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

Lori A. Shabinette  
Commissioner

Katja S. Fox  
Director

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November 2, 2021

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

**REQUESTED ACTION**

Authorize the Department of Health and Human Services, Division for Behavioral Health, to enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital. (VC#177160), Lebanon, NH in the amount of \$455,688 for the evaluation of integrated primary care, community behavioral health care and wellness services for young people with serious emotional disturbance (SED), severe mental illness (SMI), severe and persistent mental illness (SPMI), with the option to renew for up to one (1) additional year effective July 1, 2021 or upon Governor and Council approval, whichever is later, through December 31, 2023. 100% Federal Funds.

Funds are available in the following account for State Fiscal Years 2022 and 2023, and are anticipated to be available in State Fiscal Year 2024, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

**05-95-092-922010-23400000- HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, PROHEALTH NH GRANT**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	074-500585	Contracts for Prog Svc	92202340	\$209,938
2023	074-500585	Contracts for Prog Svc	92202340	\$197,000
2024	074-500585	Contracts for Prog Svc	92202340	\$48,750
			<b>Total</b>	<b>\$455,688</b>

**EXPLANATION**

This request is **Sole Source** because the Contractor was identified in the original federal ProHealth NH grant application submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA). Consequently, the availability of federal funding is contingent upon the Department continuing to contract with the current Contractor. Additionally, the existing

ProHealth contracts with the Community Mental Health Centers who subcontracted with the Contractor expired June 30, 2021. The ProHealth scope of services is incorporated into amendments with the Community Mental Health Centers for the remaining months of the grant. The Contractor will continue to conduct the evaluation and reporting of outcomes consistent with federal project requirements.

The purpose of this request is to provide evaluation, training, and consultation on community-based treatment and recovery options that promote recovery from mental illness and wellness interventions through continued implementation of the ProHealth NH Partnership Grant. The Contractor will provide training and consultation on evaluation and evidence-based wellness interventions to the Community Mental Health Centers and federally qualified health center partnerships. The Contractor will provide evaluation services in accordance with SAMHSA guidance. Evaluations will measure effectiveness in identifying and addressing serious emotional disturbance, severe mental illness, severe and persistent mental illness, and physical health indicators earlier and improving health outcomes for youth and young adults with mental illness.

The Department will monitor contracted services by reviewing:

- Reports on the proportion of individuals enrolled in ProHealth NH who received evidence-based mental health treatment and health education for weight management and tobacco use.
- Reports on the proportion of individuals enrolled in ProHealth NH who received Breath Well, Live Well Tobacco Program and Healthy Choices Healthy Changes Weight program.
- Two annual presentations, and an annual report detailing outcomes demonstrating the value in documentation of primary care, coordinated and collaborative care, health homes, and wellness interventions.

As referenced in Exhibit A of the attached contract, the parties have the option to extend the agreement for up one (1) additional year, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval.

Should the Governor and Council not authorize this request, the evaluation, training, and consultation will cease and the SAMHSA will discontinue the grant award because requirements would not be met. The services provided by the Contractor would not aid the Community Mental Health Centers providing ProHealth services to individuals with serious emotional disturbance, severe mental illness and severe and persistent mental illness.

Area served: Greater Manchester, Greater Nashua, and Strafford County.

Source of Funds: CFDA #93.243, FAIN #H79SM080245

Respectfully submitted,

  
on behalf of Commissioner Shibinette

Lori A. Shibinette  
Commissioner

Subject: Evaluation of ProHealth New Hampshire (SS-2022-DBH-01-EVALU-01)

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

**AGREEMENT**

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

**GENERAL PROVISIONS**

**1. IDENTIFICATION.**

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address 1 Medical Center Drive Lebanon, NH 03765	
1.5 Contractor Phone Number (603) 650-5000	1.6 Account Number 05-95-092-922010-23400000	1.7 Completion Date December 31, 2023	1.8 Price Limitation \$ 455,688
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature  <i>Barbara A. Vance</i> Date: 10/21/2021		1.12 Name and Title of Contractor Signatory Barbara A. Vance Vice President of Research Operations	
1.13 State Agency Signature DocuSigned by: <i>Katja S. Fox</i> ED0005804C83442... Date: 10/26/2021		1.14 Name and Title of State Agency Signatory Katja S. Fox Director	
1.15 Approval by the N.H. Department of Administration, Division of Personnel (if applicable) By: _____ Director, On: _____			
1.16 Approval by the Attorney General (Form, Substance and Execution) (if applicable) DocuSigned by: By: <i>J. Christopher Marshall</i> On: 10/26/2021			
1.17 Approval by the Governor and Executive Council (if applicable) G&C Item number: _____ G&C Meeting Date: _____			

**2. 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 B which is incorporated herein by reference ("Services").

**3. EFFECTIVE DATE/COMPLETION OF SERVICES.**

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("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 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 for Services provided in EXHIBIT B, in whole or in part. 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 reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source 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 C 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 applicable 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 employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property 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. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

**7. PERSONNEL.**

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

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

**8. EVENT OF DEFAULT/REMEDIES.**

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, 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 give the Contractor a written notice specifying the Event of Default and 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 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. 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.

**9. TERMINATION.**

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, 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 B. In addition, at the State's discretion, 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.

**10. DATA/ACCESS/CONFIDENTIALITY/PRESERVATION.**

10.1 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.

10.2 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.

10.3 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.

**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.**

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

**13. INDEMNIFICATION.** Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the

Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. 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 continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than \$1,000,000 per occurrence and \$2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 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 ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

**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. The 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. 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.

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

**18. CHOICE OF LAW AND FORUM.** This Agreement shall be governed, interpreted and 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. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

**19. CONFLICTING TERMS.** In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

**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 or modifying provisions set forth in the attached EXHIBIT A 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 with respect to the subject matter hereof.

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT A**

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**Revisions to Standard Agreement Provisions**

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

- 1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:
  - 3.3. The parties may extend the Agreement for up to one (1) additional year from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.
- 1.2. Paragraph 7, Personnel, is amended by modifying subparagraph 7.1 to read:
  - 7.1. The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor certifies 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.
- 1.3. Paragraph 7, Personnel, is amended by modifying subparagraph 7.2 to read:
  - 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's employees involved in this project, 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.
- 1.4. Paragraph 9, Termination, is amended by modifying subparagraph 9.2 to read:
  - 9.2. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than thirty (30) 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 B. In addition, at the State's discretion, the Contractor shall, within thirty (30) days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT A**

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- 1.5. Paragraph 10, Data/Access/Confidentiality/Preservation, is amended by modifying subparagraph 10.3 to read:
- 10.3 Confidentiality of data shall, to the extent applicable, be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data provided by the State requires prior written approval of the State.
- 1.6. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:
- 12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed and how corrective action shall be managed if the subcontractor's performance is inadequate. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.
- 12.4. Paragraph 14, Insurance, is amended by modifying subparagraph 14.1.2 to read:
- 14.1.2. 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 or registered to conduct business in the State of New Hampshire.
- 12.5. Paragraph 14, Insurance, is amended by modifying subparagraph 14.3 to read:
- 14.3. The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.
2. Revisions to Exhibit I, Health Insurance Portability and Accountability Act, Business Association Agreement
- 2.1. Section 3, Obligations and Activities of Business Associate, Subsection b. is amended as follows:

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT A**

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- b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:
- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
  - The unauthorized person used the protected health information or to whom the disclosure was made;
  - Whether the protected health information was actually acquired or viewed; and
  - The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment report as soon as the investigation is completed and report the findings of the risk assessment report in writing to the Covered Entity as soon as possible thereafter.

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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**Scope of Services**

**1. Statement of Work**

- 1.1. The Contractor shall provide evaluation services for the ProHealth New Hampshire (NH) program in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) guidance and applicable federal and state law, including administrative rules and regulations.
- 1.2. The Contractor shall provide training and consultation on the latest community-based treatment and recovery options that are intended to promote health wellness and recovery from mental illness and are based on scientific research and the best evidence-based practices.

**2. Evaluation Services**

- 2.1. The Contractor shall maintain required regulatory oversight of the evaluation pertaining to the Institutional Review Board (IRB) and Protection of Human Subjects in Clinical Trials.
- 2.2. The Contractor shall provide training and consultation to the Community Mental Health Centers (CMHCs) that includes, but is not limited to:
  - 2.2.1. Obtaining consent from individuals participating in ProHealth NH evaluation and wellness services.
  - 2.2.2. Ensuring client data includes an identification number (ID) for all enrolled individuals.
  - 2.2.3. Collecting and reporting information that includes, but is not limited to:
    - 2.2.3.1. Individual demographic and encounter data.
    - 2.2.3.2. Medical history and primary care provider information.
    - 2.2.3.3. Documentation related to all contact with a primary care provider.
    - 2.2.3.4. Most recent physical exam and wellness visit.
    - 2.2.3.5. De-identified information that includes height, weight, body mass index (BMI), waist circumference, blood pressure, tobacco use and/or breath carbon monoxide, and plasma glucose and lipids.
  - 2.2.4. Screening and reporting of the following:
    - 2.2.4.1. Trauma;
    - 2.2.4.2. Depression;
    - 2.2.4.3. Substance use;
    - 2.2.4.4. Medication misuse;
    - 2.2.4.5. Interest or Involvement in employment and education activities;
    - 2.2.4.6. Assertive Community Treatment services; and

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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- 2.2.4.7. Symptom management.
  - 2.2.5. Entering demographic and encounter data into the SAMHSA Performance Accountability and Review System (SPARS) system and RedCap.
  - 2.2.6. Providing individual demographic and encounter data to the Department to include content in the format, frequency, method and timeliness as specified by the Department.
  - 2.2.7. Conducting quality review on quarterly aggregate data identified in Subsections 10.5 and 10.6, SPARS, and RedCap.
  - 2.3. The Contractor shall conduct qualitative assessments of ProHealth NH for routine quality improvement that must include input from individuals, caregivers, youth, peers, providers, and other stakeholders.
- 3. Coordinated and Collaborative Care**
- 3.1. The Contractor shall provide training to support referrals to evidence-based practice (EBPs) for individuals with SMI, SPMI, and SED based on need
  - 3.2. The Contractor shall provide quarterly consultation on effective methodology to engage individuals with Serious Mental Illness (SMI), Serious and Persistent Mental Illness (SPMI), and Serious Emotional Disturbance (SED) in evaluation and services to meet the needs of individuals, including motivational enhancement and referrals for case management, integrated services, and EBP integrated treatment.
- 4. Integrated Health Home**
- 4.1. The Contractor shall provide monthly consultation on integrated health interventions in 3.2 for individuals' with SMI, SPMI, and SED behavioral health care EBP assessment and treatment.
  - 4.2. The Contractor shall provide training and consultation on person centered-shared decision making and decisions aids that support youth decision making and informed consent with treatment providers about treatment options, including pharmacotherapy.
- 5. Health Counseling and Wellness Interventions**
- 5.1. The Contractor shall provide training and consultation on wellness programs for health coaches assisting individuals with selecting options that best match individual needs and interests. The Contractor shall ensure options include, but are not limited to:
    - 5.1.1. One-time brief Motivational Enhancement interventions that include:
      - 5.1.1.1. Let's Talk About Smoking (LTAS);
      - 5.1.1.2. Vaping Education;
      - 5.1.1.3. Let's Talk About Feeling Good; and

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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- 5.1.1.4. Health Education.
- 5.1.2. Breathe Well Live Well (BWLW) program. The Contractor shall ensure the program includes:
  - 5.1.2.1. Health coaching with components of motivational interviewing, cognitive behavioral therapy, and stages of change-based interventions to motivate risk reduction and quit attempts.
  - 5.1.2.2. Manualized BWLW cessation counseling for the participant as well as Care2Quit counseling for of a person in the individuals support system to support quit attempts;
  - 5.1.2.3. Provision of nicotine replacement therapy and referrals for cessation pharmacotherapy; and
  - 5.1.2.4. Structured incentivizes program for participation and quit attempts.
- 5.1.3. Health Coaches for Hypertension Control program for individuals who are overweight or obese. The Contractor shall ensure the program includes:
  - 5.1.3.1. Health coaching with components of Motivational interviewing, Cognitive behavioral therapy, and Stages of change-based interventions;
  - 5.1.3.2. A local gym membership for twelve (12) months;
  - 5.1.3.3. A wellness specialist and an InSHAPE health mentor;
  - 5.1.3.4. A Weight Watchers membership for one (1) year to include:
    - 5.1.3.4.1. The Weight Watchers application for individuals above the age 18 years;
    - 5.1.3.4.2. MyFitnessPal application for youth under age 18 years; and
    - 5.1.3.4.3. Structured incentives program for participation and initiating behavior change.
- 5.2. The Contractor shall provide intervention manuals for the interventions outlined in 5.1 that include alternative treatment options and referrals to wellness treatment services. The Contractor shall ensure wellness treatment services and referrals based on the outcomes of health screening and treatment planning goals include:
  - 5.2.1. Web-based application and text subscriptions, Quitline NH telephonic counseling, MyLifeMyQuit, tobacco and obesity education, diabetes education programs, and other related programs.
  - 5.2.2. Access to medications associated with wellness interventions, such as nicotine replacement therapy (NRT), nicotine replacement (NRT) starter

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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packs, and onsite prescribing and pharmacy to maintain NRT supply or to access other smoking cessation medication (varenicline, bupropion).

