STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
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NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

April 21, 2015

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to establish a list of licensed medical providers, with the ability to expand to include additional licensed medical providers to provide necessary outpatient visits labs, and diagnostic tests, and outpatient procedures for clients enrolled in the New Hampshire Ryan White CARE Program. No maximum client or service volume is guaranteed. Accordingly, the price limitation among all Agreements is $100,000 each State Fiscal Year for a total of $200,000. The Agreements are effective date of Governor and Executive Council approval through June 30, 2016. 100% Other Funds.

VENDOR	LOCATION
Mary Hitchcock Memorial Hospital	Lebanon, NH

Funds are available in the following account for SFY 2015, and are anticipated to be available in SFY 2016 upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts between State Fiscal Years through the Budget Office, without further approval from the Governor and Executive Council, if needed and justified.

05-95-90-902510-2229 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF INFECTIOUS DISEASE CONTROL, PHARMACEUTICAL REBATES

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2015	530-500371	Drug Rebates	90024607	$100,000
SFY 2016	530-500371	Drug Rebates	90024607	$100,000
			Total	**$200,000**

EXPLANATION

This request is the second (2nd) of six (6) agreements that will ensure the provision of outpatient visits, labs, diagnostic tests, and outpatient procedures services to New Hampshire residents living with Human Immunodeficiency Virus (HIV), statewide, who are enrolled in the New Hampshire Ryan White CARE Program. The licensed medical practice will provide outpatient visits labs, and diagnostic tests, and outpatient procedures services to enrolled clients, on an individual, case-by-case, as needed basis. The Department anticipates that the remaining four (4) agreements will be presented at an upcoming Governor and Executive Council meeting.

The New Hampshire Ryan White CARE Program receives funding from the Health Resources and Services Administration (HRSA), Ryan White HIV/AIDS Program, Part B for medical services, oral health, and home health care services. HRSA funding is in accordance with the Ryan White HIV/AIDS Treatment Extension Act of 2009. The intent of the legislation and federal funding is to assure access to care for financially eligible individuals living with HIV/AIDS. A recipient of federal funding, the New Hampshire Ryan White CARE Program is subject to the federal mandate to implement contractual agreements with all service providers and to maintain nationally accepted fiscal, programmatic, and monitoring standards established by HRSA. Federal regulation also requires that Ryan White CARE Program funds be used as a "payer of last resort".

Should Governor and Executive Council not authorize this Request, federal regulations and monitoring standards will not be met and eligible New Hampshire residents living with HIV with immediate outpatient care needs and without access to care will not receive prevention and treatment for outpatient visits, labs, and diagnostic tests, and outpatient procedures. The services in this Contract will promote the goals of the National HIV/AIDS Strategy and maintain a continuum of care in order to reduce HIV related health disparities and the occurrence of negative health outcomes. The program currently provides services to approximately 450 to 500 clients statewide.

A Request for Applications was posted on the Department of Health and Human Services' web site on April 4, 2014 to solicit medical providers to provide outpatient services to New Hampshire Ryan White CARE program clients. In addition, an email was sent to 22 known providers on April 4, 2014, notifying them that a Request for Application was posted. Six (6) were received from licensed medical providers, and were approved for funding.

As referenced in the Request for Application and in exhibit C-1, Revisions to General Provisions, this Agreement has the option to extend for two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

The performance of this program will be measured by the number of New Hampshire Ryan White CARE Program clients that actually receive outpatient services.

The geographic area to be served is statewide.

Source of Funds: 100% Other Funds from the Pharmaceutical Rebates.

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

Respectfully submitted,

José Thier Montero, MD, MHCDS
Director

Approved by:
Nicholas A. Toumpas
Commissioner

Subject: New Hampshire Ryan White CARE Program

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services		**1.2 State Agency Address** 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hosptial d/b/a Dartmouth-Hitichcock Clinic		**1.4 Contractor Address** One Medical Center Drive Lebanon, NH 03756-0001	
1.5 Contractor Phone Number (603)653-1213	**1.6 Account Number** 05-95-90-92510-2229-530-500371	**1.7 Completion Date** June 30, 2016	**1.8 Price Limitation** $200,000
1.9 Contracting Officer for State Agency Eric D. Borrin		**1.10 State Agency Telephone Number** (603) 271-9558	
1.11 Contractor Signature		**1.12 Name and Title of Contractor Signatory** Daniel P. Jantzen, COO	

1.13 Acknowledgement: State of NH, County of Grafton

On 4/13/15, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

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

FAITH E. JOHNSTON NOTARY PUBLIC COMMISSION EXPIRES OCT. 26, 2016 [Seal] NEW HAMPSHIRE

1.13.2 Name and Title of Notary or ~~Justice of the Peace~~

FAITH E. JOHNSTON

1.14 State Agency Signature	**1.15 Name and Title of State Agency Signatory** Brook Dupee, Bureau Chief
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) By:	On: 5/1/15
1.18 Approval by the Governor and Executive Council 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, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement ("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. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely 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 consent of the N.H. Department of Administrative Services. None of the Services shall be subcontracted by the Contractor without the prior written 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 $250,000 per claim and $2,000,000 per occurrence; and
14.1.2 fire and extended coverage insurance covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.
14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than fifteen (15) 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

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certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than ten (10) 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.

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.

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Exhibit A

Scope of Services

1. Program Name: New Hampshire Ryan White CARE Program

1.1. Purpose:

The purpose of this agreement is to provide outpatient visits, labs and diagnostic tests, and outpatient procedures for clients enrolled in the New Hampshire Ryan White CARE Program (NH CARE Program). The goal of the NH CARE Program is to provide financial assistance for necessary medical services to New Hampshire (NH) residents living with Human Immunodeficiency Virus (HIV), statewide.

2. Provision of Services:

2.1. The Contractor shall act as a representative of the NH CARE Program to provide outpatient visits, labs, tests and procedures to NH CARE Program clients.

2.2. The Contractor shall provide services to enrolled NH CARE Program clients only; services provided outside of enrollment periods will not be reimbursed and the contractor shall refer clients to their Medical Case Manager as needed to re-enroll in the NH CARE Program.

2.3. The Contractor shall invoice the NH CARE Program for services using a health insurance claim form or reasonable facsimile; additional invoicing methods may be approved by the NH CARE Program; services shall be reimbursed at NH Medicaid rates.

2.4. The Contractor shall participate in an annual site visit with NH CARE Program staff.

2.5. The Contractor shall provide client level data via CAREWare (OR a bridge to CAREWare from a compatible electronic medical record) to the NH CARE Program for the completion of annual reports to the Health Resources and Services Administration (HRSA).

2.6. The Contractor shall maximize billing to NH Medicaid and private insurance. The NH CARE Program shall be the payer of last resort and will only reimburse services for clients.

2.7. The Contractor shall participate in periodic monitoring calls with the contract monitor. The contract monitor shall be the primary point of contact for all NH CARE Program questions.

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Exhibit A

3. Licensing Requirements:

Licensed Medical Providers performing services under this agreement must maintain a valid and unrestricted license to practice medicine in the United States and be free from any mental or physical impairment or condition which would preclude his/her ability to competently perform the essential functions or duties under this Agreement.

4. Licensed Medical providers shall adhere to the NH CARE Program Standards of Care for Outpatient and Ambulatory Medical Care, and all applicable Programmatic, Fiscal and Universal Monitoring Standards, as documented by HRSA:

- http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf
- http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf
- http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf

5. The Department of Health and Human Services reserves the right to discontinue this agreement should it discover any abridgment of the above partner agreements that jeopardize the intent of this agreement.

6. Entire Agreement:

The following documents are incorporated by reference into this Agreement and they constitute the entire Agreement between the State and the Contactor. General Provisions (P-37), Exhibit A Scope of Services, Exhibit B Purchase of Services, Exhibit C Special Provisions, Exhibit C-1 Revisions to General Provisions, Exhibit D Certification Regarding Drug-Free Workplace Requirements, Exhibit E Certification Regarding Lobbying, Exhibit F Certification Regarding Debarment, Suspension and Other Responsibility Matters, Exhibit G Certification Regarding the American's With Disabilities Act Compliance, Exhibit H Certification Regarding Environmental Tobacco Smoke, Exhibit I Health Insurance Portability and Accountability Act Business Associate Agreement, and Exhibit J Certification Regarding The Federal Funding Accountability and Transparency Act Compliance. In the event of any conflict or contradiction between or among the Agreement Documents, the documents shall control in the above order of precedence.

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Exhibit B

Method and Conditions Precedent to Payment

1. Subject to the Contractor's compliance with the terms and conditions of the Agreement, the Bureau of Infectious Disease Control shall reimburse the Contractor for actual outpatient Ambulatory medical care services provided by the contractor to enrolled NH CARE Program clients. Services will be reimbursed at NH Medicaid rates.
2. Price Limitation: This Agreement is one of multiple Agreements that will serve the NH CARE Program. No maximum or minimum client and service volume is guaranteed. Accordingly, the price limitation among all Agreements is identified in Block 1.8 of the P-37 for the duration of the Agreement.
3. Notwithstanding anything to the contrary herein, the Contactor agrees that payment under this Agreement may be withheld, in whole or in part, in the event of noncompliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services have not been satisfactorily completed in accordance with the terms and conditions of this Agreement.
4. The funding source for this Agreement for Outpatient Ambulatory Medical Care Services is 100% federal funds from the Pharmaceutical Rebates.
5. Contract medical provider shall complete and submit an outpatient visit, laboratory test, or diagnostic test Claim invoice, due within 30 days. Completed invoice must be submitted to:

   NH CARE Program
   Bureau of Infectious Disease Control
   Department of Health and Human Services
   Division of Public Health
   29 Hazen Drive
   Concord, NH 03301
   Fax: 603-271-4934
6. Payment will be made by the State agency subsequent to approval of the submitted invoice and if sufficient funds are available. Contractor will keep detailed records of their outpatient services related to Department of Health and Human Services funded programs and services.
7. Outpatient ambulatory medical care providers are accountable to meet the scope of services. Failure to meet the scope of services may jeopardize the funded Medical provider's current and/or future funding. Corrective action may include actions such as a contract amendment or termination of the contract.

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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 GENERAL PROVISIONS

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

   4. CONDITIONAL NATURE OF AGREEMENT.

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

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

   10.1 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.

   10.2 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.

   10.3 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.

   10.4 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.

3. Subparagraph 13 of the General Provisions of this contract, Indemnification, is replaced as follows;

   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 negligent acts or omissions or intentional misconduct 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.

4. Insurance:

Subparagraph 14.2 of the General Provisions of this contract is deleted and replaced with the following subparagraph;

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.

5. Confidentiality of Records:

Subparagraph 10 of Exhibit C of this contract, Special Provisions, is deleted and replaced with the following subparagraph;

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 disclosure of any protected health information shall be in accordance with the regulatory provisions of HIPAA; 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.

6. Extension:

This agreement has the option for a potential extension of 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.

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: Mary Hitchcock Memorial Hospital dba Dartmouth-Hitchcock

4/13/15
Date

Name: Daniel Jantzen
Title: Cheif Operating Officer

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Contractor Name: Mary Hitchcock Memorial Hospital dba Dartmouth-Hitchcock

4/13/15
Date

Name: Daniel Jantzen
Title: Chief Operating Officer

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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

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

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

Contractor Name: Mary Hitchcock Memorial Hospital dba Dartmouth-Hitchcock

4/13/15
Date

Name: Daniel Jansen
Title: Cheif Operating Officer

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

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

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

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

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

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

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

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

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

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

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

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

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

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: Mary Hitchcock Memorial Hospital dba Dartmouth-Hitchcock

4/13/15
Date

Name: Daniel Hantzen
Title: Chief Operating Officer

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: Mary Hitchcock Memorial Hospital dba Dartmouth-Hitchcock

4/13/15
Date

Name: Daniel Jantzen
Title: Chief Operating Officer

HEALTH INSURANCE PORTABILITY ACT
BUSINESS ASSOCIATE AGREEMENT

Exhibit I – Health Insurance Portability and Accountability Act, Business Associate Agreement does not apply to this contract.

