000.00
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ 16,000.00**
Concord Hospital, Inc			
Vendor # 177653-B003			
State Fiscal Year	**Class Title**	**Class Account**	**Current Budget**
2019	Contracts for Prog Svs	102-500731	$ -
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			**$ -**

Financial Detail

Granite Pathways			
Vendor # 228900-B001			
State Fiscal Year	Class Title	Class Account	Current Budget
2019	Contracts for Prog Svs	102-500731	$ 300,000.00
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			$ 300,000.00
Littleton Regional Hospital			
Vendor # TBD			
State Fiscal Year	Class Title	Class Account	Current Budget
2019	Contracts for Prog Svs	102-500731	$ 16,000.00
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			$ 16,000.00
LRGHealthcare			
Vendor # TBD			
State Fiscal Year	Class Title	Class Account	Current Budget
2019	Contracts for Prog Svs	102-500731	$ -
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			$ -
Mary Hitchcock Memorial Hospital			
Vendor # 177651-B001			
State Fiscal Year	Class Title	Class Account	Current Budget
2019	Contracts for Prog Svs	102-500731	$ -
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			$ -
The Cheshire Medical Center			
Vendor # 155405-B001			
State Fiscal Year	Class Title	Class Account	Current Budget
2019	Contracts for Prog Svs	102-500731	$ -
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			$ -
Wentworth-Douglas Hospital			
Vendor # 157797			
State Fiscal Year	Class Title	Class Account	Current Budget
2019	Contracts for Prog Svs	102-500731	$ -
2020	Contracts for Prog Svs	102-500731	$ -
2021	Contracts for Prog Svs	102-500731	$ -
Subtotal			$ -
SUB TOTAL			$ 332,000.00

TOTAL	$ 16,606,487.00

FORM NUMBER P-37 (version 5/8/15)

Subject: Access and Delivery Hub for Opioid Use Disorder Services (SS-2019-BDAS-05-ACCES-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 ANDROSCOGGIN VALLEY HOSPITAL, INC		1.4 Contractor Address 59 PAGE HILL ROAD, BERLIN, NH. 03570	
1.5 Contractor Phone Number (603) 752-2200	1.6 Account Number 05-95-92-7040-500731 05-95-92-2559-500731	1.7 Completion Date September 29, 2020	1.8 Price Limitation $1,559,611
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 Michael D. Peterson, FACHE President, Androscoggin Valley Hospital	

1.13 Acknowledgement: State of NH, County of GRAFTON

On 10/15/18, 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]

BONNIE HAMEL, NOTARY PUBLIC, STATE OF NEW HAMPSHIRE, MY COMMISSION EXPIRES SEPTEMBER 3, 2019, JUSTICE OF THE PEACE

1.13.2 Name and Title of Notary or Justice of the Peace

BONNIE HAMEL, JP

1.14 State Agency Signature Date: 10/19/18	1.15 Name and Title of State Agency Signatory Katja S Fox, Director
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:	Director, On:
1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: Assistant Attorney General	On: 10/19/18
1.18 Approval by the Governor and Executive Council *(if applicable)* By:	On:

2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials MPP
Date 10/15/2018

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 MMP

Date 10/15/19

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 MBP

Date 10/15/18

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor shall submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

1.3. For the purposes of this contract, the Contractor shall be identified as a subrecipient, in accordance with 2 CFR 200.0. *et seq.*

1.4. Notwithstanding any other provision of the Contract to the contrary, no services shall continue after September 29, 2020, and the Department shall not be liable for any payments for services provided after September 29, 2020, unless and until an appropriation for these services has been received from the state legislature and funds encumbered for the SFY 2020-2021 and SFY 2022-2023 biennia.

2. Scope of Work

2.1. The Contractor will develop, implement and operationalize a Regional Hub for substance use disorder treatment and recovery support service access (Hub).

2.2. The Contractor shall provide residents in the Berlin Region with access to referrals to substance use disorder treatment and recovery support services and other health and social services.

2.3. The Contractor shall participate in technical assistance, guidance, and oversight activities directed by the Department for implementation of Hub services.

2.4. The Contractor shall have the Hub operational by January 1, 2019 unless an alternative timeline has been approved prior to that date by the Department.

2.5. The Contractor shall collaborate with the Department to develop a plan no later than July 1, 2019 for the resources, timeline and infrastructure requirements to develop and maintain a centralized referral database of substance use disorder and mental health treatment providers.

2.5.1. The database shall include the real-time availability of services and providers to ensure rapid placement into appropriate levels of care for Hub clients which the Hub will update daily, at a minimum.

2.5.2. The data and the centralized database shall be the property of the Department.

2.6. The Contractor shall operationalize the use of the centralized database at a date agreed upon between the Department and the Contractor based on securing the resource needs identified in 2.5.