**6. Quality Improvement**

- 6.1. The Contractor shall perform, or cooperate with the performance of, quality improvement and/or utilization review activities as determined and requested by the Department.
- 6.2. The Contractor shall conduct surveys and biannual forums, as requested by the Department, to obtain feedback and input from individuals, peers, and community health workers.
- 6.3. The Contractor shall provide a report, in the format and frequency requested by the Department, that summarizes activities that includes, but is not limited to:
  - 6.3.1. Quality Improvement activities;
  - 6.3.2. Utilization review activities;
  - 6.3.3. Surveys and biannual forums; and
  - 6.3.4. Implementation of the activities identified above.
- 6.4. The Contractor shall develop management and self-review tools for wellness interventions identified in Section 5, as approved by the Department.

**7. Staffing**

- 7.1. The Contractor shall maintain staff or subcontractors that include, but are not limited to:
  - 7.1.1. 0.3 FTE director with an advanced degree in psychology or related field who provides oversight of and training for the ProHealth NH program.
  - 7.1.2. 0.1 FTE data analyst who performs the following activities:
    - 7.1.2.1. Data quality review;
    - 7.1.2.2. Data analysis;
    - 7.1.2.3. Training and support for data entry into the RedCap and federal SPARS data repositories;
  - 7.1.3. Two (2) program managers, who possess master's degrees in a psychology related field or equivalent and are licensed to practice in New Hampshire as required by applicable state and federal laws to provide training and consultation on :
    - 7.1.3.1. Wellness interventions;
    - 7.1.3.2. Recruitment and retention; and
    - 7.1.3.3. Interview and data collection techniques.

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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**8. Deliverables**

- 8.1. The Contractor shall submit enrollment, service use and outcomes reports to the Department, by the twentieth (20<sup>th</sup>) day after the end of each quarter. Reports shall contain de-identified and aggregate data that pertains to:
  - 8.1.1. Integrated mental health and primary care health homes.
  - 8.1.2. Wellness interventions delivered within the integrated health home program.
- 8.2. The Contractor shall submit an annual report, by the tenth (10<sup>th</sup>) day of August, to the Department that identifies evaluation and health outcomes required by SAMHSA.
- 8.3. The Contractor shall provide two (2) annual presentations on the aggregate data and outcomes in EBP's by the tenth (10<sup>th</sup>) day of August and six (6) months later, or as requested by the Department.

**9. Maintenance of Fiscal Integrity**

- 9.1. The Contractor shall submit a summary within thirty five (35) calendar days to the Department that includes:
  - 9.1.1. The number of interventions completed by individuals at each CMHC;
  - 9.1.2. The number of hours of training and consultation, including the hours for preparation; and
  - 9.1.3. Additional information as requested by the Department.

**10. Data Management**

- 10.1. The Contractor shall conduct human subjects data collection, management and reporting according to procedures approved and monitored by an Institutional Review Board.
- 10.2. The Contractor shall ensure all releases of confidentiality and prohibitions on disclosure of information are in compliance with all state and federal laws, including administrative rules, including the prohibition for re-disclosure of 42 CFR Part 2 information.
- 10.3. The Contractor shall collaborate with the Department to streamline, automate and align reporting with existing reports where possible.
- 10.4. The Contractor shall provide training and quality assurance of real-time National Outcome Measures (NOMs) data with the ProHealth NH Partnerships through a Department approved secure portal.
- 10.5. The Contractor shall collaborate with ProHealth NH Partnerships to provide quarterly reports to the Department that include National Outcome Measure (NOMs) and New Hampshire specific CMHC data points including, but not limited to:

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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- 10.5.1. Number of participants screened for ProHealth NH;
- 10.5.2. Number of participants newly enrolled in ProHealth NH;
- 10.5.3. Number of participants who received ProHealth NH health and behavioral screening and assessments;
- 10.5.4. Number of participants screened for trauma; depression; substance use disorders; medication use; involvement or interest in employment or education; need for assertive community treatment; and desire for symptom management;
- 10.5.5. Number of participants referred to each treatment based on needs identified in screenings;
- 10.5.6. Total number of participants who received each of the screenings and assessments in Section 2;
- 10.5.7. Total number of individuals of age group served by ProHealth NH in care at the CMHC; and
- 10.5.8. National Outcome Measures (NOMs) obtained.
- 10.6. The Contractor shall report quarterly aggregate summaries of the following items from CMHC and Federally Qualified Health Center electronic medical records:
  - 10.6.1. Number of participants in supportive housing or independent living programs;
  - 10.6.2. Number of participants who attended social and rehabilitative programs;
  - 10.6.3. Number of participants who participated in each of the EBP services listed in Section 2;
  - 10.6.4. Number of participants who attended a scheduled medical appointment;
  - 10.6.5. Number of participants who attended a scheduled mental health appointment;
  - 10.6.6. Number of participants who completed tobacco education;
  - 10.6.7. Number of participants who completed obesity education;
  - 10.6.8. Number of participants who attended Breathe Well Live Well;
  - 10.6.9. Number of participants who attended Health Choices Healthy Changes; and
  - 10.6.10. Cumulative totals of participants engaged in each of the EBP activities and Health Counseling and Wellness Interventions.
- 10.7. The Contractor shall establish follow-up rates in quarterly intervals for reporting on the proportion of individuals enrolled in ProHealth NH who received the following services:

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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- 10.7.1. Evidence-based mental health treatment for those whose mental health screening indicates a need;
- 10.7.2. Healthy lifestyle education following health screening;
- 10.7.3. Health education for tobacco among those who use tobacco as indicated in health screening;
- 10.8. The Contractor shall establish baseline rates for the following performance measures, reporting on the proportion of individuals enrolled in ProHealth NH who received the following health behavior change services:
  - 10.8.1. Breathe Well Live Well Tobacco Program for those who use tobacco; and
  - 10.8.2. Healthy Choices Healthy Changes Weight, nutrition and fitness program for those with obesity.
- 10.9. The Contractor shall report additional data as requested by the Department, which includes, but is not limited to:
  - 10.9.1. Focus groups and qualitative interviews;
  - 10.9.2. Participants' satisfactory performance in work and school settings;
  - 10.9.3. The level of compliance with prescribed medication regimes;
  - 10.9.4. The attendance at scheduled medical and behavioral health appointments; and
  - 10.9.5. Any additional ProHealth NH data specified by SAMHSA.
- 10.10. The Contractor shall provide quarterly reports on financial incentives distributed from advanced payments for incentives to the Department by the fifteenth (15) day of the following month.
- 10.11. The Contractor shall provide evaluation, training, and consultation for ProHealth NH consistent with the data collections and infrastructure efforts of the Department.

**11. Exhibits Incorporated**

- 11.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160, 162 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and as applicable 42 CFR Part 2 for the protection of substance use disorder records, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.
- 11.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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11.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

**12. Additional Terms**

**12.1. Impacts Resulting from Court Orders or Legislative Changes**

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

**12.2. Credits and Copyright Ownership**

12.2.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an 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."

12.2.2. All materials produced under the Agreement shall be done in collaboration with the Department and must be approved before printing, production, distribution or use except for use of "Let's Talk About Feeling Good" and any academic publications.

12.2.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

12.2.3.1. Brochures.

12.2.3.2. Resource directories.

12.2.3.3. Protocols or guidelines.

12.2.3.4. Posters.

12.2.3.5. Reports.

12.2.4. Prior to any publication of the materials produced hereunder, Contractor shall forward to Department a copy of the disclosure for review and comment at least thirty (30) days prior to submission for publication. Contractor shall consider all comment from the Department in good faith and remove any confidential information the Department identified during such review. Contractor shall acknowledge the Department's contributions in all such publications.

**12.3. Operation of Facilities: Compliance with Laws and Regulations**

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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12.3.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement 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.

**13. Records**

13.1. The Contractor shall keep records that include, but are not limited to:

13.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all income received or collected by the Contractor and all costs and other expenses incurred by the Contractor in the performance of the Contract.

13.1.2. All records must 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.

13.1.3.

13.2. During the term of this Agreement 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 Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT B**

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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.

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT C**



**Payment Terms**

1. This Agreement is funded by:
  - 1.1. 100%, Prohealth NH Grant, awarded by the Substance Abuse Mental Health Services Administration, CFDA 93.243, FAIN H79SM080245.
2. For the purposes of this Agreement:
  - 2.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.331.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibits C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice in a form satisfactory to the Department by the twenty fifth (25th) working day of the following month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
5. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to [dhhs.dbhinvoicesmhs@dhhs.nh.gov](mailto:dhhs.dbhinvoicesmhs@dhhs.nh.gov), or invoices may be mailed to:

Financial Manager  
Department of Health and Human Services  
129 Pleasant Street  
Concord, NH 03301
6. The Department shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available, subject to Paragraph 4 of the General Provisions Form Number P-37 of this Agreement.
7. The final invoice shall be due to the Department no later than sixty (60) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.
8. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.
9. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B, Scope of Services.
10. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable

**New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
EXHIBIT C**



to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

11. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

12. Audits

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

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

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

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

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

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

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

12.5. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the

New Hampshire Department of Health and Human Services  
Evaluation of ProHealth New Hampshire  
**EXHIBIT C**



Contract to which exception has been taken, or which have been disallowed because of such an exception.

*BAV*

10/21/2021

Exhibit C-1 Budget

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2021 - June 30, 2022

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	\$ 111,432.00	\$ 11,143.00	\$ 122,575.00	\$ -	\$ -	\$ -	\$ 111,432.00	\$ 11,143.00	\$ 122,575.00
2. Employee Benefits	\$ 33,914.00	\$ 3,391.00	\$ 37,305.00	\$ -	\$ -	\$ -	\$ 33,914.00	\$ 3,391.00	\$ 37,305.00
3. Consultants	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4. Equipment:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Rental	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Repair and Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Purchase/Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5. Supplies:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Educational	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Lab	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pharmacy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medical	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Office	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6. Travel	\$ 507.00	\$ 51.00	\$ 558.00	\$ -	\$ -	\$ -	\$ 507.00	\$ 51.00	\$ 558.00
7. Occupancy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8. Current Expenses	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Telephone	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Postage	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subscriptions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Audit and Legal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Board Expenses	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9. Software	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10. Marketing/Communications	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11. Staff Education and Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12. Subcontracts/Agreements	\$ 45,000.00	\$ 4,500.00	\$ 49,500.00	\$ -	\$ -	\$ -	\$ 45,000.00	\$ 4,500.00	\$ 49,500.00
13. Other (specific details mandatory):	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	<b>\$ 190,853.00</b>	<b>\$ 19,085.00</b>	<b>\$ 209,938.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 190,853.00</b>	<b>\$ 19,085.00</b>	<b>\$ 209,938.00</b>

Indirect As A Percent of Direct

10.0%

*BLV*

Exhibit C-2 Budget

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2022 – June 30, 2023

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	\$ 104,948.00	\$ 10,495.00	\$ 115,441.00	\$ -	\$ -	\$ -	\$ 104,948.00	\$ 10,495.00	\$ 115,441.00
2. Employee Benefits	\$ 33,895.00	\$ 3,389.00	\$ 37,084.00	\$ -	\$ -	\$ -	\$ 33,895.00	\$ 3,389.00	\$ 37,084.00
3. Consultants	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4. Equipment:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Rental	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Repair and Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Purchase/Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5. Supplies:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Educational	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Lab	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pharmacy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medical	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Office	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6. Travel	\$ 450.00	\$ 45.00	\$ 495.00	\$ -	\$ -	\$ -	\$ 450.00	\$ 45.00	\$ 495.00
7. Occupancy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8. Current Expenses	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Telephone	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Postage	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subscriptions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Audit and Legal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Board Expenses	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9. Software	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10. Marketing/Communications	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11. Staff Education and Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12. Subcontracts/Agreements	\$ 40,000.00	\$ 4,000.00	\$ 44,000.00	\$ -	\$ -	\$ -	\$ 40,000.00	\$ 4,000.00	\$ 44,000.00
13. Other (specific details mandatory):	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	\$ 179,091.00	\$ 17,909.00	\$ 197,000.00	\$ -	\$ -	\$ -	\$ 179,091.00	\$ 17,909.00	\$ 197,000.00