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: Mary Hitchcock Memorial Hospital dba Dartmouth-Hitchcock

Date 4/3/15

Name: Daniel Jantzen
Title: Chief Operating Officer

FORM A

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

1. The DUNS number for your entity is: 069910297

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

   _____ NO _✓_ YES

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

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

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

   _____ NO _✓_ YES

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

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

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

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

State of New Hampshire
Department of State

CERTIFICATE

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

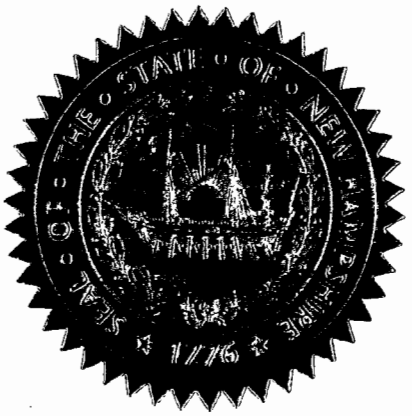
In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 8th day of April, A.D. 2015

William M. Gardner
Secretary of State

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 DARTMOUTH-HITCHCOCK CLINIC is a New Hampshire nonprofit corporation formed March 1, 1983. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



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

William M. Gardner
Secretary of State

Dartmouth-Hitchcock

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

CERTIFICATE OF VOTE/AUTHORITY

I, Barbara J. Couch of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 15th day of April 2015.

Barbara J. Couch

Barbara J. Couch, Secretary

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 15th day of April 2015 by Barbara J. Couch

Susan S. Shykula

Notary Public/~~Justice of the Peace~~
My Commission Expires: February 28, 2019

SUSAN S. SHYKULA, Notary Public
My Commission Expires February 28, 2019

CERTIFICATE OF INSURANCE

DATE:
September 17, 2014
Re-Issue Date September 18, 2014

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

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

INSURED
Mary Hitchcock Memorial Hospital
1 Medical Center Drive
Lebanon, NH 03756-0001

COMPANY AFFORDING COVERAGE

Hamden Assurance Risk Retention Group, Inc.

COVERAGES

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

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002014-A	7/1/14	6/30/15	GENERAL AGGREGATE	$NONE
					PRODUCTS-COMP/OP AGGREGATE	
X	COMMERCIAL GENERAL LIABILITY				PERSONAL ADV INJURY	
					EACH OCCURRENCE	$2,000,000
X	CLAIMS MADE				FIRE DAMAGE	
	OCCURRENCE				MEDICAL EXPENSES	
PROFESSIONAL LIABILITY					EACH CLAIM	
					ANNUAL AGGREGATE	
OTHER						

DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)
MARY HITCHCOCK MEMORIAL HOSPITAL EVIDENCE OF COVERAGE FOR GENERAL LIABILITY.
We have been advised by Deborah M. Johnson, MBA, Finance Division, Dartmouth-Hitchcock that Mary Hitchcock Memorial Hospital is entering into a contract with the State of New Hampshire who will provide funding for dental services to Dartmouth-Hitchcock's HIV patient population. Certificate of Insurance to be submitted to Elizabeth L. Biron, New Hampshire Department of Health & Human Services, 129 Pleasant Street, Concord, NH 03301.
Note: Re-Issue of Certificate of Insurance dated September 17, 2014, to reflect $2,000,000 each occurrence.

CERTIFICATE HOLDER

New Hampshire Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301
(Contact: Insurance Coordinator 603-653-1249)

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

Jeannie Ordet - Grant

Certificate of Insurance

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON YOU THE CERTIFICATE HOLDER. THIS CERTIFICATE IS NOT AN INSURANCE POLICY AND DOES NOT AMEND, EXTEND, OR ALTER THE COVERAGE AFFORDED BY THE POLICIES LISTED BELOW. POLICY LIMITS ARE NO LESS THAN THOSE LISTED, ALTHOUGH POLICIES MAY INCLUDE ADDITIONAL SUBLIMIT/LIMITS NOT LISTED BELOW.

This is to Certify that

Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon NH 03756-0001

NAME AND ADDRESS OF INSURED

Liberty Mutual. INSURANCE

is, at the issue date of this certificate, insured by the Company under the policy(ies) listed below. The insurance afforded by the listed policy(ies) is subject to all their terms, exclusions and Conditions and is not altered by any requirement, term or condition of any contract or other document with respect to which this certificate may be issued.

TYPE OF POLICY	EXP DATE ☐ CONTINUOUS ☐ EXTENDED ☑ POLICY TERM	POLICY NUMBER	LIMIT OF LIABILITY	
WORKERS COMPENSATION	7/1/2015	WA7-61D-253624-044	COVERAGE AFFORDED UNDER WC LAW OF THE FOLLOWING STATES: All states except Monopolistic States	EMPLOYERS LIABILITY Bodily Injury by Accident $1,000,000 Each Accident Bodily Injury By Disease $1,000,000 Policy Limit Bodily Injury By Disease $1,000,000 Each Person
COMMERCIAL GENERAL LIABILITY ☐ OCCURRENCE ☐ CLAIMS MADE	RETRO DATE		General Aggregate Products / Completed Operations Aggregate Each Occurrence Personal & Advertising Injury Per Person / Organization Other / Other	
AUTOMOBILE LIABILITY ☐ OWNED ☐ NON-OWNED ☐ HIRED			Each Accident—Single Limit B.I. And P.D. Combined Each Person Each Accident or Occurrence Each Accident or Occurrence	
OTHER				

ADDITIONAL COMMENTS

* If the certificate expiration date is continuous or extended term, you will be notified if coverage is terminated or reduced before the certificate expiration date.

NOTICE OF CANCELLATION: (NOT APPLICABLE UNLESS A NUMBER OF DAYS IS ENTERED BELOW.) BEFORE THE STATED EXPIRATION DATE THE COMPANY WILL NOT CANCEL OR REDUCE THE INSURANCE AFFORDED UNDER THE ABOVE POLICIES UNTIL AT LEAST ____ DAYS NOTICE OF SUCH CANCELLATION HAS BEEN MAILED TO:

Liberty Mutual Insurance Group

Certificate Holder

Department of Health and Human Services
Contracts and Procurement Unit
129 Pleasant Street
Concord NH 03301

Karyn Lessard

Karyn Lessard
AUTHORIZED REPRESENTATIVE

BEDFORD / 0116
SUITE 100 10 CORPORATE DRIVE
BEDFORD NH 03110 603-472-7100 9/5/2014
OFFICE PHONE DATE ISSUED

This certificate is executed by LIBERTY MUTUAL INSURANCE GROUP as respects such insurance as is afforded by those Companies NM 772 07-10

CERT NO.: 21484470 CLIENT CODE: LH_2538 Nicholas Misoni 9/5/2014 2:45:29 PM (EDT) Page 1 of 1

LDI COI 268896 02 11

Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

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

Our Vision

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

Values

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

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2014

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2014

Independent Auditor's Report

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and Subsidiaries ("Health System"), which comprise the consolidated balance sheet as of June 30, 2014, and the related consolidated statements of operations and changes in net assets and of cash flows for the year then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audit. We did not audit the consolidated financial statements of New London Hospital Association, Inc. and Subsidiaries, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets constituting 4.4% of consolidated total assets at June 30, 2014 and total revenues of 3.0% of consolidated total revenues for the year then ended. Those statements as of June 30, 2014 and for the nine months then ended were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for New London Hospital Association, Inc. and Subsidiaries, is based solely on the report of the other auditors. We conducted our audit 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.

pwc

Opinion

In our opinion, based on our audit and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and Subsidiaries at June 30, 2014, and the results of their operations and changes in net assets and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

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 and results of operations and changes in unrestricted net assets 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 and results of operations and changes in unrestricted net assets of the individual companies.

PricewaterhouseCoopers LLP

November 26, 2014

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheet
June 30, 2014

(in thousands of dollars)

Assets	
Current assets	
Cash and cash equivalents	$ 50,927
Patient accounts receivable, net of estimated uncollectibles of $124,404 at June 30, 2014 (Note 5)	184,606
Prepaid expenses and other current assets (Notes 3 and 14)	91,302
Total current assets	326,835
Assets limited as to use (Notes 6, 8, and 11)	629,185
Other investments for restricted activities (Notes 3, 6 and 8)	101,675
Property, plant, and equipment, net (Notes 3 and 7)	484,753
Other assets (Note 3)	72,508
Total assets	$ 1,614,956
Liabilities and Net Assets	
Current liabilities	
Current portion of long-term debt (Note 11)	$ 13,281
Current portion of liability for pension and other postretirement plan benefits (Note 12)	5,142
Accounts payable and accrued expenses (Note 14)	93,023
Accrued compensation and related benefits	78,575
Estimated third-party settlements (Note 5)	30,677
Total current liabilities	220,698
Long-term debt, excluding current portion (Note 11)	550,703
Insurance deposits and related liabilities (Note 13)	68,498
Interest rate swaps (Notes 3, 8 and 11)	24,413
Liability for pension and other postretirement plan benefits, excluding current portion (Note 12)	139,056
Other liabilities	47,980
Total liabilities	1,051,348
Net assets	
Unrestricted (Note 10)	462,675
Temporarily restricted (Notes 9 and 10)	64,664
Permanently restricted (Notes 9 and 10)	36,269
Total net assets	563,608
Commitments and contingencies (Notes 5, 7, 8, 11, and 14)	-
Total liabilities and net assets	$ 1,614,956

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Operations and Changes in Net Assets
Year Ended June 30, 2014

(in thousands of dollars)

Unrestricted revenue and other support	
Net patient service revenue, net of provision for bad debt ($47,606 in 2014) (Notes 4 and 5)	$ 1,229,848
Contracted revenue (Note 2)	92,390
Other operating revenue (Notes 2 and 6)	64,804
Net assets released from restrictions	11,670
Total unrestricted revenue and other support	1,398,712
Operating expenses	
Salaries	675,716
Employee benefits	204,152
Medical supplies and medications	196,397
Purchased services and other	163,456
Medicaid enhancement tax (Note 5)	34,488
Geisel school of medicine support	6,500
Depreciation and amortization	57,729
Interest (Note 11)	18,436
Expenditures relating to net assets released from restrictions	11,670
Total operating expenses	1,368,544
Operating income	30,168
Nonoperating gains (losses)	
Investment gains (Notes 6 and 11)	53,135
Other losses	(804)
Contribution revenue from acquisition (Note 1)	33,692
Total nonoperating gains, net	86,023
Excess of revenue over expenses	$ 116,191

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Operations and Changes in Net Assets, Continued
Year Ended June 30, 2014

(in thousands of dollars)

Unrestricted net assets		
Excess of revenue over expenses	$	116,191
Net assets released from restrictions		763
Change in funded status of pension and other postretirement benefits (Note 12)		14,769
Change in fair value of interest rate swaps (Note 11)		1,538
Increase in unrestricted net assets		133,261
Temporarily restricted net assets		
Gifts, bequests, sponsored activities		18,295
Investment gains		1,171
Change in net unrealized gains on investments		2,998
Net assets released from restrictions		(12,433)
Contribution of temporarily restricted net assets from acquisition		386
Increase in temporarily restricted net assets		10,417
Permanently restricted net assets		
Gifts and bequests		2,961
Contribution of permanently restricted net assets from acquisition		2,053
Increase in permanently restricted net assets		5,014
Change in net assets		148,692
Net assets		
Beginning of year		414,916
End of year	$	563,608