2.7. The Contractor shall collaborate with the Department to assess the Contractor's level of readiness, capacity and additional resource needs required to expand Hub services in-house to include, but not be limited to:

2.7.1.1. Medication assisted treatment induction at emergency rooms and facilitated coordination with ongoing hub care coordination inclusive of the core principles of the Medication First Model.

2.7.1.2. Outpatient and inpatient substance use disorder services, in accordance with ASAM.

2.7.1.3. Coordinating overnight placement for Hub clients engaged in Hub services between the hours of 5 pm to 8 am in need of a safe location while awaiting treatment placement the following business day.

2.7.1.4. Expanding populations for Hub core services.

2.8. The Contractor shall collaborate with the Department to identify gaps in financial and staffing resources throughout the contract period.

2.9. The Contractor, either alone or in collaboration with other Hubs, shall ensure formalized coordination with 2-1-1 NH as the public facing telephone service for all Hub service access. This coordination shall include:

2.9.1. Establishing an MOU with 2-1-1 NH which defines the workflows to coordinate 2-1-1 NH calls and Hub activities including the following workflow:

2.9.1.1. Individuals seeking substance use disorder treatment services will call 2-1-1 NH;

2.9.1.2. If an individual is seeking information only, 2-1-1 NH staff will provide that information;

2.9.1.3. If an individual is in an SUD related crisis and wants to speak with a licensed counselor and/or is seeking assistance with accessing treatment services, 2-1-1 NH staff will transfer the caller to the Hub or on-call Hub clinician.

2.9.2. The MOU with 2-1-1 NH shall include a process for bi-directional information sharing of updated referral resource databases to ensure that each entity has recently updated referral information.

2.10. The Contractor shall establish formalized agreements for coordination of services and case management services provided by Integrated Delivery Networks (IDNs) to reduce duplication of services and leverage existing integrated care projects in their region.

2.11. The Contractor with the assistance of the Department shall attempt to establish formalized agreements with:

2.11.1. Medicaid Managed Care Organizations to coordinate case management efforts on behalf of the client.

2.11.2. Private insurance carriers to coordinate case management efforts on behalf of the client.

2.12. The Contractor shall be required to create policies for obtaining patient consent to disclose protected health information as required by state administrative rules and federal and state laws for agreements reached with Managed Care Organizations and private insurance carriers as outlined in Subsection 2.11.

2.13. The Contractor shall develop a Department approved conflict of interest policy related to Hub services and self-referrals to Hub organization substance use disorder treatment and recovery support service programs funded outside of this contract that maintains the integrity of the referral process and client choice in determining placement in care.

3. Scope of Work for Hub Activities

3.1. The Contractor shall ensure that unless an alternative schedule for the Hub to meet the needs of the community is proposed and approved by the Department, the Hub provides, in one location, during normal business hours (8am-5pm) Monday through Friday, at a minimum:

3.1.1. A physical location for clients to receive face-to-face services.

3.1.2. Telephonic services for calls referred to the Hub by 2-1-1 NH.

3.1.3. Screening to assess an individual's potential need for Hub services.

3.1.4. Crisis intervention and stabilization which ensures that individuals in an acute OUD related crisis that require immediate, non-emergency intervention are provided with crisis intervention counseling services by a licensed clinician. If the client is calling rather than physically presenting at the Hub, this includes, but is not limited to:

3.1.4.1. Directing callers to 911 if a client is in imminent danger or there is an emergency.

3.1.4.2. If the client is unable or unwilling to call 911, the Hub shall contact emergency services.

3.1.5. Clinical evaluation including:

3.1.5.1. Evaluation of all American Society of Addiction Medicine Criteria (ASAM, October 2013), domains.

3.1.5.2. A level of care recommendation based on ASAM Criteria (October 2013).

3.1.5.3. Identification of client strengths and resources that can be used to support treatment and recovery.

3.1.6. Development of a clinical service plan in collaboration with the client based on the clinical evaluation referenced in Paragraph 3.1.5. The service plan shall include, but not be limited to:

3.1.6.1. Determination of an initial ASAM level of care.

3.1.6.2. Identification of any needs the client may have relative to supportive services including, but not limited to:

3.1.6.2.1. Physical health needs.

3.1.6.2.2. Mental health needs.

3.1.6.2.3. Need for peer recovery support services.

3.1.6.2.4. Social services needs.

3.1.6.2.5. Needs regarding criminal justice/Division for Children, Youth, and Families (DCYF) matters.

3.1.6.3. Plan for addressing all areas of need identified in Subparagraph 3.1.6.2 by determining goals that are patient-centered, specific, measurable, attainable, realistic, and timely (SMART goals).