Indirect As A Percent of Direct

10.0%

BRV

Exhibit C-3 Budget

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2023 – June 30, 2023

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	\$ 29,719.00	\$ 2,972.00	\$ 32,691.00	\$ -	\$ -	\$ -	\$ 29,719.00	\$ 2,972.00	\$ 32,691.00
2. Employee Benefits	\$ 9,599.00	\$ 960.00	\$ 10,559.00	\$ -	\$ -	\$ -	\$ 9,599.00	\$ 960.00	\$ 10,559.00
3. Consultants	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4. Equipment:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Rental	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Repair and Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Purchase/Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5. Supplies:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Educational	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Lab	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pharmacy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medical	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Office	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6. Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
7. Occupancy	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8. Current Expenses	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Telephone	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Postage	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subscriptions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Audit and Legal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Board Expenses	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9. Software	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10. Marketing/Communications	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11. Staff Education and Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12. Subcontracts/Agreements	\$ 5,000.00	\$ 500.00	\$ 5,500.00	\$ -	\$ -	\$ -	\$ 5,000.00	\$ 500.00	\$ 5,500.00
13. Other (specific details mandatory):	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Web Based Interventions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	<b>\$ 44,318.00</b>	<b>\$ 4,432.00</b>	<b>\$ 48,750.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 44,318.00</b>	<b>\$ 4,432.00</b>	<b>\$ 48,750.00</b>

Indirect As A Percent of Direct

10.0%

BIV



New Hampshire Department of Health and Human Services  
Exhibit D

**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 GRANTEEES 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 subparagraph 1.1.
  - 1.4. Notifying the employee in the statement required by subparagraph 1.1 that, as a condition of employment under the grant, the employee will
    - 1.4.1. Abide by the terms of the statement; and
    - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
  - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency



New Hampshire Department of Health and Human Services  
Exhibit D

- has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- 1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
    - 1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    - 1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
  - 1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.
2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

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

One Medical Center Drive, Lebanon, NH 03756

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

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021

*Barbara A. Vance*

Date

Name: Barbara A. Vance  
Title: Vice President of Research Operations



New Hampshire Department of Health and Human Services  
Exhibit E

**CERTIFICATION REGARDING LOBBYING**

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

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

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

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

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)
3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

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

Vendor Name: Mary Hitchcock Memorial Hospital

10/21/2021

*Barbara A. Vance*

Date

Name: Barbara A. Vance  
Title: Vice President of Research Operations



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

**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 <https://www.govinfo.gov/app/details/CFR-2004-title45-vol1/CFR-2004-title45-vol1-part76/context>.
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



New Hampshire Department of Health and Human Services  
Exhibit F

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

10/21/2021

*Barbara A. Vance*

Date

Name: Barbara A. Vance  
Title: Vice President of Research Operations

Contractor Initials BAV  
Date 10/21/2021



New Hampshire Department of Health and Human Services  
Exhibit G

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

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

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

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

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

Exhibit G

BAV

Contractor Initials \_\_\_\_\_

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

10/21/2021



New Hampshire Department of Health and Human Services  
Exhibit G

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

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

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

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021

*Barbara A. Vance*

Date

Name: Barbara A. Vance  
Title: Vice President of Research Operations

Exhibit G

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

Contractor Initials BAV

Date 10/21/2021



New Hampshire Department of Health and Human Services  
Exhibit H

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

10/21/2021

*Barbara A. Vance*

Date

Name: Barbara A. Vance  
Title: Vice President of Research Operations



New Hampshire Department of Health and Human Services

Exhibit I

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

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) **Definitions.**

- a. "**Breach**" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.
- b. "**Business Associate**" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
- c. "**Covered Entity**" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
- d. "**Designated Record Set**" shall have the same meaning as the term "designated recordset" in 45 CFR Section 164.501.
- e. "**Data Aggregation**" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.
- f. "**Health Care Operations**" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.
- g. "**HITECH Act**" means the Health Information Technology for Economic and Clinical Health Act, Title XIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.
- h. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.
- i. "**Individual**" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).
- j. "**Privacy Rule**" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.
- k. "**Protected Health Information**" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.



New Hampshire Department of Health and Human Services

Exhibit I

- l. "Required by Law" shall have the same meaning as the term "required by law" in 45CFR Section 164.103.
- m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.
- n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.
- o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.
- p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH Act.

**(2) Business Associate Use and Disclosure of Protected Health Information.**

- a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
- b. Business Associate may use or disclose PHI:
  - I. For the proper management and administration of the Business Associate;
  - II. As required by law, pursuant to the terms set forth in paragraph d. below; or
  - III. For data aggregation purposes for the health care operations of Covered Entity.
- c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
- d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business



New Hampshire Department of Health and Human Services

Exhibit I

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

- e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

- a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.
- b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:
- o The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
  - o The unauthorized person used the protected health information or to whom the disclosure was made;
  - o Whether the protected health information was actually acquired or viewed
  - o The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

- c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.
- d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.
- e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI



New Hampshire Department of Health and Human Services

Exhibit I

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

- f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.
- g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.
- h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.
- i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.
- j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.
- k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.
- l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business



## New Hampshire Department of Health and Human Services

## Exhibit I

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

**(4) Obligations of Covered Entity**

- a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.
- b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.
- c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

**(5) Termination for Cause**

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

**(6) Miscellaneous**

- a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.
- b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.
- c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.
- d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

3/2014

Contractor Initials

BAL

10/21/2021  
Date \_\_\_\_\_



New Hampshire Department of Health and Human Services

Exhibit I

- e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.
- f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services

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The State  
DocuSigned by:  
*Katja S. Fox*  
ED9D05B04C63442...

---

Signature of Authorized Representative

Katja S. Fox

---

Name of Authorized Representative

Director

---

Title of Authorized Representative

10/26/2021

---

Date

Mary Hitchcock Memorial Hospital

---

Name of the Contractor

*Barbara A. Vance*

---

Signature of Authorized Representative

Barbara A. Vance

---

Name of Authorized Representative

Vice President of Research Operations

---

Title of Authorized Representative

10/21/2021

---

Date



New Hampshire Department of Health and Human Services  
Exhibit J

**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

10/21/2021

*Barbara A. Vance*

Date

Name: Barbara A. Vance  
Title: Vice President of Research Operations



New Hampshire Department of Health and Human Services  
Exhibit J

FORM A

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

1. The DUNS number for your entity is: 06-991-0297
2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) \$25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

X  NO                             YES

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

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

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

       NO                       X  YES

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

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

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

Name: _____	Amount: _____

New Hampshire Department of Health and Human Services  
DHHS Security Requirements  
Exhibit K



A. Definitions

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

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.
2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.
3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.
5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.
6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

**New Hampshire Department of Health and Human Services**  
**DHHS Security Requirements**  
Exhibit K



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storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic documents or mail.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.
8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.
9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.
10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.
11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.
12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

**I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR**

**A. Business Use and Disclosure of Confidential Information.**

1. The Contractor must not use, disclose, maintain or transmit Confidential Information

New Hampshire Department of Health and Human Services  
DHHS Security Requirements  
Exhibit K



except as required or permitted under this Contract or required by law. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.

## II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If Contractor is transmitting DHHS Data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. Contractor may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS Data.
3. Encrypted Email. Contractor may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If Contractor is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. Contractor may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. Contractor may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If Contractor is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. Contractor may not transmit Confidential Data via an open wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.
9. Remote User Communication. If Contractor is employing remote communication to

**New Hampshire Department of Health and Human Services**  
**DHHS Security Requirements**  
Exhibit K



access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.

10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If Contractor is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

**III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS**

The Contractor will only retain DHHS Data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

**A. Retention**

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS Confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, current, updated, and

**New Hampshire Department of Health and Human Services**  
**DHHS Security Requirements**  
Exhibit K



maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

**B. Disposition**

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

**IV. PROCEDURES FOR SECURITY**

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

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media

**New Hampshire Department of Health and Human Services**  
**DHHS Security Requirements**  
Exhibit K



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used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.
4. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will ensure End-User will maintain an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.
5. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.
6. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.
7. The Contractor will not store any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.
8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.
9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable

New Hampshire Department of Health and Human Services  
DHHS Security Requirements  
Exhibit K



health information and as applicable under State law.

10. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at <https://www.nh.gov/doi/vendor/index.htm> for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.
11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor must notify the DHHS Security Office and the Program Contact via the email addresses provided in Section VI of this Exhibit, immediately upon the Contractor determining that a breach or security incident has occurred and that DHHS confidential Information/data may have been exposed or compromised. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.
12. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.
13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

**V. LOSS REPORTING**

The Contractor must immediately notify the State’s Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches as specified in Section IV, paragraph 11 above.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS’s documented Incident Handling and Breach Notification procedures and in accordance with– the HIPAA, Privacy and Security Rules. In addition

New Hampshire Department of Health and Human Services  
DHHS Security Requirements  
Exhibit K



to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

**VI. PERSONS TO CONTACT**

- A. DHHS contact for Data Management or Data Exchange issues:  
DHHSInformationSecurityOffice@dhhs.nh.gov
- B. DHHS contacts for Privacy issues:  
DHHSPrivacyOfficer@dhhs.nh.gov
- C. DHHS contact for Information Security issues:  
DHHSInformationSecurityOffice@dhhs.nh.gov
- D. DHHS contact for Breach notifications:  
DHHSInformationSecurityOffice@dhhs.nh.gov  
DHHSPrivacyOfficer@dhhs.nh.gov
- E. DHHS Program Area Contact:  
Christine.Bean@dhhs.nh.gov

# State of New Hampshire

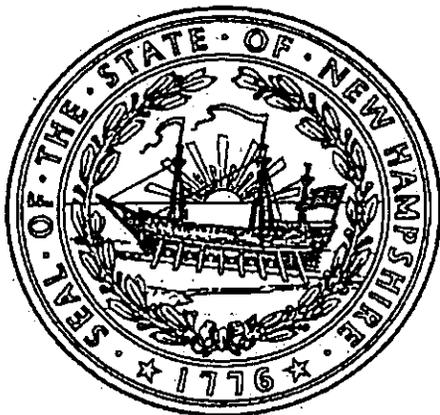
## Department of State

### CERTIFICATE

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

Business ID: 68517

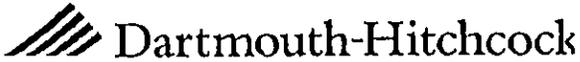
Certificate Number: 0005357410



IN TESTIMONY WHEREOF,  
I hereto set my hand and cause to be affixed  
the Seal of the State of New Hampshire,  
this 26th day of April A.D. 2021.

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

William M. Gardner  
Secretary of State



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

CERTIFICATE OF VOTE/AUTHORITY

I, Edward H. Stansfield, III, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

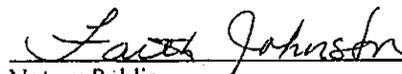
1. I am the duly elected Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital;
2. The following is a true and accurate excerpt from the December 7<sup>th</sup>, 2012 Bylaws of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital:  
**ARTICLE I – Section A. Fiduciary Duty. Stewardship over Corporate Assets**  
“In exercising this [fiduciary] duty, the Board may, consistent with the Corporation’s Articles of Agreement and these Bylaws, delegate authority to the Board of Governors, Board Committees and various officers the right to give input with respect to issues and strategies, incur indebtedness, make expenditures, enter into contracts and agreements and take such other binding actions on behalf of the Corporation as may be necessary or desirable.”
3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer, the Chief Clinical Officer, and other officers, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Edward J. Merrens, MD is the Chief Clinical Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 21 day of October, 2021

  
\_\_\_\_\_  
Edward H. Stansfield, III, Board Chair

STATE OF NH  
COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 21 day of October, 2021 by Edward H. Stansfield, III.

  
\_\_\_\_\_  
Notary Public  
My Commission Expires: 8/4/2026





**DELEGATION OF SIGNATURE AUTHORITY**

**RESEARCH CONTRACTS AND SPONSORED PROGRAM AGREEMENTS**

The authority to sign contracts, grants, consortia, center, cooperative and other research and sponsored program agreements ("Contracts") on behalf of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic (together, "Dartmouth-Hitchcock") is delegated by the Chief Executive Officer of Dartmouth-Hitchcock to the Executive Vice President of Research and Education (and, in her absence or unavailability, to another Chief Officer of Dartmouth-Hitchcock).

The authority to sign Contracts on behalf of Dartmouth-Hitchcock *which have a funding amount not to exceed \$3,000,000 and which have a term of less than five (5) years* is hereby sub-delegated by the Executive Vice President of Research and Education to the Vice President of Research Operations.

A Contract means an agreement between two or more persons that creates a legally binding obligation to do or not to do a particular thing. A Contract may be titled as an agreement, a memorandum of understanding, memorandum of agreement, a promise to pay, or may use other terminology. A Contract may or may not involve the payment of money.

Additional sub-delegation of signature authority may only be made upon written authorization of the Executive Vice President of Research and Education.

An individual with delegated/sub-delegated signature authority who signs a Contract on behalf of Dartmouth-Hitchcock has the responsibility to ensure that the Contract follows Dartmouth-Hitchcock policies, rules and guidelines and all applicable laws and regulations.

The effective date of this sub-delegation shall be the date executed by the Executive Vice President of Research and Education, as set forth below, and shall continue until revocation by the Executive Vice President of Research and Education.

A handwritten signature in black ink, appearing to read "Susan A. Reeves", written over a horizontal line.