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Cash Flows
Year Ended June 30, 2014

Cash flows from operating activities		
Change in net assets	$	148,692
Adjustments to reconcile change in net assets to net cash provided by operating and nonoperating activities		
Change in fair value of interest rate swaps		(968)
Provision for bad debt		47,606
Depreciation and amortization		58,216
Contribution revenue from acquisition		(36,131)
Change in funded status of pension and other postretirement benefits		(14,769)
(Gain) loss on disposal of fixed assets		313
Net realized gains and change in net unrealized gains on investments		(58,024)
Restricted contributions		(10,637)
Proceeds from sale of securities		413
Changes in assets and liabilities		
Patient accounts receivable, net		(54,587)
Prepaid expenses and other current assets		(7,669)
Other assets, net		(10,623)
Accounts payable and accrued expenses		10,658
Accrued compensation and related benefits		757
Estimated third-party settlements		2,389
Insurance deposits and related liabilities		(23,454)
Liability for pension and other postretirement benefits		(19,880)
Other liabilities		9,489
Net cash provided by operating and nonoperating activities		41,791
Cash flows from investing activities		
Purchase of property, plant, and equipment		(50,043)
Proceeds from sale of property, plant, and equipment		3,155
Purchases of investments		(107,216)
Proceeds from maturities and sales of investments		111,111
Cash received through acquisition		3,431
Net cash used by investing activities		(39,562)
Cash flows from financing activities		
Proceeds from line of credit		100,000
Payments on line of credit		(100,000)
Repayment of long-term debt		(27,351)
Proceeds from issuance of debt		17,066
Payment of debt issuance costs		(418)
Restricted contributions		8,519
Net cash used by financing activities		(2,184)
Increase in cash and cash equivalents		45
Cash and cash equivalents		
Beginning of year		50,882
End of year	$	50,927
Supplemental cash flow information		
Interest paid	$	22,220
Construction in progress included in accounts payable and accrued expenses		10,550
Equipment acquired through issuance of capital lease obligations		744
Donated securities		413

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

1. Organization and Reporting Entity

Dartmouth-Hitchcock Health (D-HH), is a New Hampshire (NH) nonprofit corporation exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC).

D-HH is operated for the following charitable, educational and scientific purposes:

- To establish, manage, govern, and fundraise for an integrated healthcare delivery system that best serves the purposes of preventing, diagnosing, treating and curing human illness within the New England region;
- To manage a healthcare system that provides health care services to the public in a cost-effective manner;
- To establish and maintain cooperative hospital and provider relationships throughout its system;
- To achieve excellence in clinical innovations, service, quality, cost and outcomes, supported by a strong academic program; and to integrate research, training, information technology and academic medicine in the provider organizations throughout its system.

D-HH serves as the sole corporate member of Mary Hitchcock Memorial Hospital (MHMH) and Dartmouth-Hitchcock Clinic (DHC), collectively referred to as Dartmouth-Hitchcock (D-H), which provide healthcare and related services in NH and Vermont (VT). MHMH and DHC are nonprofit corporations as described in Section 501(c)(3) of the IRC and are generally exempt from income taxes on related income pursuant to Section 501(a) of the IRC, except as otherwise noted. The historical operational integration of DHC and MHMH is supported by an affiliation agreement.

D-HH and Subsidiaries (the "Health System") is comprised of the following entities:

- D-H
    - MHMH, an acute and tertiary care teaching hospital located in Lebanon, NH.
    - DHC and Subsidiaries, a multispecialty physician practice group which operates clinics throughout NH and VT, provides, among other things, medical services to patients, medical education, and research. The accompanying consolidated financial statements include the accounts of DHC's wholly owned for profit subsidiary Pompanoosuc Investment Corporation, majority-owned Hamden Assurance Company Limited (HAC), and majority owned Hamden Assurance Risk Retention Group, Inc. (RRG) (Note 13).

      DHC has entered into various contractual arrangements with community hospitals located in Keene, Concord, Manchester, Nashua, NH and Bennington, VT in which DHC has existing community practice sites. These arrangements attempt to integrate and/or coordinate hospital and physician operations clinically and administratively within these communities (Note 2).
- The Hitchcock Foundation (THF), an organization established to provide financial aid to research and general health programs. DHC is the sole corporate member of THF.

- Dartmouth-Hitchcock Medical Center (DHMC) is organized under NH law for the exploration and coordination of matters of mutual interest to D-H, Geisel School of Medicine at Dartmouth (Geisel), a component of Dartmouth College, and the Veteran's Affairs Medical and Regional Office Center (VA) of White River Junction, VT.

- Effective October 1, 2013 D-HH became the sole corporate member of New London Hospital Association, Inc. (NLH) through an affiliation agreement. NLH is a not-for-profit organization providing inpatient, outpatient and extended care services to residents of Merrimack and Sullivan counties. Kearsarge Community Services, Inc. (KCS), a taxable corporation which owns and operates a medical office building, and New London Medical Center East, Inc. (NLMCE), a taxable corporation which operates a building, are wholly-owned subsidiaries of NLH. NLH elected to change their fiscal year end from September 30th to June 30th during fiscal year 2014. The Health System's 2014 consolidated financial statements reflect nine months of activity for NLH and its subsidiaries beginning October 1, 2013.

  In accordance with applicable accounting guidance on non-for-profit mergers and acquisitions, D-HH recorded contribution income of approximately $36,131,000 reflecting the fair value of the contributed net assets of NLH and its subsidiaries on the transaction date. Of this amount, $33,692,000 represents unrestricted net assets and is included as a nonoperating gain in the accompanying consolidated statement of operations. Restricted contribution income of $386,000 and $2,053,000 was recorded within temporarily and permanently restricted net assets, respectively, in the accompanying consolidated statement of changes in net assets. No consideration was exchanged for the net assets contributed and acquisition costs are expensed as incurred.

  The fair value of assets, liabilities, and net assets contributed by NLH and its subsidiaries at October 1, 2013 were as follows:

(in thousands)

Cash and cash equivalents	$	3,431
Patient accounts receivable, net		6,493
Prepaid expenses and other current assets		2,194
Assets limited as to use		12,932
Property, plant, and equipment, net		40,360
Other assets		5,907
Total assets acquired	$	71,317
Accounts payable and accrued expenses	$	4,560
Accrued compensation and related benefits		1,841
Estimated third-party settlements		6,806
Long-term debt		17,366
Interest rate swaps		3,096
Other liabilities		1,517
Total liabilities assumed		35,186
Unrestricted		33,692
Temporarily restricted		386
Permanently restricted		2,053
Total net assets		36,131
Total liabilities and net assets	$	71,317

A summary of the financial results of NLH and its subsidiaries included in the consolidated statement of operations and changes in net assets for the period from the date of acquisition, October 1, 2013 through June 30, 2014 is as follows:

(in thousands)

Total operating revenues	$	41,737
Total operating expenses		44,578
Operating loss		(2,841)
Nonoperating gains		1,431
Deficit of revenues over expenses		(1,410)
Net assets released from restriction used for capital purchases		15
Net assets transferred from affiliate		33,692
Increase in unrestricted net assets	$	32,297

A summary of the consolidated financial results of the Health System for the year ended June 30, 2014, as if the affiliation had occurred on July 1, 2013 is as follows (unaudited):

(in thousands)

Total operating revenues	$	1,411,744
Total operating expenses		1,383,675
Operating income		28,069
Nonoperating gains		86,388
Excess of revenues over expenses		114,457
Net assets released from restriction used for capital purchases		793
Change in funded status of pension and other post retirement benefits		14,769
Change in fair value on interest rate swaps		1,744
Increase in unrestricted net assets	$	131,763

2. Affiliated Entities

Affiliated entities include the following:

Northern New England Accountable Care Collaborative, LLC
D-HH has invested $2,000,000 in the Northern New England Accountable Care Collaborative, LLC (NNEACC) as a twenty percent owner. NNEACC was formed to improve the quality and delivery of health care by supporting research, education and the implementation of clinical effectiveness tools and standards of care, identifying unnecessary resource utilization in the delivery of care, and conducting related activities to support the charitable purposes of the member organizations.

OneCare Vermont, LLC
In 2012, D-HH and Fletcher Allen Health Care, Inc. (FAHC) formed OneCare (OCV) Vermont, a state-wide accountable care organization working with Medicare. OCV comprises an extensive network of providers, including all fourteen of Vermont's hospitals, D-H, hundreds of primary care

physicians and specialists, two federally qualified health centers, and several rural health clinics, to coordinate the health care of approximately 42,000 of Vermont's 118,000 Medicare beneficiaries.

Pioneer Accountable Care Organization (allwell)
D-HH is one of 22 health systems nationally to be selected to participate in the Pioneer Accountable Care Organization (ACO) payment model, a transformative new initiative sponsored by the Centers for Medicare and Medicaid Services (CMS) Innovation Center. Through the Pioneer ACO Model, D-HH has delegated operating function to D-H. D-H works with CMS to provide Medicare beneficiaries with higher quality care, while reducing growth in Medicare expenditures through enhanced care coordination. CMS uses robust quality measures and other criteria to reward ACOs like D-H for providing beneficiaries with a positive patient experience and better health outcomes, while also rewarding D-H for reducing growth in Medicare expenditures for the same patient population.

Everwell, Inc. (Everwell)
Effective January 1, 2014, Elliot Health Systems (EHS), a NH nonprofit organization and D-HH entered into a new affiliation in which each organization is a fifty percent member of a newly formed non-profit corporation, Everwell. The new affiliation was established to collaborate for the purpose of improving efficient and effective deployment of resources, improving the accessibility and diversity of services, improving cost effectiveness and efficiencies in the delivery of specified health care services, and increasing the value and improving the quality of health care provided.

New England Alliance for Health (NEAH)
NEAH is a NH limited liability company, which is owned and managed by MHMH. NEAH provides, on a contract basis, a range of consulting, group purchasing and other services to its members throughout NH and VT.

Other Regional Relationships – D-H

- D-H's Keene community practice and the Cheshire Medical Center, Keene's community hospital, operate collectively under a Partnership Agreement effective October 1, 1998. This agreement substantially integrates many hospital and physician operations clinically, administratively, and financially while maintaining the independent legal structure of each organization. Pursuant to this agreement, DHC recorded approximately $6,804,000 of other operating revenue in the year ended June 30, 2014. A NH non-profit Joint Coordinating Company and Coordinating Board, consisting of 19 board members, has been delegated certain responsibilities to develop and recommend strategic plans, budgets, and community health initiatives. The purpose of the partnership is to improve the planning, delivery, and integration of healthcare services to benefit the greater Keene community.

- D-H and subsidiaries of Concord Hospital (CRHC),Catholic Medical Center (Alliance Health Services), an affiliate of St. Joseph's Hospital (D-H Family Medicine Nashua, Inc.), and Southwestern Vermont Medical Center (SVMC) entered into Professional Services Agreements (PSAs), pursuant to which these facilities purchase, with certain limited exceptions, the services of all personnel employed by D-H at its Concord, NH Division, two Bedford, NH locations, its Nashua, NH satellite locations, and at SVMC located in Bennington, VT to provide healthcare services to the related communities. The payment amount for the professional services of D-H's personnel are based on fair market value considerations and are not directly or indirectly related to the volume or value of referrals or admissions, in accordance with governing law. Through the PSAs, D-H and the parties identified above provide coordination of patient care in the community and facilitate the recruitment of new and needed physicians without unnecessary duplication of services, and serve as a platform for future discussions between the parties to

explore additional collaborative programs. 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 statement of operations and changes in net assets. The PSA with D-H Family Medicine Nashua, Inc. ended June 30, 2014 and was not renewed.