3.1.6.4. When the level of care identified in 3.1.6.1 is not available to the client within 48 hours of service plan development, the service plan shall include plans for referrals to external providers to offer interim services, which are defined as:

3.1.6.4.1. At least one sixty (60) minute individual or group outpatient session per week and/or;

3.1.6.4.2. Recovery support services, as needed by the client; and/or

3.1.6.4.3. Daily calls to the client to assess and respond to any emergent needs.

3.1.7. A staff person, which can be the licensed clinician, CRSW outlined in the Staffing section, or other non-clinical support staff, capable of aiding specialty populations in accessing services that may have additional entry points to services or specific eligibility criteria. Specialty populations include, but are not limited to:

3.1.7.1. Veterans and/or service members.

3.1.7.2. Pregnant women.

3.1.7.3. DCYF involved families.

3.1.7.4. Individuals at-risk of or with HIV/AIDS.

3.1.7.5. Adolescents.

3.1.8. Facilitated referrals to substance use disorder treatment and recovery support and other health and social services which shall include, but not be limited to:

3.1.8.1. Developing and implementing adequate consent policies and procedures for client-level data sharing and shared care planning with external providers, in accordance with HIPAA and 42 CFR Part 2.

3.1.8.2. Determining referrals based on the service plan developed in Paragraph 3.1.6.

3.1.8.3. Assisting clients with obtaining services with the provider agency, as appropriate.

3.1.8.4. Contacting the provider agency on behalf of the client, as appropriate.

3.1.8.5. Assisting clients with meeting the financial requirements for accessing services including, but not limited to:

3.1.8.5.1. Identifying sources of financial assistance for accessing services and supports, and;

3.1.8.5.2. Providing assistance in accessing such financial assistance including, but not limited to:

3.1.8.5.2.1. Assisting the client with making contact with the assistance agency, as appropriate.

3.1.8.5.2.2. Contacting the assistance agency on behalf of the client, as appropriate.

3.1.8.5.2.3. Supporting the client in meeting the admission, entrance, and intake requirements of the assistance agency.

3.1.8.5.3. When no other payer is available, assisting clients with accessing services by maintaining a flexible needs fund specific to the Hub region that supports clients who meet the eligibility criteria for assistance under the NH DHHS SOR Flexible Needs Fund Policy with their financial needs including, but not limited to:

3.1.8.5.3.1. Co-pay and deductible assistance for medications and treatment services.

3.1.8.5.3.2. Treatment cost assistance to be provided when the needed service is not covered by the individual's public or private insurance.

3.1.8.5.3.3. Recovery housing vouchers.

3.1.8.5.3.4. Childcare.

3.1.8.5.3.5. Transportation.

3.1.8.5.3.6. Recreational and alternative therapies supported by evidence (for example, acupuncture).

3.1.8.5.4. Collaborating with the Department on defining the amount available and determining the process for flexible needs fund eligibility determination and notifying service providers of funds available in their region for clients to access.

3.1.9. Continuous case management services which include, but are not limited to:

3.1.9.1. Ongoing assessment in collaboration or consultation with the client's external service provider(s) of necessary support services to address needs identified in the evaluation or by the client's service provider that may create barriers to the client entering and/or maintaining treatment and/or recovery.

3.1.9.2. Supporting clients in meeting the admission, entrance, and intake requirements of the provider agency.

3.1.9.3. Ongoing follow-up and support of clients engaged in services in collaboration or consultation with the client's external service provider(s) until such time that the discharge Government Performance and Results Act (GPRA) interview in 3.1.9.6.4 is completed including, but not limited to:

3.1.9.3.1. Attempting to contact each client at a minimum, once per week until such time that the discharge GPRA Interview in Section 3.1.9.4 has been completed, according to the following guidelines:

3.1.9.3.1.1. Attempt the first contact by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available.

3.1.9.3.1.2. If the attempt in 3.1.9.3.1.1 is not successful, attempt a second contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available no sooner than two (2) days and no later than three (3) days after the first attempt.

3.1.9.3.1.3. If the attempt in 3.1.9.3.1.2 is not successful, attempt a third contact, as necessary, by telephone, in person or by an alternative method approved by the Department at such a time when the client would normally be available, no sooner than two (2) days and no later than three (3) days after the second attempt.

3.1.9.4. When the follow-up in 3.1.9.3 results in a determination that the individual is at risk of self-harm, the minimum attempts for contact shall be no less than three (3) times each week and aligned with clinical best practices for prevention of suicide.

3.1.9.5. When possible, client contact and outreach shall be conducted in coordination and consultation with the client's external service provider to ensure continuous communication and collaboration between the Hub and service provider.