Susan A. Reeves, EdD, RN  
Executive Vice President of Research and Education

Date: July 23, 2018

DATE: August 30, 2021

**CERTIFICATE OF INSURANCE****COMPANY AFFORDING COVERAGE**

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

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

**INSURED**

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

**COVERAGES**

The Policy listed below has been issued to the Named Insured above for the Policy Period notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued. The insurance afforded by the policy is subject to all the terms, exclusions and conditions of the policy. Limits shown may have been reduced by paid claims.

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002021-A	7/1/2021	7/1/2022	EACH OCCURRENCE	\$1,000,000
X CLAIMS MADE					DAMAGE TO RENTED PREMISES	\$1,000,000
					MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	\$1,000,000
					GENERAL AGGREGATE	
OTHER					PRODUCTS-COMP/OP AGG	\$1,000,000
PROFESSIONAL LIABILITY		0002021-A	07/01/2021	07/01/2022	EACH CLAIM	\$1,000,000
X CLAIMS MADE					ANNUAL AGGREGATE	\$3,000,000
OCCURENCE						
OTHER						

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

Certificate is issued as evidence of insurance.

**CERTIFICATE HOLDER**

NH Department of Health & Human Services  
129 Pleasant Street  
Concord, NH 03301

**CANCELLATION**

Should any of the above described policies be cancelled before the expiration date thereof, 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**





## Dartmouth-Hitchcock

Dartmouth-Hitchcock (D-H) is comprised of the Dartmouth-Hitchcock Medical Center and several clinics throughout New Hampshire and Vermont. Our physicians and researchers collaborate with Geisel School of Medicine scientists and faculty as well as other leading health care organizations to develop new treatments at the cutting edge of medical practice bringing the latest medical discoveries to the patient.

Dartmouth-Hitchcock includes:



### Dartmouth-Hitchcock Medical Center (DHMC)

DHMC is the state's only academic medical center, and the only Level I Adult and Pediatric Trauma Center in New Hampshire. The Dartmouth-Hitchcock Advanced Response Team (DHART), based in Lebanon and Manchester, provides ground and air medical transportation to communities throughout northern New England. DHMC was named in 2020 as the **#1** hospital in New Hampshire by U.S. News & World Report (<https://health.usnews.com/best-hospitals/area/nh>), and recognized for high performance in nine clinical specialties, procedures, and conditions.



### **The Dartmouth-Hitchcock Clinic**

The Dartmouth-Hitchcock Clinic is a network of primary and speciality care physicians located throughout New Hampshire and Vermont, with major community group practices in Lebanon, Concord, Manchester, Nashua, and Keene, NH, and Bennington, VT.



### **Mary Hitchcock Memorial Hospital**

Mary Hitchcock Memorial Hospital is New Hampshire's only teaching hospital, with an inpatient capacity of 396 beds.



### **Children's Hospital at Dartmouth-Hitchcock (CHaD)**

CHaD is New Hampshire's only children's hospital and a member of the Children's Hospital Association, providing advanced pediatric inpatient, outpatient and surgical services at DHMC in Lebanon as well as in Bedford, Concord, Manchester, Nashua, and Dover, NH.



## **Norris Cotton Cancer Center (NCCC)**

NCCC is a designated Comprehensive Cancer Center by the National Cancer Institute, and is one of the premier facilities for cancer treatment, research, prevention, and education. Interdisciplinary teams, devoted to the treatment of specific types of cancer, work together to care for patients of all ages in Lebanon, Manchester, Nashua, Keene, NH, and St. Johnsbury, VT.

## **Our mission, vision, and 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.

### **Our values**

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

## **Learn more about us**

- **Facts and Figures**
- **Community Outreach**
- **Collaborations**
- **Population Health**
- **Awards and Honors**
- **History**

# **Dartmouth-Hitchcock Health and Subsidiaries**

**Report on Federal Awards in Accordance With the  
Uniform Guidance**

**June 30, 2020**

**EIN #02-0222140**

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Index**  
**June 30, 2020**

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	Page(s)
<b>Part I - Financial Statements and Schedule of Expenditures of Federal Awards</b>	
Report of Independent Auditors .....	1-2
<b>Consolidated Financial Statements</b>	
Balance Sheets .....	3
Statements of Operations and Changes in Net Assets .....	4-5
Statements of Cash Flows .....	6
Notes to Financial Statements .....	7-48
Consolidating Supplemental Information .....	50-58
Schedule of Expenditures and Federal Awards .....	60
<b>Part II - Reports on Internal Control and Compliance</b>	
Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with <i>Government Auditing Standards</i> .....	69-70
Report of Independent Auditors on Compliance With Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance with the Uniform Guidance .....	71-72
<b>Part III - Findings and Questioned Costs</b>	
Schedule of Findings and Questioned Costs .....	74
Summary Schedule of Prior Audit Findings and Status .....	75

**Part I**

**Financial Statements and  
Schedule of Expenditures of Federal Awards**



## Report of Independent Auditors

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

### Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2020 and 2019, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended, and the related notes to the financial statements.

#### *Management's Responsibility for the Consolidated Financial Statements*

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

#### *Auditors' Responsibility*

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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



***Opinion***

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2020 and 2019, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

***Emphasis of Matter***

As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for leases and the presentation of net periodic pension costs in 2020. Our opinion is not modified with respect to these matters.

***Other Matter***

***Other Information***

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

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards for the year ended June 30, 2020 is presented for purposes of additional analysis as required by Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) and is not a required part of the consolidated financial statements. The information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the 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 schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.



***Other Reporting Required by Government Auditing Standards***

In accordance with *Government Auditing Standards*, we have also issued our report dated November 17, 2020 on our consideration of the Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters for the year ended June 30, 2020. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the effectiveness of internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control over financial reporting and compliance.

*Principatubous Cooper LLP*

Boston, Massachusetts  
November 17, 2020

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Balance Sheets**  
**June 30, 2020 and 2019**

<i>(in thousands of dollars)</i>	2020	2019
<b>Assets</b>		
<b>Current assets</b>		
Cash and cash equivalents	\$ 453,223	\$ 143,587
Patient accounts receivable (Note 4)	183,819	221,125
Prepaid expenses and other current assets	161,906	95,495
Total current assets	798,948	460,207
Assets limited as to use (Notes 5 and 7)	1,134,526	876,249
Other investments for restricted activities (Notes 5 and 7)	140,580	134,119
Property, plant, and equipment, net (Note 6)	643,586	621,256
Right of use assets, net (Note 16)	57,585	-
Other assets	137,338	124,471
Total assets	<u>\$ 2,912,563</u>	<u>\$ 2,216,302</u>
<b>Liabilities and Net Assets</b>		
<b>Current liabilities</b>		
Current portion of long-term debt (Note 10)	\$ 9,467	\$ 10,914
Current portion of right of use obligations (Note 16)	11,775	-
Current portion of liability for pension and other postretirement plan benefits (Note 11 and 14)	3,468	3,468
Accounts payable and accrued expenses	129,016	113,817
Accrued compensation and related benefits	142,991	128,408
Estimated third-party settlements (Note 4 and 17)	302,525	41,570
Total current liabilities	599,242	298,177
Long-term debt, excluding current portion (Note 10)	1,138,530	752,180
Long-term right of use obligations, excluding current portion (Note 16)	46,456	-
Insurance deposits and related liabilities (Note 12)	77,146	58,407
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11 and 14)	324,257	281,009
Other liabilities	143,678	124,136
Total liabilities	<u>2,329,309</u>	<u>1,513,909</u>
Commitments and contingencies (Notes 4, 6, 7, 10, 13, 16 and 17)		
<b>Net assets</b>		
Net assets without donor restrictions (Note 9)	431,026	559,933
Net assets with donor restrictions (Notes 8 and 9)	152,228	142,460
Total net assets	<u>583,254</u>	<u>702,393</u>
Total liabilities and net assets	<u>\$ 2,912,563</u>	<u>\$ 2,216,302</u>

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Operations and Changes in Net Assets**  
**Years Ended June 30, 2020 and 2019**

<i>(in thousands of dollars)</i>	<b>2020</b>	<b>2019</b>
<b>Operating revenue and other support</b>		
Patient service revenue (Note 4)	\$ 1,880,025	\$ 1,999,323
Contracted revenue	74,028	75,017
Other operating revenue (Note 5)	374,622	210,698
Net assets released from restrictions	16,260	14,105
Total operating revenue and other support	<u>2,344,935</u>	<u>2,299,143</u>
<b>Operating expenses</b>		
Salaries	1,144,823	1,062,551
Employee benefits	272,872	262,812
Medications and medical supplies	455,381	407,875
Purchased services and other	360,496	323,435
Medicaid enhancement tax (Note 4)	76,010	70,061
Depreciation and amortization	92,164	88,414
Interest (Note 10)	27,322	25,514
Total operating expenses	<u>2,429,068</u>	<u>2,240,662</u>
Operating (loss) income	<u>(84,133)</u>	<u>58,481</u>
<b>Non-operating gains (losses)</b>		
Investment income, net (Note 5)	27,047	40,052
Other components of net periodic pension and post retirement benefit income (Note 11)	10,810	11,221
Other losses, net (Note 10)	(2,707)	(3,562)
Loss on early extinguishment of debt	-	(87)
Total non-operating gains, net	<u>35,150</u>	<u>47,624</u>
(Deficiency) excess of revenue over expenses	<u>\$ (48,983)</u>	<u>\$ 106,105</u>

Consolidated Statements of Operations and Changes in Net Assets – Continues on Next Page

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Operations and Changes in Net Assets - Continued**  
**Years Ended June 30, 2020 and 2019**

<i>(in thousands of dollars)</i>	2020	2019
<b>Net assets without donor restrictions</b>		
(Deficiency) excess of revenue over expenses	\$ (48,983)	\$ 106,105
Net assets released from restrictions for capital	1,414	1,769
Change in funded status of pension and other postretirement benefits (Note 11)	(79,022)	(72,043)
Other changes in net assets	(2,316)	-
(Decrease) increase in net assets without donor restrictions	<u>(128,907)</u>	<u>35,831</u>
<b>Net assets with donor restrictions</b>		
Gifts, bequests, sponsored activities	26,312	17,436
Investment income, net	1,130	2,682
Net assets released from restrictions	(17,674)	(15,874)
Contribution of assets with donor restrictions from acquisition	-	383
Increase in net assets with donor restrictions	<u>9,768</u>	<u>4,627</u>
Change in net assets	(119,139)	40,458
<b>Net assets</b>		
Beginning of year	<u>702,393</u>	<u>661,935</u>
End of year	<u>\$ 583,254</u>	<u>\$ 702,393</u>

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

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Statements of Cash Flows

#### Years Ended June 30, 2020 and 2019

---

<i>(in thousands of dollars)</i>	2020	2019
<b>Cash flows from operating activities</b>		
Change in net assets	\$ (119,139)	\$ 40,458
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	93,857	88,770
Amortization of right of use asset	8,218	-
Payments on right of use lease obligations - operating	(7,941)	-
Change in funded status of pension and other postretirement benefits	79,022	72,043
Gain on disposal of fixed assets	(39)	(1,101)
Net realized gains and change in net unrealized gains on investments	(14,060)	(31,397)
Restricted contributions and investment earnings	(3,605)	(2,292)
Proceeds from sales of securities	-	1,167
Changes in assets and liabilities		
Patient accounts receivable	37,306	(1,803)
Prepaid expenses and other current assets	(78,907)	2,149
Other assets, net	(13,385)	(9,052)
Accounts payable and accrued expenses	9,772	17,898
Accrued compensation and related benefits	14,583	2,335
Estimated third-party settlements	260,955	429
Insurance deposits and related liabilities	18,739	2,378
Liability for pension and other postretirement benefits	(35,774)	(33,104)
Other liabilities	19,542	12,267
Net cash provided by operating and non-operating activities	<u>269,144</u>	<u>161,145</u>
<b>Cash flows from investing activities</b>		
Purchase of property, plant, and equipment	(128,019)	(82,279)
Proceeds from sale of property, plant, and equipment	2,987	2,188
Purchases of investments	(321,152)	(361,407)
Proceeds from maturities and sales of investments	82,986	219,996
Cash received through acquisition	-	4,863
Net cash used in investing activities	<u>(363,198)</u>	<u>(216,639)</u>
<b>Cash flows from financing activities</b>		
Proceeds from line of credit	35,000	30,000
Payments on line of credit	(35,000)	(30,000)
Repayment of long-term debt	(10,665)	(29,490)
Proceeds from issuance of debt	415,336	26,338
Repayment of finance lease	(2,429)	-
Payment of debt issuance costs	(2,157)	(228)
Restricted contributions and investment earnings	3,605	2,292
Net cash provided by (used in) financing activities	<u>403,690</u>	<u>(1,088)</u>
Increase (decrease) in cash and cash equivalents	309,636	(56,582)
<b>Cash and cash equivalents</b>		
Beginning of year	143,587	200,169
End of year	<u>\$ 453,223</u>	<u>\$ 143,587</u>
<b>Supplemental cash flow information</b>		
Interest paid	\$ 22,562	\$ 23,977
Net assets acquired as part of acquisition, net of cash acquired	-	(4,863)
Construction in progress included in accounts payable and accrued expenses	17,177	1,546
Donated securities	-	1,167

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

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

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

#### **June 30, 2020 and 2019**

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#### **1. Organization and Community Benefit Commitments**

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of the following entities: Dartmouth-Hitchcock Clinic and Subsidiaries (DHC), Mary Hitchcock Memorial Hospital and Subsidiaries (MHMH), (DHC and MHMH together are referred to as D-H), The New London Hospital Association and Subsidiaries (NLH), Windsor Hospital Corporation (d/b/a Mt. Ascutney Hospital and Health Center) and Subsidiaries (MAHHC), Cheshire Medical Center and Subsidiaries (Cheshire), Alice Peck Day Memorial Hospital and Subsidiary (APD), and the Visiting Nurse and Hospice for Vermont and New Hampshire and Subsidiaries (VNH). The "Health System" consists of D-HH, its members and their subsidiaries.