3. Summary of Significant Accounting Policies

Basis of Presentation

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

Use of Estimates

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

Excess of Revenue Over Expenses

The consolidated statement of operations and changes in net assets include excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisition, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

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

Charity Care and Provision for Bad Debts

D-H and NLH provide care to patients who meet certain criteria under their financial assistance policies without charge or at amounts less than their established rates. Because D-H and NLH do not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 4 and 5).

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and bad debt. 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 5).

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

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds and pooled/comingled funds, and all investments in debt securities are considered to be trading securities reported at fair value with changes in fair value included in the 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 8).

Investments in pooled/commingled investment funds that represent investments where the Health System owns shares or units of pooled funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in 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 date on a non-distressed basis.

D-H and THF, are partners in a NH general partnership established for the purpose of operating a master investment program of pooled investment accounts. MHMH has been designated to serve as the managing general partner and, in such capacity, has the authority to bind the partners and the partnership under the agreement. Substantially all of D-H's board-designated and restricted assets, and certain of THF's board-designated assets and restricted assets, were invested in these pooled funds by purchasing units based on the market value of the pooled funds at the end of the month prior to receipt of any new additions to the funds. Interest, dividends, and realized and unrealized gains and losses earned on pooled funds are allocated monthly based on the weighted average units outstanding at the prior month-end.

Investment income or losses (including change in unrealized and realized gains and losses on unrestricted investments, change in fair value of equity method investments, interest, and dividends) are included in excess of revenue over expenses classified as nonoperating gains and losses, unless the income or loss is restricted by donor or law (Note 10).

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

Level 1 Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.

Level 2 Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.

Level 3 Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

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

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

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

Gifts of capital assets such as land, buildings, or equipment are reported as unrestricted support, and excluded from 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 sheet as other assets, are amortized over the term of the related bonds. Amortization is recorded within depreciation and amortization in the consolidated statement of operations and changes in net assets using the straight-line method which approximates the effective interest method.

Trade Name
In connection with the affiliation of NLH, the Health System recorded an intangible asset of $2,200,000 associated with the trade name of NLH. The intangible asset is recorded within other assets on the consolidated statement of financial position. The Health System considers this to be an indefinite-lived asset, assesses the trade name at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes an impairment charge for the amount by which the carrying amount of the trade name exceeds its fair value. There was no impairment charge recorded for the year ended June 30, 2014.

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

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

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

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

NLH does not apply hedge accounting to its interest rate swap and annual changes in the fair value of its swap is recorded within excess of revenues over expenses.

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

4. Charity Care and Community Benefits

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

Consistent with this mission, D-H 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. D-H actively supports community-based healthcare and promotes the coordination of services among healthcare providers and social services organizations. In addition, D-H 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, D-H provides significant support for academic and research programs.

The mission of NLH is to provide safe quality care for every patient, every time in partnership with patients, families, and healthcare providers.

NLH provides acute and primary health care from emergency services to family medical practice to neurosurgical care and essential wellness and prevention services for the 34,000 residents in their service area, a significant proportion of whom are uninsured and/or dependent on Medicaid/Medicare benefits. This population includes a large elderly population and a significant number of rural, low-income families. D-H and NLH file separate annual Community Benefits Reports with the State of NH which outline the community and charitable benefits they provide. The broad categories used in the Community Benefit Reports to summarize these benefits are as follows:

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

- *Health Professional education*, including both financial and nonfinancial support in the form of undergraduate training, internships (clinical and nonclinical), residency education programs, scholarships, and continuing heath professional education.

- *Subsidized health services* are services provided even though there is a financial loss because they 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* representing costs in excess of awards for numerous health research and service initiatives awarded to the organizations.

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

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

- *Charity care (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the year ended June 30, 2014, D-H and NLH provided financial assistance to patients in the amount of approximately $56,372,000 as measured by gross charges. The estimated cost of providing this care for the year ended June 30, 2014 was approximately $22,477,000. The estimated costs of providing charity care services are determined using a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.

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

- The *uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2013 was approximately $119,356,953. The 2014 Community Benefits Reports are expected to be filed in February 2015.

The following table summarizes the value of the community benefit initiatives outlined in D-H and NLH's most recently filed Community Benefit Reports for the year ended June 30, 2013:

(Unaudited, in thousands of dollars)

Community health services	$	4,005
Health professional education		31,743
Subsidized health services		12,524
Research		5,930
Financial contributions		8,028
Community building activities		871
Community benefit operations		62
Charity care		20,482
Government-sponsored health care services		181,174
Total community benefit value	$	264,819

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the year ended June 30, 2014, the Health System reported a provision for bad debts of approximately $47,606,000. The Health System also routinely provides services to Medicare patients at reimbursement levels that are below the costs of the care provided.

5. Patient Service Revenue and Accounts Receivable

Patient service revenue is reported net of contractual allowances and the provision for bad debt as follows for the year ended June 30, 2014:

(in thousands of dollars)

Gross patient service revenue	$	3,246,221
Less: Contractual allowances		1,968,767
Less: Provision for bad debt		47,606
Net patient service revenue	$	1,229,848

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

Accounts receivable, prior to adjustment for doubtful accounts, are summarized as follows at June 30, 2014:

(in thousands of dollars)

Receivables	
Patients	$ 169,766
Third-party payors	137,371
Nonpatient	1,873
	$ 309,010

The allowance for doubtful accounts of $124,404,000 as of June 30, 2014 is established to reserve for uncollectible amounts due primarily from patients.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the year ended June 30, 2014:

Medicare	39 %
Anthem/Blue Cross	20
Commercial insurance	21
Medicaid	13
Self-pay/Other	7
	100 %

D-H and NLH have agreements with third-party payors that provide for payments at amounts different from their established rates. A summary of the acute care payment arrangements in effect during the year ended June 30, 2014 with major third-party payors follows:

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

As a Critical Access Hospital (CAH), NLH is reimbursed by Medicare at 101% of reasonable costs for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. NLH is reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. The nursing home is not impacted by CAH designation. Medicare reimburses nursing home care based on an acuity driven prospective payment system with no retrospective settlement.

Medicaid:
D-H payment for inpatient services rendered to NH Medicaid beneficiaries are based on a prospective payment system, while outpatient services are reimbursed on a retrospective cost basis

or fee schedules. NH Medicaid Outpatient Direct Medical Education costs are reimbursed, as a pass-through, based on the filing of the Medicare cost report. Payment for inpatient and outpatient services rendered to VT Medicaid beneficiaries are based on prospective payment systems.

NLH inpatient services are reimbursed at prospectively determined per diem rates which are not subject to retroactive adjustment. Outpatient services are reimbursed under a cost based reimbursement methodology. NLH receives an interim payment with final settlement determined after the filing and audit of the annual cost report. The skilled nursing facility is reimbursed on a prospectively determined per diem rate.

During the year ended June 30, 2014, the Health System recorded State of NH Medicaid Enhancement Tax (MET) expense of $34,488,000. The tax is calculated at 5.5% of certain gross patient revenues in accordance with instructions received from the State of NH. The MET expense is included in operating expenses in the consolidated statement of operations and changes in net assets.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax "SB 369". As part of the agreement the parties have agreed to resolve all pending litigation related to MET and Medicaid Rates, including the Catholic Medical Center Litigation, the Northeast Rehabilitation Litigation, 2014 DRA Refund Requests, the State Rate Litigation. As part of the Medicaid Enhancement Tax Agreement Effective July 1, 2014, a "Trust / Lock Box" dedicated fund mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services. During the year ended June 30, 2014, the Health System received disproportionate share hospital (DSH) payments of $12,631,782.

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the American Recovery and Reinvestment Act (ARRA) provides incentives for the adoption and use of health information technology by Medicare and Medicaid providers and eligible professionals over the next several years with an anticipated end date of December 31, 2016, depending on the program. CMS has published a final rule to define Stage 1 meaningful use of certified Electronic Health Record (EHR) technology and establish criteria for the incentive program. MHMH and DHC are currently in the CMS defined measurement period for Year 3 meaningful use which will also be measured using the same Stage 1 criteria. On September 4, 2012, CMS published a final rule to define Stage 2 meaningful use criteria with an implementation date of October 1, 2013 for the hospital and January 1, 2014 for the physicians. D-H has recognized $6,833,075 in meaningful use incentives for both the Medicare and Vermont Medicaid programs during the year ended June 30, 2014. NLH recorded no meaningful use revenue from the Medicare EHR programs for the nine month period ending June 30, 2014.

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

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

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

The Health System has provided for their estimated final settlements with all payors based upon applicable contracts and reimbursement legislation and timing in effect for all open years (2007 - 2014). The differences between the amounts provided and the actual final settlement, if any, is recorded as an adjustment to net patient service revenue as amounts become known or as years are no longer subject to audits, reviews and investigations. During 2014, changes in estimates related to D-H settlements with third-party payors resulted in increases in net patient service revenue of approximately $4,076,601 in the consolidated statement of operations and changes in net assets.

6. Investments

The composition of investments at June 30, 2014 is set forth in the following table

(in thousands of dollars)

Assets limited as to use	
Internally designated by board	
Cash and short-term investments	$ 7,463
U.S. government securities	36,930
Domestic corporate debt securities	83,224
Global debt securities	126,451
Domestic equities	111,970
International equities	54,778
Emerging markets equities	40,344
Private equity funds	25,146
Hedge funds	50,370
	536,676
Investments held by captive insurance companies (Note 13)	
U.S. government securities	45,897
Domestic corporate debt securities	22,005
Global debt securities	3,770
Domestic equities	7,286
International equities	13,058
	92,016
Held by trustee under indenture agreement (Note 11)	
Cash and short-term investments	493
Total assets limited as to use	$ 629,185

(in thousands of dollars)

Other investments for restricted activities	
Cash and short-term investments	$ 4,215
U.S. government securities	13,872
Domestic corporate debt securities	26,689
Global debt securities	19,034
Domestic equities	15,901
International equities	7,461
Emerging markets equities	5,162
Private equity funds	3,101
Hedge funds	6,212
Other	28
Total other investments for restricted activities	$ 101,675

Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case by case basis. The fair value method is used when debt securities or equity securities 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 sheet date on a non-distressed basis.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2014. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 8.

	2014		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 12,171	$ -	$ 12,171
U.S. government securities	96,699	-	$ 96,699
Domestic corporate debt securities	101,467	30,451	$ 131,918
Global debt securities	67,544	81,711	$ 149,255
Domestic equities	123,620	11,537	$ 135,157
International equities	13,763	61,534	$ 75,297
Emerging markets equities	185	45,321	$ 45,506
Private equity funds	-	28,247	$ 28,247
Hedge funds	-	56,582	$ 56,582
Other	28	-	$ 28
	$ 415,477	$ 315,383	$ 730,860

Investment income (losses) is comprised of the following for the year ended June 30, 2014:

(in thousands of dollars)

Unrestricted		
Interest and dividend income, and other	$	5,241
Net realized gains on sales of securities		15,464
Change in net unrealized gains on investments		38,685
Interest expense (Note 11)		(3,669)
		55,721
Temporarily restricted		
Interest and dividend income, net		294
Net realized gains on sales of securities		877
Change in net unrealized gains on investments		2,998
		4,169
	$	59,890

For the year ended June 30, 2014 unrestricted investment income (losses) is reflected in the accompanying consolidated statement of operations and changes in net assets as operating revenue of approximately $2,586,000 and as non-operating gains (losses) of approximately $53,135,000.

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 agreements expire. 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, 2014, the Health System has committed to contribute approximately $101,285,000 to such funds, of which the Health System has contributed approximately $67,206,000 and has outstanding commitments of $34,079,000.

7. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2014:

(in thousands of dollars)

Land	$	25,839
Land improvements		30,450
Buildings and improvements		619,243
Equipment		507,077
Equipment under capital leases		16,128
		1,198,737
Less: Accumulated depreciation and amortization		729,757
Total depreciable assets, net		468,980
Construction in progress		15,773
	$	484,753

As of June 30, 2014 construction in progress primarily consists of the construction of the Williamson Research building in Lebanon, NH. The estimated cost to complete this project is $13,250,000 at June 30, 2014.

Depreciation and amortization expense included in operating and non-operating activities was approximately $58,073,000 for 2014.

8. Fair Value Measurements

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

Cash and short-term investments: Consists of money market funds and are valued at NAV reported by the financial institution.

Domestic, emerging markets and international equities: Consists of actively traded equity securities and mutual funds which are valued at the closing price reported on an active market on which the individual securities are traded (Level 1 measurements).

U.S. government securities, domestic corporate and global debt securities: Consists of U.S. government securities, domestic corporate and global debt securities, mutual funds and pooled/commingled funds that invest in U.S. government securities, domestic corporate and global debt securities. Securities are valued based on quoted market prices or dealer quotes where available (Level 1 measurement). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings and maturities, rather than on specific bids and offers for a designated security. Investments in mutual funds are measured based on the quoted NAV as of the close of business in the respective active market (Level 1 measurements).

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

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2014:

(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets:						
Investments						
Cash and short term investments	$ 11,144	$ 1,027	-	$ 12,171	Daily	1
U.S. government securities	96,699	-	-	96,699	Daily	1
Domestic corporate debt securities	33,201	68,266	-	101,467	Daily–Monthly	1–15
Global debt securities	57,911	9,633	-	67,544	Daily–Monthly	1–15
Domestic equities	123,620	-	-	123,620	Daily–Monthly	1–10
International equities	13,763	-	-	13,763	Daily–Monthly	1–11
Emerging market equities	185	-	-	185	Daily–Monthly	1–7
Other	-	28	-	28	Not applicable	Not applicable
Total investments	336,523	78,954	-	415,477		
Deferred compensation plan assets						
Cash and short-term investments	2,753	26	-	2,779		
U.S. government securities	80	-	-	80		
Domestic corporate debt securities	4,798	-	-	4,798		
Global debt securities	835	-	-	835		
Domestic equities	19,318	-	-	19,318		
International equities	8,735	-	-	8,735		
Emerging market equities	2,198	-	-	2,198		
Real Estate	1,665	-	-	1,665		
Multi Strategy Fund	6,079	-	-	6,079		
Guaranteed Contract	-	-	75	75		
Total deferred compensation plan assets	46,461	26	75	46,562	Not applicable	Not applicable
Beneficial interest in perpetual trust	-	-	1,909	1,909	Not applicable	Not applicable
Contribution receivable from charitable Remainder trust	-	-	2,118	2,118	Not applicable	Not applicable
Total assets	$382,984	$78,980	$4,102	$466,066		
Liabilities:						
Interest rate swaps	$ -	$24,413	$ -	$ 24,413	Not applicable	Not applicable
Total liabilities	$ -	$24,413	$ -	$ 24,413		

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

(in thousands of dollars)	Beneficial interest in perpetual trust	Contribution receivable from charitable remainder trust	Guaranteed Contract	Total
Balance at beginning of year	$ 1,823	$ -	$ 72	$ 1,895
Purchases:	-	2,118	-	2,118
Net unrealized gains/ (losses)	86	-	3	89
Balance at end of year	$ 1,909	$ 2,118	$ 75	$ 4,102

There were no transfers into and out of Level 1 and Level 2 measurements due to changes in valuation methodologies during the year ended June 30, 2014.

9. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2014:

(in thousands of dollars)

Healthcare services	$ 28,210
Research	22,699
Purchase of equipment	2,681
Charity care	1,511
Health education	7,688
Other	1,875
	$ 64,664

Permanently restricted net assets consist of the following at June 30, 2014:

(in thousands of dollars)

Healthcare services	$ 16,016
Research	7,634
Purchase of equipment	4,675
Charity care	2,820
Health education	5,124
	$ 36,269

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

10. Board Designated and Endowment Funds

Net assets include approximately 50 individual funds established for a variety of purposes including both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

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

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

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2014.

Endowment net asset composition by type of fund consists of the following at June 30, 2014:

	2014			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 13,738	$ 36,269	$ 50,007
Board-designated endowment funds	19,834	-	-	19,834
Total endowed net assets	$ 19,834	$ 13,738	$ 36,269	$ 69,841

Changes in endowment net assets for the year ended June 30, 2014:

	2014			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at beginning of year	$ 19,304	$ 11,672	$ 31,255	$ 62,231
Net investment return	341	3,457	-	3,798
Contributions	-	42	2,718	2,760
Transfers	450	(280)	243	413
Release of appropriated funds	(261)	(1,539)	-	(1,800)
Net asset transfer from affiliate	-	386	2,053	2,439
Balances at end of year	$ 19,834	$ 13,738	$ 36,269	$ 69,841

11. Indebtedness

Long-Term Debt

A summary of long-term debt at June 30, 2014 follows:

(in thousands of dollars)

Variable rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2013, principal maturing in varying annual amounts, through August 2043 (1)	$	17,923
Series 2011, principal maturing in varying annual amounts, through August 2031 (4)		93,395
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2012A, principal maturing in varying annual amounts, through August 2031 (2)		74,695
Series 2012B, principal maturing in varying annual amounts, through August 2031 (2)		40,990
Series 2010, principal maturing in varying annual amounts, through August 2040 (5)		75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (6)		115,225
Other		
Series 2012, principal maturing in varying annual amounts, through July 2019 (3)		146,000
Obligations under capital leases		2,086
Note payable to a financial institution payable in interest free monthly installments of $4,211, through September 2015; collateralized by associated equipment		56
		565,370
Less		
Original issue discount, net		1,386
Current portion		13,281
	$	550,703

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

(in thousands of dollars)

2015	$	13,281
2016		15,671
2017		16,014
2018		16,497
2019		16,830
Thereafter		487,077
	$	565,370

Outstanding revenue bonds as of June 30, 2014 include:

NLH Bonds:

(1) Series 2013 Revenue Bonds

In October 2013, NLH refunded its Series 2007 Revenue Bonds through the issuance of New Hampshire Health and Education Facilities Authority (NHHEFA) Series 2013 Revenue Bonds of $15,520,000. Additional borrowings were obtained (up to $9,480,000 Revenue Bonds, Series 2013B) for the construction of a new health center building in Newport, NH. The bonds mature in variable amounts through 2043, the maturity date of the bonds, but are subject to mandatory tender in ten years. Interest is payable monthly and is equal to the sum of .72 times the Adjusted LIBOR Rate plus .72 times the credit spread rate. The bonds are collateralized by the gross receipts and property of New London Hospital Association, Inc. (NLHA). As part of the bond refinancing, the swap arrangement was effectively terminated for federal tax purposes with respect to the Series 2007 Revenue Bonds but remains in effect.

As of March 31, 2014, NLH's debt service coverage ratio was .69 which is below the covenant minimum of 1.1 to 1.0; therefore NLH was in violation of its covenant. NLH received a waiver of compliance from its lenders as of the date of this report.

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds:

MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The remaining members of the obligated group consist of MHMH and DHC. Effective August 1, 2013, Cooley Dickinson Hospital, Inc. (CDH) formally withdrew from the DHOG.

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

(2) Series 2012A and 2012B Revenue Bonds

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

(3) Series 2012 Bank Loan

MHMH and DHC, through the DHOG, issued the Bank of America, N.A. Series 2012 note, in July 2012. The proceeds from the Series 2012 note were used to prefund the D-H defined benefit pension plan. Interest on the Series 2012 note accrues at a fixed rate of 2.47% and matures at various dates through 2019.

(4) **Series 2011 Revenue Bonds**
MHMH, through the DHOG, issued NHHEFA Revenue Bonds, Series 2011 in August 2011. The proceeds from the Series 2011 Revenue Bonds were primarily used to advance refund the Series 2001A Revenue Bonds. The Series 2011 Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30, 2014 was 1.04%. The Series 2011 Bonds are callable by the bank upon the end of seven years or may be renegotiated at that time.

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

(6) **Series 2009 Revenue Bonds**
MHMH, through the DHOG, issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 3.00% and 6.00% and mature at various dates through August 2038.

Outstanding joint and several indebtedness of the DHOG at June 30, 2014 approximates $545,305,000.

The Master Trust Indenture requires that members of the DHOG establish certain debt service funds with the proceeds of the bonds, including the maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $493,000 at June 30, 2014 are classified as assets limited as to use in the accompanying consolidated balance sheet. For the year ended June 30, 2014 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statement of operations and changes in net assets as operating expense of approximately $18,436,000 and as a reduction of investment income of $3,669,000.

The estimated fair value of D-HH's long-term debt as of June 30, 2014 was approximately $555,500,000 which was determined by discounting the future cash flows of each instrument at rates that reflect rates currently observed in publicly traded debt markets for debt of similar terms to organizations with comparable credit risk. The inputs to the assumptions used to determine the estimated fair value are based on observable inputs and are classified as level 2. For variable rate debt, the carrying value is equal to the fair value.

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

In connection with the issuance of the Series 2001A Bonds, D-H entered into an interest rate swap agreement (Fixed Payor Swap), with a notional amount of $118,780,000, as a hedge against the variability of cash flows associated with its variable rate Series 2001A Bonds. The interest rate swap agreement matures August 31, 2031. The interest rate swap agreement effectively fixed the interest rate on the Series 2001A Bonds at 4.56%. As a result of the credit market disruptions in the

autumn of 2008, the counterparty to the Fixed Payor Swap exercised its option to apply the Securities Industry and Financial Markets Association (SIFMA) rate index through August 1, 2011 for purposes of calculating the interest to be received under the Fixed Payor Swap. The SIFMA rate index replaced the previous method of using the rate of interest on the Series 2001A Bonds. Effective August 1, 2011 and through the maturity of the agreement, the interest to be received under the Fixed Payor Swap is based on the LIBOR index.

In connection with the advance refunding of the Series 2001A Revenue Bonds through the issuance of the Series 2011 Revenue Bonds, D-H also amended the Fixed Payor Swap resulting in a partial redemption of approximately $4,068,000 and a re-designation as a cash flow hedge of the Series 2011 Revenue Bonds, effective September 1, 2011. The notional amount of the amended Fixed Payor Swap is $91,040,000. The amended Fixed Payor Swap effectively fixes the interest rate on the Series 2011 Revenue Bonds at 4.56%.

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

NLH retained its interest rate swap agreement on $15,000,000 of its outstanding bond obligation to hedge the interest rate risk associated with the Series 2013 bond. The interest rate swap agreement requires the NLH to pay the swap counterparty, a fixed rate of 3.9354% in exchange for the counterparty's payment to NLH of a variable rate based on 67% of the USD-LIBOR-BBA. NLH retains the sole right to terminate the swap agreement should the need arise.

At June 30, 2014 the fair value of the Health System's interest rate swaps was a liability of $24,413,000. The change in fair value during the year ended June 30, 2014 was recorded as a $1,538,000 increase to unrestricted net assets and a $570,000 nonoperating loss. There was no material impact on operations due to hedge ineffectiveness.

12. Employee Benefits

Defined Benefit Plan

Employees of D-H who were employed or offered employment prior to February 9, 2006, and who met certain age and service requirements were covered by one of two defined benefit pension plans. The benefits are based on years of service and the employee's average compensation. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future.