3.1.9.5.1. Each successful contact shall include, but not be limited to:

3.1.9.5.1.1. Inquiry on the status of each client's recovery and experience with their external service provider.

3.1.9.5.1.2. Identification of client needs.

3.1.9.5.1.3. Assisting the client with addressing needs, as identified in Subparagraph 3.1.6.2.

3.1.9.5.1.4. Providing early intervention to clients who have relapsed or whose recovery is at risk.

3.1.9.6. Collecting and documenting attempts to collect client-level data at multiple intervals including, but not limited to ensuring the GPRA Interview tool is completed and entered into the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Performance Accountability and Reporting System (SPARS), at a minimum:

3.1.9.6.1. At intake or within three (3) days following initial client contact.

3.1.9.6.2. Three (3) months post intake into Hub services.

3.1.9.6.3. Six (6) months post intake into Hub services.

3.1.9.6.4. Upon discharge from the initially referred service.

3.1.9.6.4.1. If the client is discharged from services before the time intervals in 3.1.9.6.2 or 3.1.9.6.3 the Hub must make every reasonable effort to conduct a follow-up GPRA for that client.

3.1.9.6.4.2. If a client is re-admitted into services after discharge or being lost to care, the Hub is not required to re-administer the intake GPRA but must complete a follow-up GPRA for the time interval in 3.1.9.6.2 and 3.1.9.6.3 closest to the intake GPRA

3.1.9.7. Documenting any loss of contact in the SPARS system using the appropriate process and protocols as defined by SAMHSA through technical assistance provided under the State Opioid Response grant.

3.1.9.8. Ensuring that contingency management strategies are utilized to increase client engagement in follow-up GPRA interviews which may include, but are not limited to gift cards provided to clients for follow-up participation at each follow-up interview which shall not exceed thirty dollars ($30) in value.

3.1.9.8.1. Payments to incentivize participation in treatment are not allowable.

3.1.10. Naloxone purchase, distribution, information, and training to individuals and organizations who meet the eligibility criteria for receiving kits under the NH DHHS Naloxone Distribution Policy regarding the use of naloxone.

3.2. The Contractor shall ensure that, at a minimum, after-hours (5pm to 8am), on-call, telephonic services are provided by a licensed clinician affiliated with one or more of the Hubs, seven (7) days a week and that the clinician has the ability to coordinate continued client care with the Hub in the individual's region.

3.2.1. On-call staffing by licensed clinicians shall be sufficient to meet the call volumes during the hours outlined in Subsection 3.2 to ensure that clients are not on hold or receiving busy signals when transferred from 2-1-1 NH.

3.2.2. The Contractor shall give preference to licensed clinicians with the ability to assess for co-occurring mental health needs.

3.2.3. Telephonic services to be provided include, at a minimum:

3.2.3.1. Crisis intervention and stabilization which ensures that individuals in an acute OUD related crisis that require immediate, non-emergency intervention are provided with crisis counseling services by a licensed clinician.

3.2.3.2. Directing callers to 911 if a client is in imminent danger or there is an emergency.

3.2.3.2.1. If the client is unable or unwilling to call 911, contacting emergency services on behalf of the client.

3.2.3.3. Screening.

3.2.3.4. Coordinating with shelters or emergency services, as needed.

3.2.3.5. Providing clinical evaluation telephonically, if appropriate, based on the callers mental state and health status.

3.2.3.6. Scheduling the client for face-to-face intake at the client's Hub for an evaluation and referral services, if determined necessary.

3.2.3.7. Ensuring a Continuity of Operations Plan for landline outage.

3.3. The Contractor shall obtain treatment consent forms from all clients served, either in-person or through electronic means, to ensure compliance with all applicable state and federal confidentiality laws.

3.4. The Contractor shall provide services for both day and overnight shifts in accordance with:

3.4.1. The twelve (12) Core Functions of the Alcohol and Other Drug Counselor.

3.4.2. The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice, available at http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171.

3.4.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium, available at http://www.internationalcredentialing.org/Resources/Candidate%20Guides/PR%20candidate%20guide%201-14.pdf.

3.4.4. TIP 27: Comprehensive Case Management for Substance Abuse Treatment, available at https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215.

3.5. The Contractor shall utilize recent and inform any future developments of a comprehensive needs assessment of their region. The needs assessment shall be coordinated with existing regional partners including, but not limited to:

3.5.1. Regional Public Health Networks

3.5.2. Integrated Delivery Networks

3.5.3. Continuum of Care Facilitators

3.6. The Contractor shall inform the inclusion of regional goals into the future development of needs assessments in Subsection 3.5 that the Contractor and its partners in the region have over the contract period including, but not limited to reductions in:

3.6.1.1. Naloxone use.

3.6.1.2. Emergency Room use.

3.6.1.3. Overdose related fatalities.

3.7. The Contractor shall have policies and procedures that allow them to accept referrals and evaluations from SUD treatment and other service providers.