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

D-HH, Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, The New London Hospital Association, Cheshire Medical Center, and Alice Peck Day Memorial Hospital are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Windsor Hospital Corporation and the Visiting Nurse and Hospice for VT and NH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

On September 30, 2019, D-HH and GraniteOne Health ("GOH") entered into an agreement ("The Combination Agreement") to combine their respective healthcare systems. The GOH system is comprised of Catholic Medical Center ("CMC"), an acute care community hospital in Manchester, New Hampshire, Huggins Hospital ("HH") located in Wolfeboro, NH and Monadnock Community Hospital, ("MCH") located in Petersborough, NH. Both HH and MCH are designated as Critical Access Hospitals. The three member hospitals of GOH have a combined licensed bed count of 380 beds. GOH is a non-profit, community based health care system. The overarching rationale for the proposed combination is to improve access to high quality primary and specialty care in the most convenient, cost-effective sites of service for patients and the communities served by D-HH and GOH. Other stated benefits of the combination include reinforcing the rural health network, investing in needed capacity to accommodate unmet and anticipated demand, and drawing on our combined strengths to attract the necessary health care workforce. The parties have submitted regulatory filings with the Federal Trade Commission and the New Hampshire Attorney General's office seeking approval of the proposed transaction.

#### **Community Benefits**

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

Consistent with this mission, the Health System provides high quality, cost effective, comprehensive, and integrated healthcare to individuals, families, and the communities it serves regardless of a patient's ability to pay. The Health System actively supports community-based healthcare and promotes the coordination of services among healthcare providers and social services organizations. In addition, the Health System also seeks to work collaboratively with other

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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area healthcare providers to improve the health status of the region. As a component of an integrated academic medical center, the Health System provides significant support for academic and research programs.

Certain member hospitals of the Health System file annual Community Benefits Reports with the State of NH which outline the community and charitable benefits each provides. VT hospitals are not required by law to file a state community benefit report. The categories used in the Community Benefit Reports to summarize these benefits are as follows:

- *Community Health Services* include activities carried out to improve community health and could include community health education (such as classes, programs, support groups, and materials that promote wellness and prevent illness), community-based clinical services (such as free clinics and health screenings), and healthcare support services (enrollment assistance in public programs, assistance in obtaining free or reduced costs medications, telephone information services, or transportation programs to enhance access to care, etc.).
- *Health Professions Education* includes uncompensated costs of training medical students, Residents, nurses, and other health care professionals
- *Subsidized health services* are services provided by the Health System, resulting in financial losses that meet the needs of the community and would not otherwise be available unless the responsibility was assumed by the government.
- *Research support and other grants* represent costs in excess of awards for numerous health research and service initiatives awarded to the organizations within the Health System.
- *Financial Contributions* include financial contributions of cash, as well as in-kind contributions such as time, supplies, and expertise to local organizations to address community health needs.
- *Community-Building Activities* include expenses incurred to support the development of programs and partnerships intended to address public health challenges as well as social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement.
- *Community Benefit Operations* includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.
- *Charity Care and Costs of Government Sponsored Health Care* includes losses, at-cost, incurred by providing health care services to persons qualifying for hospital financial assistance programs, and uncompensated costs of providing health care services to patients who are Medicaid Beneficiaries.
- *The uncompensated cost of care for Medicaid patients* reported in the unaudited Community Benefits Reports for 2019 was approximately \$143,013,000. The 2020 Community Benefits Reports are expected to be filed in February 2021.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

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The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2019:

*(in thousands of dollars)*

Government-sponsored healthcare services	\$ 291,013
Health professional education	40,621
Charity care	15,281
Subsidized health services	15,165
Community health services	6,895
Research	5,238
Community building activities	3,777
Financial contributions	1,597
Community benefit operations	<u>1,219</u>
Total community benefit value	<u>\$ 380,806</u>

In fiscal years 2020 and 2019, funds received to offset or subsidize charity care costs provided were \$1,224,000 and \$487,000, respectively.

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

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

### **June 30, 2020 and 2019**

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## **2. Summary of Significant Accounting Policies**

### **Basis of Presentation**

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America, and have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 954, *Healthcare Entities*, which addresses the accounting for healthcare entities. The net assets, revenue, expenses, and gains and losses of healthcare entities are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets without donor restrictions are amounts not subject to donor-imposed stipulations and are available for operations. Net assets with donor restrictions are those whose use has been limited by donors to a specific time period or purpose, or whose use has been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

### **Use of Estimates**

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

### **(Deficiency) Excess of Revenue over Expenses**

The consolidated statements of operations and changes in net assets include the (deficiency) excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on investments of net assets without donor restrictions, which are utilized to provide charity and other operational support. Peripheral activities, including contribution of net assets without donor restrictions from acquisitions, loss on early extinguishment of debt, realized gains/losses on sales of investment securities and changes in unrealized gains/losses on investments are reported as non-operating gains (losses).

Changes in net assets without donor restrictions which are excluded from the (deficiency) excess of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets, and change in funded status of pension and other postretirement benefit plans).

### **Charity Care**

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

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

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

#### **June 30, 2020 and 2019**

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The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. The amount of charges for implicit price concessions is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 1 and 4).

#### **Patient Service Revenue**

The Health System applies the accounting provisions of ASC 606, *Revenue from Contracts with Customers* (ASC 606). Patient service revenue is reported at the amount of consideration to which the Health System expects to be entitled from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and implicit pricing concessions. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as estimates change or final settlements are determined (Note 4).

#### **Contracted Revenue**

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

#### **Other Revenue**

The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes the Department of Health and Human Services ("HHS") Coronavirus Aid, Relief, and Economic Securities Act ("CARES Act" Provider Relief Funds ("Provider Relief Funds") operating agreements, grant revenue, cafeteria sales and other support service revenue.

#### **Cash Equivalents**

Cash and cash equivalents include amounts on deposit with financial institutions; short-term investments with maturities of three months or less at the time of purchase and other highly liquid investments, primarily cash management funds. Short-term highly liquid investments held within the endowment and similar investment pools are classified as investments rather than cash equivalents and restricted cash is defined as that which is legally restricted to withdrawal and usage.

#### **Investments and Investment Income**

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

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the (deficiency) excess of revenues over expenses. All investments, whether

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

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

#### **June 30, 2020 and 2019**

---

held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a non-distressed basis.

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

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

#### **Fair Value Measurement of Financial Instruments**

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

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

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

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

#### **Property, Plant, and Equipment**

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

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

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

#### **June 30, 2020 and 2019**

---

leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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

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

#### **Bond Issuance Costs**

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

#### **Intangible Assets and Goodwill**

The Health System records within other assets on the consolidated balance sheets goodwill and intangible assets such as trade names and leases-in-place. The Health System considers trade names and goodwill to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded \$10,007,000 and \$10,524,000 as intangible assets associated with its affiliations as of June 30, 2020 and 2019, respectively.

#### **Gifts**

Gifts without donor restrictions are recorded net of related expenses as non-operating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair value at the date the gift is received. Gifts are reported with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

---

#### Recently Issued Accounting Pronouncements

In January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which addresses certain aspects of recognition, measurement, presentation and disclosure of financial instruments. This guidance allows an entity to choose, investment-by-investment, to report an equity investment that neither has a readily determinable fair value, nor qualifies for the practical expedient for fair value estimation using NAV, at its cost minus impairment (if any), plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issue. Impairment of such investments must be assessed qualitatively at each reporting period. Entities must disclose their financial assets and liabilities by measurement category and form of asset either on the face of the balance sheet or in the accompanying notes. The ASU is effective for annual reporting periods beginning after December 15, 2018 or fiscal year 2020 for the Health System. The provision to eliminate the requirement to disclose the fair value of financial instruments measured at cost (such as the fair value of debt) was early adopted during the year ended June 30, 2017. The standard has been adopted during the current fiscal year and no material impact was noted.

In February 2016, the FASB issued ASU 2016-02 – *Leases (Topic 842)*. Under the new guidance, lessees are required to recognize the following for all leases (with the exception of leases with a term of twelve months or less) at the commencement date: (a) a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis; and (b) a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. Leases are classified as either operating or finance. Operating leases result in straight-line expense in the statement of operations (similar to previous operating leases), while finance leases result in more expense being recognized in the earlier years of the lease term (similar to previous capital leases). The Health System adopted the new standard on July 1, 2019 using the modified retrospective approach. The Health System elected the transition method that allows for the application of the standard at the adoption date rather than at the beginning of the earliest comparative period presented in the consolidated financial statements. The Health System also elected available practical expedients (Note 16).

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. Under the new standard, the service cost component of the net benefit cost will be included within income from operations as a component of benefits expenses and the other components of net benefit cost as defined by ASC 715 will be reported in non-operating activities within the consolidated statements of operations and changes in net assets. The standard also prohibits reporting of the other components of net benefit cost in the same line as other pension related changes on the statements of operations and changes in net assets. ASU 2017-07 is effective for the fiscal year ended June 30, 2020 and is applied on a retrospective basis.

#### Reclassifications

As a result of adopting the provisions of ASU 2017-07, the Health System reclassified \$11,221,000 from benefits expense to non-operating activities within the consolidated statements of operations and changes in net assets for the fiscal year ended June 30, 2019. The amount included in non-operating activities for the fiscal year ending June 30, 2020 was \$10,810,000.

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

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

#### **June 30, 2020 and 2019**

---

### **3. Acquisition**

Effective July 1, 2018, Alice Peck Day Memorial Hospital became the sole corporate member of APD LifeCare Center Inc. (LifeCare). LifeCare owns and operates Harvest Hill, an assisted living facility, the Woodlands, a residential living community and the Elizabeth S. Hughes Care Unit, which provides hospice care.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, Alice Peck Day Memorial Hospital recorded goodwill related to the acquisition of LifeCare of approximately \$5,131,000. Restricted contribution income of \$383,000 was recorded within net assets with donor restrictions in the accompanying consolidated statement of changes in net assets. Included in the transaction was LifeCare's cash balance of \$4,863,000. No consideration was exchanged for the net assets assumed and acquisition costs were expensed as incurred.

### **4. Patient Service Revenue and Accounts Receivable**

The Health System reports patient service revenue at amounts that reflect the consideration to which it expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payers (including managed care payers and government programs), and others; and they include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Health System bills patients and third-party payers several days after the services were performed or shortly after discharge. Revenue is recognized as performance obligations are satisfied under contracts by providing healthcare services to patients.

The Health System determines performance obligations based on the nature of the services provided. Revenues for performance obligations satisfied over time are recognized based on actual charges incurred in relation to total expected charges as this method provides a reasonable estimate of the transfer of services over the term of performance obligations based on inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services. For inpatient services, performance obligations are measured from admission to the point when there are no further services required for the patient, which is generally the time of discharge. For outpatient services and physician services, performance obligations are recognized at a point in time when the services are provided and no further patient services are deemed necessary.

Generally, the Health System's patient service performance obligations relate to contracts with a duration of less than one year, therefore the Health System has elected to apply the optional exemption provided in ASC 606-10-50-14a and, therefore, we are not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. This generally refers to inpatient services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Established charges represent gross charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately entitled to for services it provides. Therefore, they are not displayed in the Health System's consolidated statements of operations and changes in net assets.

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

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

#### **June 30, 2020 and 2019**

---

Hospitals are paid amounts negotiated with insurance companies or set by government entities, which are typically less than established or standard charges. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts. Gross charges are what hospitals charge all patients prior to the application of contractual adjustments and implicit price concessions.

#### **Explicit Pricing Concessions**

Revenues for the Health System under the traditional fee-for service Medicare and Medicaid programs are based on prospectively determined rates per discharge or visit, reasonable (allowable) cost, or prospective rates per episodic period, depending on the type of provider.