On March 14, 2013, the D-H Board of Trustees approved the enactment of a five-year delayed freeze of the defined benefit plan. After December 31, 2017 participants will no longer earn benefits under the defined benefit plan, and will transition to the defined contribution plan. The Board also approved the elimination of the transition payments associated with the 2006 choice program after December 31, 2017.

In addition, D-H began a process to settle the obligations of the defined benefit pension plan through a bulk lump sum distribution and purchase of annuity contracts to settle a portion of the benefit obligations due to retirees. The annuity purchase process will follow broad guidelines established by the Department of Labor ("DOL") and plan to continue over the next five years.

In addition to the defined benefit pension plans, D-H established the Dartmouth-Hitchcock Retirement Program in 2006. The Dartmouth-Hitchcock Retirement Program consists of three components, all defined contribution in nature: an employer-sponsored 403(b) pre-tax program, an

employer-sponsored 401(a) plan, and a nonqualified supplemental retirement program. Under the Dartmouth-Hitchcock Retirement Program, D-H has allowed certain employees of DHC and MHMH to continue to earn benefit service in the defined benefit pension plan, provided that they met certain criteria. Other employees, comprised of employees (1) who received an offer of employment on or after February 9, 2006, (2) who have not been eligible to participate in or accrue benefits under the defined benefit pension plans, and (3) who have made the choice to irrevocably elect to participate in the new retirement program, are not eligible to earn benefit service in the defined benefit pension plans after December 31, 2006.

D-H also sponsors postretirement healthcare plans for retired employees, and DHC provides postretirement life insurance benefits for retired employees.

Net periodic pension expense included in employee benefits in the consolidated statement of operations and changes in net assets is comprised of the components listed below for the year ended June 30, 2014:

(in thousands of dollars)

Service cost for benefits earned during the year	$	12,122
Interest cost on projected benefit obligation		41,821
Expected return on plan assets		(55,177)
Net prior service cost		380
Net loss amortization		17,285
	$	16,431

The following assumptions were used to determine net periodic pension expense as of June 30, 2014:

Weighted average discount rate	5.50 %
Rate of increase in compensation	Age Graded
Expected long-term rate of return on plan assets	7.75 %

The following table sets forth the funded status and amounts recognized in D-H's consolidated financial statements for the above referenced defined benefit pension plans at June 30, 2014:

(in thousands of dollars)

Change in benefit obligation	
Benefit obligation at beginning of year	$ 812,374
Service cost	12,122
Interest cost	41,821
Benefits paid	(31,467)
Actuarial (gain) loss	94,207
Settlements	(51,975)
Benefit obligation at end of year	877,082
Change in plan assets	
Fair value of plan assets at beginning of year	718,064
Actual return on plan assets	112,218
Benefits paid	(31,467)
Employer contributions	37,050
Settlements	(51,975)
Fair value of plan assets at end of year	783,890
Funded status of the plans	(93,192)
Current portion of liability for pension	(5,142)
Long term portion of liability for pension	(88,050)
Liability for pension	$ (93,192)

For the year ended June 30, 2014 the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheet.

Amounts not yet reflected in net periodic pension expense and included in the change in unrestricted net assets are as follows as of June 30, 2014:

(in thousands of dollars)

Net actuarial loss	$ 311,084
Prior service cost	989
	$ 312,073

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension expense in 2015 are as follows:

(in thousands of dollars)

Unrecognized prior service cost	$ 380
Net actuarial loss	24,050
	$ 24,430

The accumulated benefit obligation for the defined benefit pension plans was approximately $856,673,000 at June 30, 2014.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2014:

Weighted average discount rate	4.90 %
Rate of increase in compensation	Age Graded
Expected long-term rate of return on plan assets	7.75

The primary investment objective for the Plan assets is to support the Pension liabilities of the Pension Plan for Employees of D-H, 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 plan liabilities. As of June 30, 2014, it is expected that the LDI strategy will hedge approximately 70% of the interest rate risk associated with the pension liabilities. To achieve these appreciation and hedging objectives, plan assets 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%
Domestic debt securities (non-Governmental)	20–58	42
International debt securities	6–26	10
Domestic equities	5–35	18
International equities	5–15	10
Emerging market equities	3–13	5
Private equity funds	0–5	-
Hedge funds	5–18	12

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

The Boards of Trustees of D-H, as Plan Sponsors, oversee the design, structure, and prudent professional management of the D-H 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 Plan's assets are the same as outlined in Note 8. 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. D-H 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 Level 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth D-H Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2014:

(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 7,205	$ 51,347	$ -	$ 58,552	Daily	1
Domestic debt securities	74,388	241,679	-	316,067	Daily–Monthly	1–15
Global debt securities	39,591	46,151	-	85,742	Daily–Monthly	1–15
Domestic equities	131,761	10,390	-	142,151	Daily–Monthly	1–10
International equities	-	77,262	-	77,262	Daily–Monthly	1–11
Emerging market equities	-	41,537	-	41,537	Daily–Monthly	1–17
Private equity funds	-	-	3,944	3,944	See Note 6	See Note 6
Hedge funds	-	30,169	28,466	58,635	Quarterly–Annual	60–96
Total investments	$ 252,945	$ 498,535	$ 32,410	$ 783,890		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the year ended June 30, 2014:

(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 26,449	$ 12,761	$ 39,210
Purchases	-	6	6
Sales	(709)	(9,220)	(9,929)
Net realized (losses) gains	(59)	1,470	1,411
Net unrealized gains	2,785	(1,073)	1,712
Balances at end of year	$ 28,466	$ 3,944	$ 32,410

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2014 were approximately $7,187,000. There were no transfers into and out of Level 3 measurements during the year ended June 30, 2014.

There were no transfers into and out of Level 1 and Level 2 measurements due to changes in valuation methodologies during the year ended June 30, 2014.

The weighted average asset allocation for the D-H Plans at June 30, 2014 by asset category is as follows:

Cash and short-term investments	7 %
Domestic debt securities (non-Governmental)	40
Global debt securities	11
Domestic equities	18
International equities	10
Emerging market equities	5
Private equity funds	1
Hedge funds	8
	100 %

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

D-H is expected to contribute approximately $37,000,000 to the Plans in 2015.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2015 and thereafter:

(in thousands of dollars)	**Pension Plans**
2015	$ 30,664
2016	30,979
2017	33,735
2018	36,867
2019	40,192
2020-2024	252,092

Defined Contribution Plans
The Dartmouth-Hitchcock Retirement Plan is an employer-sponsored 401(a) plan, under which D-H makes base, transition, and match contributions based on specified percentages of compensation and employee deferrals. The 401(a) plan includes a discretionary match provision. The discretionary match contributions paid during the year ended June 30, 2014 were $3,419,000. Total employer contributions to the plan of $33,068,000 in 2014 are included in employee benefits in the accompanying consolidated statement of operations and changes in net assets.

NLH has a tax-sheltered annuity plan under which contributions can be made into the plans by all employees. NLH makes contributions to the plan computed at a percentage of yearly earnings, for employees who meet certain annual and consecutive service requirements, as defined by the plan documents. NLH has temporarily suspended further contributions on behalf of its employees for 2014.

Postretirement Medical and Life Benefits
D-H has postretirement medical and life benefit plans covering certain of its active and former employees. The plans generally provide medical and life insurance benefits to certain retired employees of D-H who meet age and years of service requirements. The plans are not funded.

Net periodic postretirement medical and life benefit cost is comprised of the components listed below for the year ended June 30, 2014:

(in thousands of dollars)

Service cost	$	1,803
Interest cost		4,411
Amortization of net transition asset		7
	$	6,221

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in D-H's consolidated financial statements at June 30, 2014:

(in thousands of dollars)

Change in benefit obligation		
Benefit obligation at beginning of year	$	84,538
Service cost		1,803
Interest cost		4,411
Benefits paid		(5,770)
Actuarial loss		5,450
Plan amendments		(39,426)
Benefit obligation at end of year		51,006
Funded status of the plans		(51,006)
Liability for postretirement medical and life benefits	$	(51,006)

The plan amendments are primarily related to the Board's decision to offer retiree health care benefits to post-65 retirees and covered post-65 dependents through a private Medicare exchange beginning in April 2015.

For the year ended June 30, 2014 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 sheet.

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

(in thousands of dollars)

Net prior service credit	$	(39,426)
Net actuarial loss		9,559
	$	(29,867)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement expense in 2014 are as follows:

(in thousands of dollars)

Net prior service credit	$ (5,974)
Net loss	513
	$ (5,461)

In determining the accumulated postretirement medical and life benefit obligation, D-H used a discount rate of 4.7% in 2014 and an assumed healthcare cost trend rate of 7.25%, trending down to 4.75% in 2019 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, 2014 by $4,411,000 and the net periodic postretirement medical benefit cost for the year then ended by $576,000. 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, 2014 by $3,759,000 and the net periodic postretirement medical benefit cost for the year then ended by $649,000.

13. Professional and General Liability Insurance Coverage

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

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

Selected financial data of HAC and RRG, taken from the latest available audited and unaudited financial statements, respectively at June 30, 2014 are summarized as follows:

(in thousands of dollars)	HAC *(audited)*	RRG *(unaudited)*	Total
Assets	$ 104,644	$ 1,880	$ 106,524
Shareholders' equity	13,620	569	14,189
Net income	-	26	26

14. Commitments and Contingencies

Litigation

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

Operating Leases and Other Commitments

The Health System leases certain facilities and equipment under operating leases with varying expiration dates. The Health System's rental expense totaled approximately $9,925,000 for the year ended June 30, 2014. Minimum future lease payments under non-cancelable operating leases at June 30, 2014 were as follows:

(in thousands of dollars)

2015	$ 6,854
2016	5,638
2017	2,525
2018	1,343
2019	913
Thereafter	1,767
	$ 19,040

Line of Credit

On July 28, 2011 D-H entered into a Loan Agreement with a financial institution establishing access to revolving loans of up to $60,000,000. Interest is variable and determined using LIBOR. The Loan Agreement was due to expire on February 28, 2014, and an extension was negotiated through February 28, 2015 with the provision that the maximum revolving amount from May 1, 2014 through September 30, 2014 shall be temporarily reduced to $30,000,000. As of and for the twelve months ended June 30, 2014, there was no outstanding balance and interest expense was approximately $185,000 and is included in the consolidated statement of operations and changes in net assets.

NLH had a $2,000,000 available line of credit with a local bank, collateralized by a second security interest in the NLH gross receipts and accounts receivable. Interest on borrowings was charged at the Wall Street Journal Prime plus .5%. The line of credit expired in October 2013 as part of the NLH's refunding of its 2007 Series Revenue Bonds.

15. Functional Expenses

Approximate operating expenses of the Health System by function are as follows for the year ended June 30, 2014:

(in thousands of dollars)

Program services	$ 1,188,407
Management and general	172,026
Fundraising	8,111
	$ 1,368,544

16. Subsequent Events

The Health System has assessed the impact of subsequent events through November 26, 2014, 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.

Effective July 1, 2014, D-HH became the sole corporate member of Mt. Ascutney Hospital and Health Center (MAHHC) through an affiliation agreement. The new affiliation is intended to strengthen the clinical services offered by MAHHC, continue to improve population health in the region and reduce overall healthcare spending.

D-HH's board of trustees has elected to cease operations of ivy MD effective October 3, 2014.

MHMH, through the DHOG, issued NHHEFA Revenue Bonds, Series 2014A and 2014B in August 2014 through a private placement with two financial institutions. The Series 2014A and 2014B Revenue Bonds were primarily used to refinance a portion of the Series 2009 Revenue Bonds. The Series 2014A and 2014B Revenue Bonds accrue interest variably and mature at various dates through 2033.