4. Subcontracting for Hubs

4.1. The Hub shall submit any and all subcontracts they propose to enter into for services provided through this contract to the Department for approval prior to execution.

4.2. The Hub may subcontract with prior approval of the Department for support and assistance in providing core Hub services; except that such core services shall not be subcontracted providers whose principal operations are to serve individuals with a specific diagnosis of substance use disorders.

4.2.1. Core Hub services are defined, for purposes of this contract, as screening, assessment, evaluation, referral, continuous case management, GPRA data completion, and naloxone distribution.

4.2.2. The Hub shall at all times be responsible for continuous oversight of, and compliance with, all Core Hub services and shall be the single point of contact with the Department for those Core services.

4.2.3. Any subcontract for support and assistance in providing Core Hub services shall ensure that the patient experience is consistent across the continuum of Core Hub services and that the subcontracted entities and personnel are at all times acting, in name and in fact, as agents of the Hub. The Hub shall consolidate Core Hub services, to the greatest extent practicable, in a single location.

5. Staffing

5.1. The Contractor shall meet, at a minimum, the following staffing requirements:

5.1.1. Between 8am-5pm, 5 days/week, Monday through Friday:

5.1.1.1. At least one (1) clinician with the ability to provide clinical evaluations for ASAM level of care placement, in-person or telephonically;

5.1.1.2. At least one (1) Recovery support worker (CRSW);

5.1.1.2.1. The CRSW shall be able to fulfill recovery support and care coordination functions

5.1.1.3. A staff person, which can be a licensed clinician, CRSW, or other non-clinical support staff capable of aiding specialty populations as outlined in Paragraph 3.1.7.

5.1.2. Sufficient staffing levels that are appropriate for the services provided and the number of clients served based on available staffing and the budget established for the Hub.

5.1.3. All unlicensed staff providing treatment, education and/or recovery support services shall be under the direct supervision of a licensed supervisor.

5.1.4. No licensed supervisor shall supervise more than twelve (12) unlicensed staff unless the Department has approved an alternative supervision plan.

5.1.5. Peer clinical supervision is provided for all clinicians including, but not limited to:

5.1.5.1. Weekly discussion of cases with suggestions for resources or alternative approaches.

5.1.5.2. Group supervision to help optimize the learning experience, when enough candidates are under supervision.

5.2. The Contractor must ensure sufficient licensed clinician telephone coverage, at a minimum, between the hours of 5 pm and 8 am, 7 days/week, who have the ability to provide services as outlined in Subsection 3.2. This may be provided either by the Contractor alone or in collaboration with other Hubs.

5.3. The Contractor must meet the training requirements for staff which include, but are not limited to:

5.3.1.1. For all clinical staff:

5.3.1.1.1. Suicide prevention and early warning signs.

5.3.1.1.2. The 12 Core Functions of the Alcohol and Other Drug Counselor.

5.3.1.1.3. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics.

5.3.1.1.4. An approved course on the twelve (12) core functions and The Addiction Counseling Competencies: The Knowledge, Skills; and Attitudes of Professional Practice within twelve (12) months of hire.

5.3.1.1.5. A Department approved ethics course within twelve (12) months of hire.

5.3.1.2. For recovery support staff and other non-clinical staff working directly with clients:

5.3.1.2.1. Knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee.

5.3.1.2.2. The standards of practice and ethical conduct, with particular emphasis given to the individual's role and appropriate responsibilities, professional boundaries, and power dynamics, and confidentiality safeguards in accordance with HIPAA and 42 CFR Part 2, and state rules and laws.

5.3.1.2.3. The four (4) recovery domains as described by the International Credentialing and Reciprocity Consortium, available at http://www.internationalcredentialing.org/Resources/Candidate%20Guides/PR%20candidate%20guide%201-14.pdf.

5.3.1.2.4. An approved ethics course within twelve (12) months of hire.

5.3.1.3. Required trainings in Subsection 5.3 may be satisfied through existing licensure requirements and/or through Department approved alternative training curriculums and/or certifications.

5.3.1.4. Ensuring all recovery support staff and clinical staff receive continuous education regarding substance use disorders, at a minimum annually.

5.3.1.5. Providing in-service training to all staff involved in client care within fifteen (15) days of the contract effective date or the staff person's start date on the following:

5.3.1.5.1. The contract requirements.

5.3.1.5.2. All other relevant policies and procedures provided by the Department.

5.3.1.6. The Contractor shall provide its staff, subcontractors, or end users as defined in Exhibit K, with periodic training in practices and procedures to ensure compliance with information security, privacy or confidentiality in accordance with state administrative rules and state and federal laws.