- Inpatient acute care services provided to Medicare program beneficiaries are paid using the prospective payment system ("PPS") to determine rates-per-discharge. These rates vary according to a patient classification system ("DRG"), based on diagnostic, clinical and other factors. In addition, inpatient capital costs (depreciation and interest) are reimbursed by Medicare on the basis of a prospectively determined rate per discharge. Medicare outpatient services are paid on a prospective payment system, based on a pre-determined amount for each outpatient procedure (APC), subject to various mandated modifications. Retrospectively determined cost-based revenues under these programs, such as indirect medical education, direct graduate medical education, disproportionate share hospital, transplant services, and bad debt reimbursement are based on the hospital's cost reports and are estimated using historical trends and current factors. The Health System's payments for inpatient services rendered to New Hampshire ("NH") and Vermont ("VT") Medicaid beneficiaries are based on PPS, while outpatient services are reimbursed on a retrospective cost basis or fee schedules for NH beneficiaries. VT outpatient beneficiaries are paid on a prospective basis per outpatient procedure.
- Inpatient acute, swing, and outpatient services furnished by critical access hospitals ("CAH") are reimbursed by Medicare at 101% of reasonable costs, subject to 2% sequestration, excluding ambulance services and inpatient hospice care.
- Providers of home health services to patients eligible for Medicare home health benefits are paid on a prospective basis, with no retrospective settlement. The prospective payment is based on the scoring attributed to the acuity level of the patient at a rate determined by federal guidelines.
- Hospice services to patients eligible for Medicare hospice benefits are paid on a per diem basis, with no retrospective settlement, provided the aggregate annual Medicare reimbursement is below a predetermined aggregate capitated rate.
- The Health System's cost based services to Medicare and Medicaid are reimbursed during the year based on varying interim payment methodologies. Final settlement is determined after the submission of an annual cost report and subject to audit of this report by Medicare and Medicaid auditors, as well as administrative and judicial review. Because the laws, regulations, and rule interpretations, governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change over time by material amounts.
- Revenues under Managed Care Plans (Plans) consist primarily of payment terms involving mutually agreed upon rates per diagnosis, discounted fee-for service rates, or similar contractual arrangements. These revenues are also subject to review and possible audit.

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

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

#### **June 30, 2020 and 2019**

---

The Plans are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustments in accordance with contractual terms in place with the Plans following their review and adjudication of each bill.

The Health System is not aware of any claims, disputes, or unsettled matters with any payer that would materially affect its revenues for which it has not adequately provided in the accompanying Health System's consolidated financial statements.

The Health System provides charity care to patients who are unable to pay for healthcare services they receive as determined by financial conditions. Patients who qualify receive partial or full adjustments to charges for services rendered. The Health System's policy is to treat amounts qualified as charity care as explicit price concessions and as such are not reported in net patient service revenue.

Vermont imposes a provider tax on home health agencies in the amount of 4.25% of annual net patient revenue. In fiscal years 2020 and 2019, home health provider taxes paid were \$624,000 and \$628,000, respectively.

#### **Medicaid Enhancement Tax & Disproportionate Share Hospital**

On May 22, 2018, the State of New Hampshire and all New Hampshire hospitals (Hospitals) agreed to resolve disputed issues and enter into a seven-year agreement to stabilize Disproportionate Share Hospital (DSH) payments, with provisions for alternative payments in the event of legislative changes to the DSH program. Under the agreement, the State committed to make DSH payments to the Hospitals in an amount no less than 86% of the Medicaid Enhancement Tax (MET) proceeds collected in each fiscal year, in addition to providing for directed payments or increased rates for Hospitals in an amount equal to 5% of MET proceeds collected from state fiscal year (SFY) 2020 through SFY 2024. The agreement prioritizes DSH payments to critical access hospitals in an amount equal to 75% of allowable uncompensated care (UCC), with the remainder distributed to Hospitals without critical access designation in proportion to their allowable UCC amounts.

During the years ended June 30, 2020 and 2019, the Health System received DSH payments of approximately, \$71,133,000 and \$69,179,000 respectively. DSH payments are subject to audit and therefore, for the years ended June 30, 2020 and 2019, the Health System recognized as revenue DSH receipts of approximately \$67,500,000 and approximately \$64,864,000, respectively.

During the years ended June 30, 2020 and 2019, the Health System recorded State of NH MET and State of VT Provider taxes of \$76,010,000 and \$70,061,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain patient service revenues. The Provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

#### **Implicit Price Concessions**

Generally, patients who are covered by third-party payer contracts are responsible for related co-pays, co-insurance and deductibles, which vary depending on the contractual obligations of patients. The Health System also provides services to uninsured patients and offers those patients a discount from standard charges. The Health System estimates the transaction price for patients with co-pays, co-insurance, and deductibles and for those who are uninsured based on historical collection experience and current market conditions. The discount offered to uninsured patients reduces the transaction price at the time of billing. The uninsured and patient responsible

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

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

### **June 30, 2020 and 2019**

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accounts, net of discounts recorded, are further reduced through implicit price concessions based on historical collection trends for similar accounts and other known factors that impact the estimation process. Subsequent changes to the estimate of transaction price are generally recorded as adjustments to net patient services revenue in the period of change.

The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Health System expects to collect based on collection history with similar patients. Although outcomes vary, the Health System's policy is to attempt to collect amounts due from patients, including co-pays, co-insurance and deductibles due from insurance at the time of service while complying with all federal and state statutes and regulations, including but not limited to, the Emergency Medical Treatment and Active Labor Act (EMTALA). Through various systems and processes the Health System estimates Medicare and Medicaid net patient service revenue and cost report settlements and accrues final expected settlements. For filed cost reports, the accrual is recorded based on those filings, subsequent activity, and on historical trends and other relevant evidence. For periods in which a cost report is yet to be filed, accruals are based on estimates of what is expected to be reported, and any trends and relevant evidence. Cost reports generally must be filed within five months of the closing period.

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely amount. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and historical settlement activity, including assessments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews or investigations. As of June 30, 2020 and 2019, the Health System had reserves of \$302,525,000 and \$41,570,000, respectively, recorded in Estimated third-party settlements. Included in the 2020 Estimated third party settlements is \$239,500,000 of Medicare accelerated and advanced payments, received as working capital support during the novel coronavirus ("COVID-19") outbreak at June 30, 2020. In addition, \$10,900,000 has been recorded in Other liabilities as of June 30, 2020 and 2019, respectively.

For the years ended June 30, 2020 and 2019, additional increases in revenue of \$2,314,000 and \$1,800,000, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

Net operating revenues for the hospital operations of the PPS and CAH, and other business segments consist primarily of patient service revenues, principally for patients covered by Medicare, Medicaid, managed care and other health plans as well as patients covered under the Health System's uninsured discount and charity care programs.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

The table below shows the Health System's sources of net operating revenues presented at the net transaction price for the years ended June 30, 2020 and 2019.

<i>(in thousands of dollars)</i>	<b>2020</b>		
	<b>PPS</b>	<b>CAH</b>	<b>Total</b>
<b>Hospital</b>			
Medicare	\$ 461,990	\$ 64,087	\$ 526,077
Medicaid	130,901	10,636	141,537
Commercial	718,576	60,715	779,291
Self Pay	2,962	2,501	5,463
Subtotal	<u>1,314,429</u>	<u>137,939</u>	<u>1,452,368</u>
<b>Professional</b>			
Professional	383,503	22,848	406,351
VNA	-	-	21,306
Other Revenue	-	-	376,185
Provider Relief Fund	-	-	88,725
Total operating revenue and other support	<u>\$ 1,697,932</u>	<u>\$ 160,787</u>	<u>\$ 2,344,935</u>

<i>(in thousands of dollars)</i>	<b>2019</b>		
	<b>PPS</b>	<b>CAH</b>	<b>Total</b>
<b>Hospital</b>			
Medicare	\$ 456,197	\$ 72,193	\$ 528,390
Medicaid	134,727	12,794	147,521
Commercial	746,647	64,981	811,628
Self Pay	8,811	2,313	11,124
Subtotal	<u>1,346,382</u>	<u>152,281</u>	<u>1,498,663</u>
<b>Professional</b>			
Professional	454,425	23,707	478,132
VNA	-	-	22,528
Other Revenue	-	-	299,820
Total operating revenue and other support	<u>\$ 1,800,807</u>	<u>\$ 175,988</u>	<u>\$ 2,299,143</u>

#### Accounts Receivable

The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2020 and 2019:

	<b>2020</b>	<b>2019</b>
Medicare	36%	34%
Medicaid	13%	12%
Commercial	39%	41%
Self Pay	12%	13%
Patient accounts receivable	<u>100%</u>	<u>100%</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

**5. Investments**

The composition of investments at June 30, 2020 and 2019 is set forth in the following table:

<i>(in thousands of dollars)</i>	<b>2020</b>	<b>2019</b>
<b>Assets limited as to use</b>		
Internally designated by board		
Cash and short-term investments	\$ 9,646	\$ 21,890
U.S. government securities	103,977	91,492
Domestic corporate debt securities	199,462	196,132
Global debt securities	70,145	83,580
Domestic equities	203,010	167,384
International equities	123,205	128,909
Emerging markets equities	22,879	23,086
Real Estate Investment Trust	313	213
Private equity funds	74,131	64,563
Hedge funds	36,964	32,287
	<u>843,732</u>	<u>809,536</u>
<b>Investments held by captive insurance companies (Note 12)</b>		
U.S. government securities	15,402	23,241
Domestic corporate debt securities	8,651	11,378
Global debt securities	8,166	10,080
Domestic equities	15,150	14,617
International equities	7,227	6,766
	<u>54,596</u>	<u>66,082</u>
<b>Held by trustee under indenture agreement (Note 10)</b>		
Cash and short-term investments	236,198	631
Total assets limited as to use	<u>1,134,526</u>	<u>876,249</u>
<b>Other investments for restricted activities</b>		
Cash and short-term investments	7,186	6,113
U.S. government securities	28,055	32,479
Domestic corporate debt securities	35,440	29,089
Global debt securities	11,476	11,263
Domestic equities	26,723	20,981
International equities	15,402	15,531
Emerging markets equities	2,766	2,578
Private equity funds	9,483	7,638
Hedge funds	4,013	8,414
Other	36	33
Total other investments for restricted activities	<u>140,580</u>	<u>134,119</u>
Total investments	<u>\$ 1,275,106</u>	<u>\$ 1,010,368</u>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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

The following tables summarize the investments by the accounting method utilized, as of June 30, 2020 and 2019. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

<i>(in thousands of dollars)</i>	2020		
	Fair Value	Equity	Total
Cash and short-term investments	\$ 253,030	\$ -	\$ 253,030
U.S. government securities	147,434	-	147,434
Domestic corporate debt securities	198,411	45,142	243,553
Global debt securities	44,255	45,532	89,787
Domestic equities	195,014	49,869	244,883
International equities	77,481	68,353	145,834
Emerging markets equities	1,257	24,388	25,645
Real Estate Investment Trust	313	-	313
Private equity funds	-	83,614	83,614
Hedge funds	-	40,977	40,977
Other	36	-	36
	\$ 917,231	\$ 357,875	\$ 1,275,106

<i>(in thousands of dollars)</i>	2019		
	Fair Value	Equity	Total
Cash and short-term investments	\$ 28,634	\$ -	\$ 28,634
U.S. government securities	147,212	-	147,212
Domestic corporate debt securities	164,996	71,603	236,599
Global debt securities	55,520	49,403	104,923
Domestic equities	178,720	24,262	202,982
International equities	76,328	74,878	151,206
Emerging markets equities	1,295	24,369	25,664
Real Estate Investment Trust	213	-	213
Private equity funds	-	72,201	72,201
Hedge funds	-	40,701	40,701
Other	33	-	33
	\$ 652,951	\$ 357,417	\$ 1,010,368

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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For the years ended June 30, 2020 and 2019 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as other operating revenue of approximately \$936,000 and \$983,000 and as non-operating gains of approximately \$27,047,000 and \$40,052,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2020 and 2019, the Health System has committed to contribute approximately \$172,819,000 and \$164,319,000 to such funds, of which the Health System has contributed approximately \$119,142,000 and \$109,584,000 and has outstanding commitments of \$53,677,000 and \$54,735,000, respectively.

#### 6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	2020	2019
Land	\$ 40,749	\$ 38,232
Land improvements	39,820	42,607
Buildings and improvements	893,081	898,050
Equipment	927,233	888,138
Equipment under capital leases	-	15,809
	<u>1,900,883</u>	<u>1,882,836</u>
Less: Accumulated depreciation and amortization	1,356,521	1,276,746
Total depreciable assets, net	544,362	606,090
Construction in progress	99,224	15,166
	<u>\$ 643,586</u>	<u>\$ 621,256</u>

As of June 30, 2020, construction in progress primarily consists of two projects. The first project, started in fiscal 2019, consists of the addition of the ambulatory surgical center (ASC) located in Manchester, NH. The estimated cost to complete the project is \$42 million. The anticipated completion date is the second quarter of fiscal 2021. The second project, involves the addition of the in-patient tower located in Lebanon, NH. The estimated cost to complete the tower project is \$140 million over the next three fiscal years.