Consolidating Supplemental Information

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheet
June 30, 2014

(in thousands of dollars)	Dartmouth–Hitchcock Obligated Group	Dartmouth–Hitchcock Health	New London Hospital	The Hitchcock Foundation	Dartmouth–Hitchcock Medical Center	Eliminations	Dartmouth–Hitchcock Health and Subsidiaries
Assets							
Current assets							
Cash and cash equivalents	$ 45,438	377	4,179	213	720	-	50,927
Patient accounts receivable, net	178,066	-	6,540	-	-	-	184,606
Prepaid expenses and other current assets	92,372	4,503	2,907	171	496	(9,147)	91,302
Total current assets	315,876	4,880	13,626	384	1,216	(9,147)	326,835
Assets limited as to use	618,393	-	10,792	-	-	-	629,185
Other investments for restricted activities	77,622	-	-	24,053	-	-	101,675
Property, plant, and equipment, net	442,441	534	39,101	2	2,675	-	484,753
Other assets	62,791	3,213	7,870	10	159	(1,535)	72,508
Total assets	$ 1,517,123	8,627	71,389	24,449	4,050	(10,682)	1,614,956
Liabilities and Net Assets							
Current liabilities							
Current portion of long-term debt	$ 12,487	-	794	-	-	-	13,281
Current portion of liability for pension and other postretirement plan benefits	5,142	-	-	-	-	-	5,142
Accounts payable and accrued expenses	87,663	9,623	2,907	1,304	673	(9,147)	93,023
Accrued compensation and related benefits	76,407	-	2,168	-	-	-	78,575
Estimated third-party settlements	25,103	-	5,574	-	-	-	30,677
Total current liabilities	206,802	9,623	11,443	1,304	673	(9,147)	220,698
Long-term debt, excluding current portion	532,336	-	18,367	-	-	-	550,703
Insurance deposits and related liabilities	68,498	-	-	-	-	-	68,498
Interest rate swaps	21,103	-	3,310	-	-	-	24,413
Liability for pension and other postretirement plan benefits, excluding current portion	139,056	-	-	-	-	-	139,056
Other liabilities	46,568	-	1,412	-	-	-	47,980
Total liabilities	1,014,363	9,623	34,532	1,304	673	(9,147)	1,051,348
Net assets							
Unrestricted	415,333	(996)	32,297	14,358	3,218	(1,535)	462,675
Temporarily restricted	57,518	-	318	6,669	159	-	64,664
Permanently restricted	29,909	-	4,242	2,118	-	-	36,269
Total net assets	502,760	(996)	36,857	23,145	3,377	(1,535)	563,608
Commitments and contingencies	-	-	-	-	-	-	-
Total liabilities and net assets	$ 1,517,123	8,627	71,389	24,449	4,050	(10,682)	1,614,956

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statement of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2014

(in thousands of dollars)	Dartmouth–Hitchcock Obligated Group	Dartmouth–Hitchcock Health	New London Hospital	The Hitchcock Foundation	Dartmouth–Hitchcock Medical Center	Eliminations	Dartmouth–Hitchcock Health and Subsidiaries
Unrestricted revenue and other support							
Net patient service revenue	$ 1,190,366	-	39,482	-	-	-	1,229,848
Contracted revenue	91,034	1,004	-	710	-	(358)	92,390
Other operating revenue	57,306	2,435	2,161	1,704	6,933	(5,735)	64,804
Net assets released from restrictions	10,274	-	94	1,302	-	-	11,670
Total unrestricted revenue and other support	1,348,980	3,439	41,737	3,716	6,933	(6,093)	1,398,712
Operating expenses							
Salaries	649,981	1,071	21,070	-	-	3,594	675,716
Employee Benefits	198,359	311	4,783	-	-	699	204,152
Medical supplies and medications	188,905	-	7,512	-	-	(20)	196,397
Purchased services and other	150,033	6,077	5,897	2,816	6,934	(8,301)	163,456
Medicaid enhancement tax	32,636	-	1,852	-	-	-	34,488
Geisel school of medicine support	4,875	1,625	-	-	-	-	6,500
Depreciation and amortization	54,894	103	2,711	-	21	-	57,729
Interest	17,777	-	659	-	-	-	18,436
Expenditures relating to net assets released from restrictions	10,274	-	94	1,302	-	-	11,670
Total operating expenses	1,307,734	9,187	44,578	4,118	6,955	(4,028)	1,368,544
Operating margin	41,246	(5,748)	(2,841)	(402)	(22)	(2,065)	30,168
Nonoperating gains (losses)							
Investment gains	49,729	(267)	1,144	2,529	-	-	53,135
Other, net	(3,489)	333	287	-	-	2,065	(804)
Contribution revenue from acquisition	-	33,692	-	-	-	-	33,692
Total nonoperating gains, net	46,240	33,758	1,431	2,529	-	2,065	86,023
Excess (deficiency) of revenue over expenses	87,486	28,010	(1,410)	2,127	(22)	-	116,191
Unrestricted net assets:							
Net assets released from restrictions (Note 8)	485	-	15	263	-	-	763
Change in funded status of pension and other postretirement benefits	14,769	-	-	-	-	-	14,769
Net assets transferred to affiliate	(4,435)	(29,257)	33,692	-	-	-	-
Additional paid in capital	-	1,348	-	-	-	(1,348)	-
Change in fair value on interest rate swaps	1,538	-	-	-	-	-	1,538
Increase (decrease) in unrestricted net assets	$ 99,843	101	32,297	2,390	(22)	(1,348)	133,261

Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

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

Our Vision

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

Values

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

Dartmouth-Hitchcock

Name	Title (if officer, otherwise please write trustee/director)	Begin Term	End Term
Vincent S. Conti	Trustee	8/13/2009	12/31/2021
Barbara Couch	Trustee	3/25/2009	12/31/2021
Michael J. Goran, MD	Trustee	1/1/2006	12/31/2017
Alan C Keiller	Trustee/Board Treasurer	2004	12/31/2015
Jennie L Norman	Trustee/Board Secretary	2006	12/31/2017
Hugh C. Smith, MD	Trustee	2006	12/31/2017
Anne-Lee Verville	Trustee	12/31/2008	12/31/2020
Wiley Souba, MD, ScD	Trustee/Ex-Officio, Dean DMS	10/1/2010	Ex-Officio
Richard S. Shreve	Trustee/Ex Officio President Appointee	1/1/2005	12/31/2016
William J. Conaty	Trustee	6/1/2011	5/31/2023
William W. Helman, IV	Trustee	4/28/2011	12/31/2023
Robert A. Oden, Jr., PhD	Trustee/Board Chair Eff 1/1/2013	1/27/2011	12/31/2023
James Weinstein	Trustee/Ex-Officio/President	11/14/2011	Ex-Officio

Edward Jonathan Merrens, MD, MS
Curriculum Vitae – April 2014

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Lebanon, New Hampshire 03756 USA
edward.j.merrens@hitchcock.org

Home:
Post Office Box 1217
96 Meetinghouse Road
Norwich, Vermont 05055 USA

EDUCATION:

DATE	DEGREE	INSTITUTION
2013	Masters in Healthcare Delivery Science (MS)	Tuck School of Business and the Geisel School of Medicine, Dartmouth College, Hanover, NH
1994	Medical Doctor (MD)	Dartmouth Medical School, Hanover, NH (Geisel School of Medicine at Dartmouth)
1988	Bachelor of Arts (BA)	Dartmouth College, Hanover, NH

POSTDOCTORAL TRAINING:

DATE	SPECIALTY	INSTITUTION
1997 - 1998	Internal Medicine, Chief Resident	University of Washington, Seattle, WA
1995 - 1997	Internal Medicine Residency	University of Washington, Seattle, WA
1994 - 1995	Internal Medicine Internship	University of Washington, Seattle, WA

LICENSURE AND CERTIFICATION:

DATE	LICENSURE	CERTIFICATION
1994 - 1998	Washington State Medical License	not renewed
1997 - 2017	American Board of Internal Medicine	Diplomate - No. 176490
1998	New Hampshire Medical License	No. 10335
2013 - 2015	Basic Life Support (CPR/AED)	
2009	Advanced Cardiac Life Support (ACLS)	

ACADEMIC APPOINTMENTS:

DATE	ACADEMIC TITLE	INSTITUTION
1999	Assistant Professor	Geisel School of Medicine at Dartmouth, Hanover, NH
1998	Instructor in Medicine	Dartmouth Medical School, Hanover, NH
1997	Acting Instructor	University of Washington Department of Medicine

HOSPITAL APPOINTMENTS:

DATE	TITLE	INSTITUTION
1998 - 2002	Director, Consult Service	General Internal Medicine, DHMC
2000 - 2010	Medical Director, Inpatient Medicine 1E/3E	Dartmouth-Hitchcock Medical Center (DHMC)
2001 - 2002	Associate Section Chief	General Internal Medicine, DHMC
2002 - 2004	Director, Inpatient Affairs	General Internal Medicine, DHMC
2005 – 2010	Associate Program Director	Department of Medicine, DHMC
2005 - 2012	Section Chief, Hospital Medicine	Department of Medicine, DHMC
2010 - 2012	Medical Director, Inpatient Services	Dartmouth-Hitchcock Medical Center (DHMC)
2012 – Present	Chief Medical Officer	Dartmouth-Hitchcock Medical Center (DHMC)

OTHER PROFESSIONAL POSITIONS:

DATE	POSITION/TITLE	INSTITUTION/ORGANIZATION
1998 – Present	Team Physician, Medical Director	United States Biathlon Association (USBA)
1998 – Present	Team Physician	United States Olympic Committee (USOC)

MAJOR COMMITTEE ASSIGNMENTS AND CONSULTATIONS:
National/International:

YEAR	COMMITTEE	ROLE	INSTITUTION

2001	United States Olympic Committee	MD	21st World University Games - Beijing, China
2002	United States Olympic Committee	MD	2002 Olympic Winter Games - Salt Lake City, USA
2006	United States Olympic Committee	MD	2006 Olympic Winter Games - Torino, Italy
2010	United States Olympic Committee	MD	2010 Olympic Winter Games - Vancouver, Canada
2012	Biathlon World Championships	MD	Ruhpolding, Germany
2014	United States Olympic Committee	MD	2014 Olympic Winter Games – Sochi, Russia

Regional:

YEAR	COMMITTEE	ROLE	INSTITUTION
2012 - 2013	Vermont Hospitalist Leaders	Member	Dartmouth-Hitchcock Medical Center

Institutional:

YEAR	COMMITTEE	ROLE	INSTITUTION
1998 – 2002	Internship Advisory	Chair	Dartmouth Medical School
1999	Section of Nephrology, Search	Member	Dartmouth-Hitchcock Medical Center
1999	Section of Dermatology Search	Member	Dartmouth-Hitchcock Medical Center
1999 – 2002	Continuing Medical Education	Member	Dartmouth-Hitchcock Medical Center
2000 – 2002	Restraints	Co-Chair	Dartmouth-Hitchcock Medical Center
2000 – 2011	House staff Quality Assurance	Member	Dartmouth-Hitchcock Medical Center
2001	Section of Emergency Medicine Search	Member	Dartmouth-Hitchcock Medical Center
2001- 2006	Dept of Medicine Education	Member	Dartmouth-Hitchcock Medical Center
2001- 2002	Point of Care Testing	Member	Dartmouth-Hitchcock Medical Center
2002 - 2003	General Internal Medicine Search	Member	Dartmouth-Hitchcock Medical Center
2002 - 2008	Inpatient Capacity and Flow	Member	Dartmouth-Hitchcock Medical Center
2003 – Present	Compensation	Member	Dartmouth-Hitchcock Medical Center
2003 – 2005	Ad hoc Committee on Compensation	Member	Dartmouth-Hitchcock Medical Center
2004 – 2008	Computer Information System Steering	Member	Dartmouth-Hitchcock Medical Center
2005 – 2010	Medication Reconciliation	Member	Dartmouth-Hitchcock Medical Center
2006 – 2012	DHMC Board of Governors	Member	Dartmouth-Hitchcock Medical Center
2007	DHMC Anticoagulation Task Force	Member	Dartmouth-Hitchcock Medical Center
2008	Dept. of Orthopedics Vice-Chair Search	Member	Dartmouth-Hitchcock Medical Center
2008	Section of Pulmonary Medicine, Search	Member	Dartmouth-Hitchcock Medical Center
2008 – 2010	Clinical Practice	Member	Dartmouth-Hitchcock Medical Center
2008 – 2010	Community Acquired Pneumonia	Chair	Dartmouth-Hitchcock Medical Center
2008 – 2012	Board of Trustees	Member	Dartmouth-Hitchcock Medical Center
2008 – 2012	Assembly of Overseers	Member	Dartmouth-Hitchcock Medical Center
2008 – 2012	Board of Trustees - Finance	Member	Dartmouth-Hitchcock
2008 – 2012	Board of Trustees - Quality Credentials	Member	Dartmouth-Hitchcock
2009	Board of Trustees - Ad Hoc	Member	Dartmouth-Hitchcock Health (DHH)
2010	Dept of Orthopedics, Residency Review	Chair	Dartmouth-Hitchcock Medical Center
2010	Section of Dermatology, Internal Review	Member	Dartmouth-Hitchcock Medical Center
2010 - Present	Quality and Value Committee	Member	Dartmouth-Hitchcock Medical Center
2010 – Present	Ambulatory, Perioperative and Inpatient	Member	Dartmouth-Hitchcock Medical Center
2010 – Present	Access, Capacity and Throughput	Member	Dartmouth-Hitchcock Medical Center
2012 – Present	Critical Care Redesign	Facilitator	Dartmouth-Hitchcock Medical Center
2011 – Present	Inpatient Hospice Care	Member	Dartmouth-Hitchcock Medical Center
2011 – 2013	Wound Care Program	Leader	Dartmouth-Hitchcock Medical Center
2012 – Present	Readmissions Reduction HEN	Member	Dartmouth-Hitchcock Medical Center
2013 – Present	One-DH Credentialing Project	Leader	Dartmouth-Hitchcock Medical Center
2013 – Present	Section of Hospital Medicine, Search	Member	Dartmouth-Hitchcock Medical Center
2013 – Present	Section of Palliative Med, Search	Member	Dartmouth-Hitchcock Medical Center
2013 – Present	Compensation Redesign Committee	Leader	Dartmouth-Hitchcock Medical Center
2013 – Present	Board of Trustees - Finance	Member	Dartmouth-Hitchcock
2014 – Present	Bylaws Redesign	Leader	Dartmouth-Hitchcock Medical Center
2014 – Present	Institutional Ethics Committee	Member	Dartmouth-Hitchcock Medical Center
2014 – Present	Enhancement Advisory Group for GME	Member	Dartmouth-Hitchcock Medical Center

MEMBERSHIP, OFFICE & COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

DATE	SOCIETY	ROLE
1995 – Present	American College of Physicians	Member
1998 – Present	New Hampshire Medical Society	Member
1998 – Present	Grafton County Medical Society	Member
1999 – Present	Society of General Internal Medicine	Member
1999 – Present	American College of Sports Medicine	Member
2000 – Present	United States Olympic Committee	Sports Medicine Society Member
2001 – 2009	Society of Hospital Medicine (SHM)	Member
2007 – 2008	Society of Hospital Medicine (SHM)	Academic Task Force
2010 - Present	Society of Hospital Medicine (SHM)	Fellow in Hospital Medicine (FHM)

EDITORIAL BOARDS:

DATE	ROLE	BOARD NAME
1991-1994	Editorial Board	Dartmouth Medicine Magazine
1999 – 2002	Reviewer	Journal of General Internal Medicine (JGIM)
1998	Reviewer	British Medical Journal, Reviewer for Clinical Evidence
2000 – Present	Associate Editor	Annals of Internal Medicine
2007	Reviewer	Oxford Press – Handbook Clinical Medicine/Acute Medicine

AWARDS AND HONORS:

DATE	AWARD
1994	Upjohn Achievement Award, Dartmouth Medical School
1994 - 1995	Intern of the Year – University of Washington Department of Medicine
1995 – 1996	Award for Excellence in Internal Medicine – University of Washington Department of Medicine
1996 – 1997	Outstanding Resident of the Year - University of Washington Department of Medicine
2008	Arnold P. Gold Humanism in Medicine Honor Society Award, Dartmouth Medical School
2005 - 2012	Department of Medicine Excellence in Teaching Awards
2006	Excellence in Teaching Award, Dartmouth Medical School Class of 2007
2010	Alpha Omega Alpha (AOA) – Honor Medical Society
2011- 2013	New Hampshire Magazine's Top Doctors (Hospitalist)

JOURNAL REFEREE ACTIVITIES:

DATE	JOURNAL NAME

Other Activities:

TEACHING EXPERIENCE/CURRENT TEACHING RESPONSIBILITIES:

Dartmouth Medical School:

DATE	TEACHING
1998 – Present	Inpatient Medical Service teaching with 3rd year Medical students on Medical clerkship rotation
2004 – Present	Inpatient Hospitalist Service teaching with 4th year DMS Sub-Interns

Dartmouth-Hitchcock Medical Center:

1998 – Present	Inpatient Medical Service teaching with Interns and Residents on the inpatient teaching service

INVITED PRESENTATIONS:

Regional:

DATE	TOPIC	ORGANIZATION	LOCATION
4/25/2014	Promoting Professional Accountability: Dealing with Behaviors that Undermine A Culture of Safety; Guest speaker	Vanderbilt Medical Center Center for Patient & Professional Advocacy	Hanover, NH

4/23/2014	The Hospitalists Role in Developing a Sustainable Health System: Moving from Volume to Value Grand Rounds Speaker	Newton-Wellesley Hospital	Newton, MA
4/11/2014	Planning for Death: Ethics and Legalities Guest Speaker	Dartmouth Ilead Course	Hanover, NH
4/5/2014	The Dartmouth Symposium on Health Care Delivery Science, Panel Speaker	Dartmouth College, MHCDS The Tuck School of Business	Hanover, NH
9/27/2013	Heath Care Reform: Vermont and New Hampshire Leading the Debate	Geisel School of Medicine	Lebanon, NH
7/20/2013	Leadership Panel	MHCDS Summer Residency	Hanover, NH
5/30/2013	Accountable Care and Hospitalists	Springfield Hospital Grand Rounds	Springfield, VT
10/23/2012	Hospital Medicine, history and impact on care delivery and Accountable care	New London Hospital Grand Rounds	New London, NH
10/10/2012	Emergency Medicine, Accountable Care and the regional role of DH	DHMC Emergency Medicine Resident Conference	DHMC, Lebanon, NH
6/12/2012	Hospital Medicine - Opportunities and Challenges in Healthcare Delivery	Valley Regional Hospital Grand Rounds	Claremont, NH
1/19/2012	Doctors, Sections, Boards and Everything in Between	Volunteer Auxiliary Board	DHMC, Lebanon, NH
5/13/2010	Hepatorenal Syndrome: Understanding and Managing the Renal Dysfunction of Cirrhosis	General Internal Medicine Educational Conference	DHMC, Lebanon, NH
3/14/2010	Advanced Communication Skills for the Inpatient Physician	Dartmouth Medical School Advanced Medical Science Course	DHMC, Lebanon, NH
4/22/2010	Alumni Share Knowledge Forum "The Practice: Diverse Pathways"	Dartmouth Medical School	DHMC, Lebanon, NH
2/19/2009	The Evolution of Inpatient Care	Clinical Practice Committee	DHMC, Lebanon, NH
1/31/2009	Health and Nutrition for Nordic Ski Performance	Ford Sayre Ski Council	Hanover, NH
12/8/2008	Exercise Induced Asthma and Bronchospasm in Nordic Skiers	Noon talk	DHMC, Lebanon, NH

National:

DATE	TOPIC	ORGANIZATION	LOCATION
5/17/2013	Accountable Care and Hospitalist	Society for Hospital Medicine	Washington, DC
5/21/2010	Nutrition for Performance	United States Biathlon team and Olympic officials	Lake Placid, NY

2009	Altitude Training: Hypoxic Training and Athletic Performance	United States Biathlon team	Lake Placid, NY
10/24/2009	Medical care of the Biathlete	United States Biathlon team	Lake Placid, NY
3/3/2009	Medical Care of the Elite Winter Athlete	New England Medical Assn 52nd Annual Conference	Stowe, VT
2008	Effect of an Inpatient Anticoagulation Service on Improving the Safe Use of Warfarin Sodium	Society of Hospital Medicine Annual Meeting	San Diego, CA
6/14/2008	Medical care of the Biathlete	United States Biathlon team and US Olympic Committee	Lake Placid, NY

International:

DATE	TOPIC	ORGANIZATION	LOCATION
11/29/2008	Medical care of the Biathlete	IBU World Cup	Ostersund, Sweden
11/29/2008	Nutrition for Performance in Biathlon	IBU World Cup	Ostersund, Sweden

MAJOR RESEARCH INTERESTS:

RESEARCH FUNDING: (Be sure to include dates, amounts, whether you are PI or co-PI)
Past:
1. DHMC Quality Research Grant, 2007-8 - Inpatient Anticoagulation, Principle Investigator

BIBLIOGRAPHY:
Journal Articles:

1. Zlotnick D, Merrens E, Fingar E, et al. 69-year-old male presenting with hypotension and anasarca. Am J Hematol 2008;83:311–314.
2. Zlotnick D, Merrens E, Fingar E, et al. Intravascular lymphoma as a recurrence of testicular Non-Hodgkin's lymphoma confirmed by polymerase chain reaction. Am J Hematol 2008;83:681-682.
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1. Merrens, EJ, Meeting 24/7 Demands, Dartmouth Medicine Magazine – Page 31, Summer 2005

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1. Sheffield JV, Merrens EJ. More about Thrombotic Thrombocytopenic Purpura. Letter, New Engl J Med. 1998 Feb 19; 338(8):548

Book Chapters:

1. Merrens, EJ (Chapter on Biliary disease), Glasheen J (Editor) Hospital Medicine Secrets. Elsevier Publishing (2006)

Updated: 4/24/2014

4.2.3 Medical License

Change of Address must be reported in writing to:
New Hampshire Board of Medicine
121 South Fruit Street - STE 301
Concord, NH 03301-2412 (Chapt. 329-161)

State of New Hampshire
BOARD OF MEDICINE

EDWARD J MERRENS, MD

License #: 10335
Issued: 7/1/1998

has been duly registered to practice medicine in this state through

6/30/2016

Mark Sullivan PA-C
President

EDWARD J MERRENS, MD
DHMC - HOSPITAL MEDICINE
ONE MEDICAL CENTER DR
LEBANON NH 03756

REC'D APR 25 2014

SM

MARY HITCHCOCK MEMORIAL HOSPITAL DBA DARTMOUTH HITCHCOCK

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
James Weinstein, MD	Chief Executive Officer	$1,250,000	0.0%	$ 0.00
Robin Kilfeather-Mackey	Chief Financial Officer	$525,0785	0.0%	$ 0.00
Daniel Jantzen	Chief Operating Officer	$525,000	0.0%	$ 0.00
Edward Merrens, MD	Chief Medical Officer	$375,000	0.0%	$ 0.00