5.4. The Contractor shall notify the Department in writing:

5.4.1. When a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program, within one (1) month of hire.

5.4.2. When there is not sufficient staffing to perform all required services for more than one (1) month, within fourteen (14) calendar days.

5.5. The Contractor shall have policies and procedures related to student interns to address minimum coursework, experience, and core competencies for those interns having direct contact with individuals served by this contract.

5.5.1. The Contractor shall ensure that student interns complete an approved ethics course and an approved course on the twelve (12) core functions as described in Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice within six (6) months of beginning their internship.

6. Reporting

6.1. The Contractor shall submit quarterly de-identified, aggregate client reports to the Department on each client served, as required by SAMHSA. The data shall include:

6.1.1. Diagnoses.

6.1.2. Demographic characteristics.

6.1.3. Substance use.

6.1.4. Services received and referrals made, by provider organization name.

6.1.5. Types of MAT received.

6.1.6. Length of stay in treatment.

6.1.7. Employment status.

6.1.8. Criminal justice involvement.

6.1.9. Housing.

6.1.10. Flexible needs funds used and for what purpose.

6.1.11. Numbers of naloxone kits distributed and by category, including but not limited to client, organization, family member, etc.

6.2. The Contractor shall report quarterly on federally required data points specific to this funding opportunity as identified by SAMHSA over the grant period.

7. Performance Measures

7.1. The Contractor shall attempt to complete a GPRA interview for 100% of Hub clients at intake or within three (3) days following initial client contact, at (3) months post intake, at six (6) months post intake, and upon discharge from Hub referred services.

7.2. In accordance with SAMHSA State Opioid Response grant requirements, the Contractor shall ensure that the GPRA interview follow-up rate at (3) months and six (6) months post intake for Hub clients is no less than 80%.

8. Deliverables

8.1. The Contractor shall have the Hub in the Berlin Region operational by January 1, 2019 unless an alternative timeline has been submitted to and approved by the Department.

8.2. The Contractor shall collaborate with the Department to develop a report by July 1, 2019 to determine the Contractor's level of readiness, capacity and resource needs required to expand services in-house as outlined in Subsection 2.7.

8.3. The Contractor shall collaborate with the Department on development of a plan no later than July 1, 2019 for the resources, timeline and infrastructure requirements to develop and maintain a centralized referral database of substance use disorder and mental health treatment providers as outlined in Subsection 2.5.

9. State Opioid Response (SOR) Grant Standards

9.1. The Contractor and/or referred providers shall ensure that only FDA-approved MAT for Opioid Use Disorder (OUD) is utilized. FDA-approved MAT for OUD includes:

9.1.1. Methadone.

9.1.2. Buprenorphine products, including:

9.1.2.1. Single-entity buprenorphine products.

9.1.2.2. Buprenorphine/naloxone tablets,

9.1.2.3. Buprenorphine/naloxone films.

9.1.2.4. Buprenorphine/naloxone buccal preparations.

9.1.2.5. Long-acting injectable buprenorphine products.

9.1.2.6. Buprenorphine implants.

9.1.2.7. Injectable extended-release naltrexone.

9.2. The Contractor and/or referred providers shall only provide medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

9.3. The Contractor and/or referred providers shall ensure that clients receiving financial aid for recovery housing utilizing SOR funds shall only be in a recovery housing facility that is aligned with the National Alliance for Recovery Residences standards

and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.

9.4. The Contractor and/or referred providers shall assist clients with enrolling in public or private health insurance, if the client is determined eligible for such coverage.

9.5. The Contractor and/or referred providers shall accept clients on MAT and facilitate access to MAT on-site or through referral for all clients supported with SOR Grant funds, as clinically appropriate.

9.6. The Contractor and/or referred providers shall coordinate with the NH Ryan White HIV/AIDs program for clients identified as at risk of or with HIV/AIDS.

9.7. The Contractor and/or referred providers shall ensure that all clients are regularly screened for tobacco use, treatment needs and referral to the QuitLine as part of treatment planning.