The construction in progress as of June 30, 2019, included both the ASC, as well as renovations taking place at the various pharmacy locations to bring their facilities compliant with Regulation USP800. The pharmacy upgrade was completed during the first quarter of fiscal year 2021. Capitalized interest of \$2,297,000 and \$0 is included in Construction in progress as of June 30, 2020 and 2019, respectively.

Depreciation and amortization expense included in operating and non-operating activities was approximately \$92,217,000 and \$88,496,000 for 2020 and 2019, respectively.

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

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

#### **June 30, 2020 and 2019**

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#### **7. Fair Value Measurements**

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

##### **Cash and Short-Term Investments**

Consists of money market funds and are valued at net asset value (NAV) reported by the financial institution.

##### **Domestic, Emerging Markets and International Equities**

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

##### **U.S. Government Securities, Domestic Corporate and Global Debt Securities**

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

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2020 and 2019:

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

		2020				Redemption	Days'
<i>(in thousands of dollars)</i>		Level 1	Level 2	Level 3	Total	or Liquidation	Notice
<b>Assets</b>							
<b>Investments</b>							
Cash and short term investments	\$	253,030	\$ -	\$ -	\$ 253,030	Daily	1
U.S. government securities		147,434	-	-	147,434	Daily	1
Domestic corporate debt securities		17,577	180,834	-	198,411	Daily-Monthly	1-15
Global debt securities		22,797	21,458	-	44,255	Daily-Monthly	1-15
Domestic equities		187,354	7,660	-	195,014	Daily-Monthly	1-10
International equities		77,481	-	-	77,481	Daily-Monthly	1-11
Emerging market equities		1,257	-	-	1,257	Daily-Monthly	1-7
Real estate investment trust		313	-	-	313	Daily-Monthly	1-7
Other		2	34	-	36	Not applicable	Not applicable
Total Investments		<u>707,245</u>	<u>209,986</u>	<u>-</u>	<u>917,231</u>		
<b>Deferred compensation plan assets</b>							
Cash and short-term investments		5,754	-	-	5,754		
U.S. government securities		51	-	-	51		
Domestic corporate debt securities		7,194	-	-	7,194		
Global debt securities		1,270	-	-	1,270		
Domestic equities		24,043	-	-	24,043		
International equities		3,571	-	-	3,571		
Emerging market equities		27	-	-	27		
Real estate		11	-	-	11		
Multi strategy fund		51,904	-	-	51,904		
Guaranteed contract		-	-	92	92		
Total deferred compensation plan assets		<u>93,825</u>	<u>-</u>	<u>92</u>	<u>93,917</u>	Not applicable	Not applicable
Beneficial interest in trusts		-	-	9,202	9,202	Not applicable	Not applicable
Total assets	\$	<u>\$ 801,070</u>	<u>\$ 209,986</u>	<u>\$ 9,294</u>	<u>\$ 1,020,350</u>		

		2019				Redemption	Days'
<i>(in thousands of dollars)</i>		Level 1	Level 2	Level 3	Total	or Liquidation	Notice
<b>Assets</b>							
<b>Investments</b>							
Cash and short term investments	\$	28,634	\$ -	\$ -	\$ 28,634	Daily	1
U.S. government securities		147,212	-	-	147,212	Daily	1
Domestic corporate debt securities		34,723	130,273	-	164,996	Daily-Monthly	1-15
Global debt securities		28,412	27,108	-	55,520	Daily-Monthly	1-15
Domestic equities		171,318	7,402	-	178,720	Daily-Monthly	1-10
International equities		76,295	33	-	76,328	Daily-Monthly	1-11
Emerging market equities		1,295	-	-	1,295	Daily-Monthly	1-7
Real estate investment trust		213	-	-	213	Daily-Monthly	1-7
Other		-	33	-	33	Not applicable	Not applicable
Total investments		<u>488,102</u>	<u>164,849</u>	<u>-</u>	<u>652,951</u>		
<b>Deferred compensation plan assets</b>							
Cash and short-term investments		2,952	-	-	2,952		
U.S. government securities		45	-	-	45		
Domestic corporate debt securities		4,932	-	-	4,932		
Global debt securities		1,300	-	-	1,300		
Domestic equities		22,403	-	-	22,403		
International equities		3,576	-	-	3,576		
Emerging market equities		27	-	-	27		
Real estate		11	-	-	11		
Multi strategy fund		48,941	-	-	48,941		
Guaranteed contract		-	-	89	89		
Total deferred compensation plan assets		<u>84,187</u>	<u>-</u>	<u>89</u>	<u>84,276</u>	Not applicable	Not applicable
Beneficial interest in trusts		-	-	9,301	9,301	Not applicable	Not applicable
Total assets	\$	<u>\$ 572,289</u>	<u>\$ 164,849</u>	<u>\$ 9,390</u>	<u>\$ 746,528</u>		

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

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

<i>(in thousands of dollars)</i>	<b>2020</b>		
	<b>Beneficial Interest in Perpetual Trust</b>	<b>Guaranteed Contract</b>	<b>Total</b>
<b>Balances at beginning of year</b>	\$ 9,301	\$ 89	\$ 9,390
Net unrealized (losses) gains	(99)	3	(96)
<b>Balances at end of year</b>	<b>\$ 9,202</b>	<b>\$ 92</b>	<b>\$ 9,294</b>

<i>(in thousands of dollars)</i>	<b>2019</b>		
	<b>Beneficial Interest in Perpetual Trust</b>	<b>Guaranteed Contract</b>	<b>Total</b>
<b>Balances at beginning of year</b>	\$ 9,374	\$ 86	\$ 9,460
Net unrealized (losses) gains	(73)	3	(70)
<b>Balances at end of year</b>	<b>\$ 9,301</b>	<b>\$ 89</b>	<b>\$ 9,390</b>

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2020 and 2019.

**8. Net Assets with Donor Restrictions**

Net assets with donor restrictions are available for the following purposes at June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	<b>2020</b>	<b>2019</b>
Investments held in perpetuity	\$ 59,352	\$ 56,383
Healthcare services	33,976	20,140
Research	22,116	26,496
Health education	16,849	19,833
Charity care	12,366	12,494
Other	4,488	3,841
Purchase of equipment	3,081	3,273
	<b>\$ 152,228</b>	<b>\$ 142,460</b>

Income earned on donor restricted net assets held in perpetuity is available for these purposes.

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

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

#### **June 30, 2020 and 2019**

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#### **9. Board Designated and Endowment Funds**

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

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

Net assets without donor restrictions include funds designated by the Board of Trustees to function as endowments, the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Net assets with donor restrictions that are temporary in nature, either restricted by time or purpose, include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the restrictions on these funds have been met, the funds are reclassified to net assets without donor restrictions.

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

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

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2020 and 2019.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

---

Endowment net asset composition by type of fund consists of the following at June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	2020		
	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	\$ -	\$ 80,039	\$ 80,039
Board-designated endowment funds	33,714	-	33,714
Total endowed net assets	\$ 33,714	\$ 80,039	\$ 113,753

<i>(in thousands of dollars)</i>	2019		
	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	\$ -	\$ 78,268	\$ 78,268
Board-designated endowment funds	31,421	-	31,421
Total endowed net assets	\$ 31,421	\$ 78,268	\$ 109,689

Changes in endowment net assets for the years ended June 30, 2020 and 2019 are as follows:

<i>(in thousands of dollars)</i>	2020		
	Without Donor Restrictions	With Donor Restrictions	Total
<b>Balances at beginning of year</b>	\$ 31,421	\$ 78,268	\$ 109,689
Net investment return	713	1,460	2,173
Contributions	890	2,990	3,880
Transfers	14	267	281
Release of appropriated funds	676	(2,946)	(2,270)
<b>Balances at end of year</b>	\$ 33,714	\$ 80,039	\$ 113,753
<b>Balances at end of year</b>		80,039	
Beneficial interest in perpetual trusts		6,782	
Net assets with donor restrictions		\$ 86,821	

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

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<i>(in thousands of dollars)</i>	<b>2019</b>		
	<b>Without Donor Restrictions</b>	<b>With Donor Restrictions</b>	<b>Total</b>
<b>Balances at beginning of year</b>	\$ 29,506	\$ 78,197	\$ 107,703
Net investment return	1,184	2,491	3,675
Contributions	804	1,222	2,026
Transfers	(73)	(1,287)	(1,360)
Release of appropriated funds	-	(2,355)	(2,355)
<b>Balances at end of year</b>	<b>\$ 31,421</b>	<b>\$ 78,268</b>	<b>\$ 109,689</b>
<b>Balances at end of year</b>		78,268	
Beneficial interest in perpetual trusts		8,422	
Net assets with donor restrictions		<u>\$ 86,690</u>	

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

**10. Long-Term Debt**

A summary of long-term debt at June 30, 2020 and 2019 is as follows:

<i>(in thousands of dollars)</i>	2020	2019
<b>Variable rate issues</b>		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	\$ 83,355	\$ 83,355
<b>Fixed rate issues</b>		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2020A, principal maturing in varying annual amounts, through August 2059 (2)	125,000	-
Series 2017A, principal maturing in varying annual amounts, through August 2040 (3)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (3)	109,800	109,800
Series 2019A, principal maturing in varying annual amounts, through August 2043 (4)	99,165	-
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	25,160	25,865
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	24,315	25,145
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	19,765	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (7)	14,530	14,530
Series 2016B, principal maturing in varying annual amounts, through August 2045 (8)	10,970	10,970
<b>Note payable</b>		
Note payable to a financial institution due in monthly interest only payments through May 2023 (9)	125,000	-
Total obligated group debt	<u>\$ 1,062,597</u>	<u>\$ 722,162</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

A summary of long-term debt at June 30, 2020 and 2019 is as follows (continued):

<i>(in thousands of dollars)</i>	2020	2019
<b>Other</b>		
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	\$ 287	\$ 445
Note payable to a financial institution with entire principal due June 2029 that is collateralized by land and building. The note payable is interest free	273	323
Mortgage note payable to the US Dept of Agriculture; monthly payments of \$10,892 include interest of 2.375% through November 2046	2,560	2,629
Obligations under capital leases	-	17,526
Total nonobligated group debt	<u>3,120</u>	<u>20,923</u>
Total obligated group debt	<u>1,062,597</u>	<u>722,162</u>
Total long-term debt	<u>1,065,717</u>	<u>743,085</u>
 Add: Original issue premium and discounts, net	 89,542	 25,542
 Less: Current portion	 9,467	 10,914
Debt issuance costs, net	7,262	5,533
	<u>\$ 1,138,530</u>	<u>\$ 752,180</u>

Aggregate annual principal payments for the next five years ending June 30 and thereafter are as follows:

<i>(in thousands of dollars)</i>	2020
2021	\$ 9,467
2022	9,419
2023	131,626
2024	1,871
2025	1,954
Thereafter	<u>911,380</u>
	<u>\$ 1,065,717</u>

**Dartmouth-Hitchcock Obligated Group (DHOG) Debt**

MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group consist of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and, APD. D-HH is designated as the obligated group agent.

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

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

#### **June 30, 2020 and 2019**

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

#### **(1) Series 2018A and Series 2018B Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2018A and Series 2018B in February 2018. The Series 2018A Revenue Bonds were primarily used to refund a portion of Series 2015A and Series 2016A. The Series 2018B were primarily used to refund a portion of Series 2015A and Series 2016A, Revolving Line of Credit, Series 2012 Bank Loan and the Series 2015A and Series 2016A Swap terminations. A loss on the extinguishment of debt of approximately \$578,000 was recognized in non-operating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2018A Revenue Bonds is variable with a current interest rate of 5.00% and matures in variable amounts through 2037. The interest on the Series 2018B Revenue Bonds is fixed with an interest rate of 4.18% and matures in variable amounts through 2048.

#### **(2) Series 2020A Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds Series 2020A in February, 2020. The proceeds from the Series 2020A Revenue Bonds are being used primarily to fund the construction of a 212,000 square foot inpatient pavilion in Lebanon, NH as well as various equipment. The interest on the Series 2020A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2059.

#### **(3) Series 2017A and Series 2017B Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

#### **(4) Series 2019A Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds Series 2019A in October, 2019. The proceeds from the Series 2019A Revenue Bonds are being used primarily to fund the construction of a 91,000 square foot expansion of facilities in Manchester, NH to include an Ambulatory Surgical Center as well as various equipment. The interest on the Series 2019A Revenue Bonds is fixed with an interest rate of 4.00% and matures in variable amounts through 2043.

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

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

#### **June 30, 2020 and 2019**

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##### **(5) Series 2018C Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2018C in August, 2018. The Series 2018C Revenue Bonds were used primarily to refinance the Series 2010 Revenue Bonds. The interest on the series 2018C Revenue Bonds is fixed with an interest rate of 3.22% and matures in variable amounts through 2030.

##### **(6) Series 2012 Revenue Bonds**

The NHHEFA issued \$29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%), and matures in variable amounts through 2039.