Exhibit B

Methods and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Form P-37, Block 1.8, Price Limitation for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. The Contractor agrees to provide the services in Exhibit A, Scope of Service in compliance with funding requirements. Failure to meet the scope of services may jeopardize the funded Contractor's current and/or future funding.
3. This contract is funded with funds from the Substance Abuse and Mental Health Services Administration CFDA #93.788, Federal Award Identification Number (FAIN) H79TI081685 and TI080246.
4. The Contractor shall keep detailed records of their activities related to Department funded programs and services.
5. The Contractor shall ensure that a minimum amount of funds determined by the Department for each State Fiscal Year is set aside for the purpose of naloxone purchase and distribution.
6. The Contractor shall include in their budget a line-item for a flexible needs fund in an amount no less than $50,000 of the budget per State Fiscal Year, to provide financial assistance to clients for services not otherwise covered through another payer source.
7. The Contractor shall not use funds to pay for bricks and mortar expenses.
8. The Contractor shall include in their budget, at their discretion the following:
   - 8.1. Funds to meet staffing requirements of the contract
   - 8.2. Funds to provide clinical and recovery support services in the contract that are not otherwise reimbursable by public or private insurance or through other Federal and State contracts
   - 8.3. Funds to meet the GPRA and reporting requirements of the contract
   - 8.4. Funds to meet staff training requirements of the contract
9. Funds remaining after satisfaction of 5 and 6 above may be used by the Contractor to support the scope of work outlined in Exhibit A.
10. Payment for said services shall be made monthly as follows:
    - 10.1. Payment for start-up costs in State Fiscal Year 19 not to exceed $500,000 shall be allowable for costs associated with staffing and infrastructure needs required to meet the January 1, 2019 service effective date.
    - 10.2. Payment beyond start-up costs shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this agreement, and shall be in accordance with the approved line item.
    - 10.3. The Contractor shall submit an invoice in a form satisfactory to the State by the twentieth (20th) working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The invoice must be completed, signed, dated and returned to the Department in order to initiate

payment. The Contractor agrees to keep detailed records of their activities related to Department-funded programs and services.

10.4. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available.

10.5. The final invoice shall be due to the State no later than forty (40) days after the contract Form P-37, Block 1.7 Completion Date.

10.6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to: Abby.Shockley@dhhs.nh.gov.

10.7. Payments may be withheld pending receipt of required reports or documentation as identified in Exhibit A, Scope of Services, and in this Exhibit B.

10.8. Notwithstanding paragraph 18 of the Form P-37, General Provisions, an amendment limited to transfer the funds within the budget and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

11. The Contractor shall provide a final budget for State Fiscal Year 2021 no later than March 31, 2020 for Department approval, which shall be submitted for Governor and Executive Council approval no later than June 30, 2020.

New Hampshire Department of Health and Human Services

Bidder/Program Name: Androscoggin Valley Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services

Budget Period: SFY 19 (G&C Approval - 6/30/2019)

Line Item	Total Program Cost			Contractor Share / Match			Funded
	Direct	Indirect	Total	Direct	Indirect	Total	Direct
1. Total Salary/Wages	$ 322,000.00	$ -	$ 322,000.00	$ -	$ -	$ -	$ 322,000.00
2. Employee Benefits	$ 112,700.00	$ -	$ 112,700.00	$ -	$ -	$ -	$ 112,700.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ 10,000.00	$ -	$ 10,000.00	$ -	$ -	$ -	$ 10,000.00
Pharmaceuticals	$ 280,133.00	$ -	$ 280,133.00	$ -	$ -	$ -	$ 280,133.00
Medical	$ 1,000.00	$ -	$ 1,000.00	$ -	$ -	$ -	$ 1,000.00
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00
7. Occupancy	$ 14,500.00	$ -	$ 14,500.00	$ -	$ -	$ -	$ 14,500.00
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ 8,000.00	$ -	$ 8,000.00	$ -	$ -	$ -	$ 8,000.00
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ 4,000.00	$ -	$ 4,000.00	$ -	$ -	$ -	$ 4,000.00
10. Marketing/Communications	$ 10,000.00	$ -	$ 10,000.00	$ -	$ -	$ -	$ 10,000.00
11. Staff Education and Training	$ 13,800.00	$ -	$ 13,800.00	$ -	$ -	$ -	$ 13,800.00
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ 16,000.00	$ -	$ 16,000.00	$ -	$ -	$ -	$ 16,000.00
Fees	$ 50,000.00	$ -	$ 50,000.00	$ -	$ -	$ -	$ 50,000.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 821,133.00	$ -	$ 821,133.00	$ -	$ -	$ -	$ 821,133.00
Indirect As A Percent of Direct		0.0%					

New Hampshire Department of Health and Human Services

Bidder/Program Name: Androscoggin Valley Hospital

Budget Request for: Access and Delivery Hub for Opioid Use Disorder Services

Budget Period: SFY 26 (7/1/2025-6/30/2026)

Line Item	Total Program Cost			Contractor Share/Match			Funded
	Direct	Indirect	Total	Direct	Indirect	Total	Direct
1. Total Salary/Wages	$ 322,000.00	$ -	$ 322,000.00	$ -	$ -	$ -	$ 322,000.00
2. Employee Benefits	$ 112,500.00	$ -	$ 112,500.00	$ -	$ -	$ -	$ 112,500.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ 10,000.00	$ -	$ 10,000.00	$ -	$ -	$ -	$ 10,000.00
Pharmacy/Nitrogen	$ 153,478.00	$ -	$ 153,478.00	$ -	$ -	$ -	$ 153,478.00
Medical	$ 3,600.00	$ -	$ 3,600.00	$ -	$ -	$ -	$ 3,600.00
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 2,000.00	$ -	$ 2,000.00	$ -	$ -	$ -	$ 2,000.00
7. Occupancy	$ 14,500.00	$ -	$ 14,500.00	$ -	$ -	$ -	$ 14,500.00
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ 5,000.00	$ -	$ 5,000.00	$ -	$ -	$ -	$ 5,000.00
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ 500.00	$ -	$ 500.00	$ -	$ -	$ -	$ 500.00
10. Marketing/Communications	$ 3,000.00	$ -	$ 3,000.00	$ -	$ -	$ -	$ 3,000.00
11. Staff Education and Training	$ 9,700.00	$ -	$ 9,700.00	$ -	$ -	$ -	$ 9,700.00
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ 65,000.00	$ -	$ 65,000.00	$ -	$ -	$ -	$ 65,000.00
Fees	$ 50,000.00	$ -	$ 50,000.00	$ -	$ -	$ -	$ 50,000.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 738,478.00	$ -	$ 738,478.00	$ -	$ -	$ -	$ 738,478.00
Indirect As A Percent of Direct		0.0%					

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP)**: As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections**: The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors**: DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act, NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

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. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account in the event funds are reduced or unavailable.

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 C, Special Provisions, Paragraph 10, Confidentiality of Records, is deleted and is replaced as follows:

The Contractor is a covered entity as defined under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 160, 162 and 164, and shall comply with all confidentiality requirements and safeguards set forth in state and federal law and rules. The Contractor is also a substance use disorder provider as defined under 42 CFR Part 2 and shall safeguard confidential information as required. The Contractor shall ensure compliance with all consent and notice requirements prohibiting the redisclosure of confidential information in accordance with 42 CFR Part 2.

All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the disclosure of any protected health information shall be in accordance with the regulatory provisions of HIPAA, 42 CFR Part 2, and applicable state and federal laws and rules. Further, the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, their attorney or guardian. Notwithstanding anything to the contrary contained herein, the covenants and conditions contained in this Paragraph 10 of Exhibit C shall survive the termination of the Contract for any reason whatsoever.

3. Renewal

3.1. The Department reserves the right to extend this Agreement for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, written agreement of the parties and approval of the Governor and Executive Council.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   1.2. Establishing an ongoing drug-free awareness program to inform employees about
      1.2.1. The dangers of drug abuse in the workplace;
      1.2.2. The grantee's policy of maintaining a drug-free workplace;
      1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
      1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
      1.4.1. Abide by the terms of the statement; and
      1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

10/15/2018
Date

Name: Michael D. Peterson, FACHE
Title: President

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor Name:

10/15/18
Date

Name: Michael D. Peterson, FACHE
Title: President

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (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.

Contractor Name:

Date 10/15/2018

Name: Michael D. Peterson, FACHE
Title: President

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

10/15/2018
Date

Name: Michael D. Peterson, FACHE
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 Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

10/15/2018
Date

Name: Michael D. Peterson, FACHE
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 MDP

Date 10/15/14

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:

10/15/2018
Date

Name: Michael D. Peterson, FACHE
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: 069910263

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 X YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

DHHS Security Requirements

Exhibit K

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates a 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.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information

except as required or permitted under this Contract or required by law. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.

II. 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 cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. Contractor may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS Data.
3. Encrypted Email. Contractor may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If Contractor is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. Contractor may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. Contractor may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If Contractor is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. Contractor may not transmit Confidential Data via an open wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If Contractor is employing remote communication to access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If Contractor is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain DHHS Data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS Confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have

currently-supported and hardened operating systems, current, updated, and maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor and will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from

creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. 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 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 work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

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. The Contractor will not store 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.

8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160

and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable health information and as applicable under State law.

10. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer, and additional email addresses provided in Section VI, of any security breach within 24-hours of the time that the Contractor learns of its occurrence. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

12. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches within 24- hours of the time that the Contractor learns of their occurrence.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with the HIPAA, Privacy and Security Rules. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and

procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS contact for Data Management or Data Exchange issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

B. DHHS contacts for Privacy issues:
DHHSPrivacyOfficer@dhhs.nh.gov

C. DHHS contact for Information Security issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

D. DHHS contact for Breach notifications:
DHHSInformationSecurityOffice@dhhs.nh.gov
DHHSPrivacyOfficer@dhhs.nh.gov