##### **(7) Series 2014A and Series 2014B Revenue Bonds**

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

##### **(8) Series 2016B Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2016B in July 2016 through a private placement with a financial institution. The Series 2016B Revenue Bonds were used to finance 2016 projects. The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2045.

##### **(9) Note payable to financial institution**

The DHOG issued a note payable to TD Bank in May 2020. Issued in response to the COVID-19 pandemic, the proceeds from the note will be used to fund working capital as needs require. The interest on the note payable is fixed with an interest rate of 2.02% and matures in 2023.

Outstanding joint and several indebtedness of the DHOG at June 30, 2020 and 2019 approximates \$1,062,597,000 and \$722,162,000, respectively.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately \$236,198,000 and \$631,000 at June 30, 2020 and 2019, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 5). In addition, debt service reserves of approximately \$9,286,000 and \$1,331,000 at June 30, 2020 and 2019, respectively, are classified as other current assets in the accompanying consolidated balance sheets. The debt service reserves are mainly comprised of escrowed construction funds at June 30, 2020 and escrowed funds held for future principal and interest payments at June 30, 2019.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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For the years ended June 30, 2020 and 2019 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately \$27,322,000 and \$25,514,000 and other non-operating losses of \$3,784,000 and \$3,784,000, respectively.

#### 11. Employee Benefits

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

All of the defined benefit plans within the Health System have been frozen and therefore there are no remaining participants earning benefits in any of the Health System's defined benefit plans.

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

#### Defined Benefit Plans

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	<b>2020</b>	<b>2019</b>
Service cost for benefits earned during the year	\$ 170	\$ 150
Interest cost on projected benefit obligation	43,433	47,814
Expected return on plan assets	(62,436)	(65,270)
Net loss amortization	12,032	10,357
Total net periodic pension expense	<u>\$ (6,801)</u>	<u>\$ (6,949)</u>

The following assumptions were used to determine net periodic pension expense as of June 30, 2020 and 2019:

	<b>2020</b>	<b>2019</b>
Discount rate	3.00% - 3.10%	3.90% - 4.60%
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50%

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	2020	2019
<b>Change in benefit obligation</b>		
Benefit obligation at beginning of year	\$ 1,135,523	\$ 1,087,940
Service cost	170	150
Interest cost	43,433	47,814
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Actuarial loss	139,469	93,358
Settlements	(38,549)	(42,306)
Benefit obligation at end of year	<u>1,209,100</u>	<u>1,135,523</u>
<b>Change in plan assets</b>		
Fair value of plan assets at beginning of year	897,717	884,983
Actual return on plan assets	121,245	85,842
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Employer contributions	19,986	20,631
Settlements	(38,549)	(42,306)
Fair value of plan assets at end of year	<u>929,453</u>	<u>897,717</u>
Funded status of the plans	(279,647)	(237,806)
Less: Current portion of liability for pension	<u>(46)</u>	<u>(46)</u>
Long term portion of liability for pension	<u>(279,601)</u>	<u>(237,760)</u>
Liability for pension	<u>\$ (279,647)</u>	<u>\$ (237,806)</u>

As of June 30, 2020 and 2019, the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in net assets without donor restrictions include approximately \$546,818,000 and \$478,394,000 of net actuarial loss as of June 30, 2020 and 2019, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2021 for net actuarial losses is \$12,752,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately \$1,209,282 and \$1,135,770,000 at June 30, 2020 and 2019, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	4.20% - 4.50%
Rate of increase in compensation	N/A	N/A

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of both June 30, 2020 and 2019, it is expected that the LDI strategy will hedge approximately 60% of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5%	3%
U.S. government securities	0–10	5
Domestic debt securities	20–58	40
Global debt securities	6–26	7
Domestic equities	5–35	18
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	1
Private equity funds	0–5	0
Hedge funds	5–18	10

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

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

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

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

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	2020				Redemption or Liquidation	Days' Notice
	Level 1	Level 2	Level 3	Total		
<b>Investments</b>						
Cash and short-term investments	\$ -	\$ 7,154	\$ -	\$ 7,154	Daily	1
U.S. government securities	49,843	-	-	49,843	Daily-Monthly	1-15
Domestic debt securities	133,794	318,259	-	452,053	Daily-Monthly	1-15
Global debt securities	-	69,076	-	69,076	Daily-Monthly	1-15
Domestic equities	152,688	24,947	-	177,635	Daily-Monthly	1-10
International equities	13,555	70,337	-	83,892	Daily-Monthly	1-11
Emerging market equities	-	39,984	-	39,984	Daily-Monthly	1-17
REIT funds	-	2,448	-	2,448	Daily-Monthly	1-17
Private equity funds	-	-	17	17	See Note 7	See Note 7
Hedge funds	-	-	47,351	47,351	Quarterly-Annual	60-96
Total investments	<u>\$ 349,880</u>	<u>\$ 532,205</u>	<u>\$ 47,368</u>	<u>\$ 929,453</u>		

<i>(in thousands of dollars)</i>	2019				Redemption or Liquidation	Days' Notice
	Level 1	Level 2	Level 3	Total		
<b>Investments</b>						
Cash and short-term investments	\$ 166	\$ 18,232	\$ -	\$ 18,398	Daily	1
U.S. government securities	48,580	-	-	48,580	Daily-Monthly	1-15
Domestic debt securities	122,178	273,424	-	395,602	Daily-Monthly	1-15
Global debt securities	428	75,146	-	75,574	Daily-Monthly	1-15
Domestic equities	159,259	18,316	-	177,575	Daily-Monthly	1-10
International equities	17,232	77,146	-	94,378	Daily-Monthly	1-11
Emerging market equities	321	39,902	-	40,223	Daily-Monthly	1-17
REIT funds	357	2,883	-	3,240	Daily-Monthly	1-17
Private equity funds	-	-	21	21	See Note 7	See Note 7
Hedge funds	-	-	44,126	44,126	Quarterly-Annual	60-96
Total investments	<u>\$ 348,521</u>	<u>\$ 505,049</u>	<u>\$ 44,147</u>	<u>\$ 897,717</u>		

The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	2020		
	Hedge Funds	Private Equity Funds	Total
<b>Balances at beginning of year</b>	\$ 44,126	\$ 21	\$ 44,147
<b>Net unrealized gains (losses)</b>	3,225	(4)	3,221
<b>Balances at end of year</b>	<u>\$ 47,351</u>	<u>\$ 17</u>	<u>\$ 47,368</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

<i>(in thousands of dollars)</i>	<b>2019</b>		
	<b>Hedge Funds</b>	<b>Private Equity Funds</b>	<b>Total</b>
<b>Balances at beginning of year</b>	\$ 44,250	\$ 23	\$ 44,273
<b>Net unrealized losses</b>	(124)	(2)	(126)
<b>Balances at end of year</b>	<u>\$ 44,126</u>	<u>\$ 21</u>	<u>\$ 44,147</u>

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2020 and 2019 were approximately \$18,261,000 and \$14,617,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2020 and 2019.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2020 and 2019.

The weighted average asset allocation for the Health System's Plans at June 30, 2020 and 2019 by asset category is as follows:

	<b>2020</b>	<b>2019</b>
Cash and short-term investments	1 %	2 %
U.S. government securities	5	5
Domestic debt securities	49	44
Global debt securities	8	9
Domestic equities	19	20
International equities	9	11
Emerging market equities	4	4
Hedge funds	5	5
	<u>100 %</u>	<u>100 %</u>

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

The Health System is expected to contribute approximately \$25,755,000 to the Plans in 2021 however actual contributions may vary from expected amounts.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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

*(in thousands of dollars)*

2021	\$	51,007
2022		53,365
2023		55,466
2024		57,470
2025		59,436
2026 – 2028		321,419

Effective May 1, 2020, the Health System terminated a defined benefit plan and settled the accumulated benefit obligation of \$18,795,000 by purchasing nonparticipating annuity contracts. The plan assets at fair value were \$11,836,000.

#### Defined Contribution Plans

The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately \$51,222,000 and \$40,537,000 in 2020 and 2019, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax-sheltered annuity plans are available to employees of the Health System. Plan specifications vary by member and plan. No employer contributions were made to any of these plans in 2020 and 2019 respectively.

#### Postretirement Medical and Life Benefits

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

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2020 and 2019:

*(in thousands of dollars)*

	2020	2019
Service cost	\$ 609	\$ 384
Interest cost	1,666	1,842
Net prior service income	(5,974)	(5,974)
Net loss amortization	469	10
	<u>\$ (3,230)</u>	<u>\$ (3,738)</u>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2020 and 2019:

<i>(in thousands of dollars)</i>	2020	2019
<b>Change in benefit obligation</b>		
Benefit obligation at beginning of year	\$ 46,671	\$ 42,581
Service cost	609	384
Interest cost	1,666	1,842
Benefits paid	(3,422)	(3,149)
Actuarial loss	2,554	5,013
	<u>48,078</u>	<u>46,671</u>
Benefit obligation at end of year	<u>\$ (48,078)</u>	<u>\$ (46,671)</u>
Funded status of the plans		
Current portion of liability for postretirement medical and life benefits	\$ (3,422)	\$ (3,422)
Long term portion of liability for postretirement medical and life benefits	<u>(44,656)</u>	<u>(43,249)</u>
Liability for postretirement medical and life benefits	<u>\$ (48,078)</u>	<u>\$ (46,671)</u>

As of June 30, 2020 and 2019, the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic postretirement medical and life benefit income and included in the change in net assets without donor restrictions are as follows:

<i>(in thousands of dollars)</i>	2020	2019
Net prior service income	\$ (3,582)	\$ (9,556)
Net actuarial loss	10,335	8,386
	<u>\$ 6,753</u>	<u>\$ (1,170)</u>

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2021 for net prior service cost is \$5,974,000.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2021 and thereafter:

*(in thousands of dollars)*

2021	\$	3,422
2022		3,436
2023		3,622
2024		3,642
2025		3,522
2026-2028		16,268

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 2.90% in 2020 and an assumed healthcare cost trend rate of 6.50%, trending down to 5.00% in 2024 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2020 and 2019 by \$1,772,000 and \$1,601,000 and the net periodic postretirement medical benefit cost for the years then ended by \$122,000 and \$77,000, respectively. Decreasing the assumed healthcare cost trend rates by one percentage point in each year would decrease the accumulated postretirement medical benefit obligation as of June 30, 2020 and 2019 by \$1,603,000 and \$1,452,000 and the net periodic postretirement medical benefit cost for the years then ended by \$108,000 and \$71,000, respectively.

#### 12. Professional and General Liability Insurance Coverage

Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic, along with Dartmouth College, Cheshire Medical Center, The New London Hospital Association, Mt. Ascutney Hospital and Health Center, and the Visiting Nurse and Hospice for VT and NH are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2018 Alice Peck Day Memorial Hospital is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Clinic, and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2020 and 2019, are summarized as follows:

	2020		
	HAC	RRG	Total
<i>(in thousands of dollars)</i>			
Assets	\$ 93,686	\$ 1,785	\$ 95,471
Shareholders' equity	13,620	50	13,670
	2019		
	HAC	RRG	Total
<i>(in thousands of dollars)</i>			
Assets	\$ 75,867	\$ 2,201	\$ 78,068
Shareholders' equity	13,620	50	13,670

### 13. Commitments and Contingencies

#### Litigation

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

#### Lines of Credit

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from \$10,000,000 up to \$30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 31, 2021. There was no outstanding balance under the lines of credit as of June 30, 2020 and 2019. Interest expense was approximately \$20,000 and \$95,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

### 14. Functional Expenses

Operating expenses are presented by functional classification in accordance with the overall service missions of the Health System. Each functional classification displays all expenses related to the underlying operations by natural classification. Salaries, employee benefits, medical supplies and medications, and purchased services and other expenses are generally considered variable and are allocated to the mission that best aligns to the type of service provided. Medicaid enhancement tax is allocated to program services. Interest expense is allocated based on usage of debt-financed space. Depreciation and amortization is allocated based on square footage and specific identification of equipment used by department.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2020:

<i>(in thousands of dollars)</i>	2020			
	Program Services	Management and General	Fundraising	Total
<b>Operating expenses</b>				
Salaries	\$ 981,320	\$ 161,704	\$ 1,799	\$ 1,144,823
Employee benefits	231,361	41,116	395	272,872
Medical supplies and medications	454,143	1,238	-	455,381
Purchased services and other	236,103	120,563	3,830	360,496
Medicaid enhancement tax	76,010	-	-	76,010
Depreciation and amortization	26,110	65,949	105	92,164
Interest	5,918	21,392	12	27,322
Total operating expenses	<u>\$ 2,010,965</u>	<u>\$ 411,962</u>	<u>\$ 6,141</u>	<u>\$ 2,429,068</u>
<b>Non-operating income</b>				
Employee benefits	\$ 9,239	\$ 1,549	\$ 22	\$ 10,810
Total non-operating income	<u>\$ 9,239</u>	<u>\$ 1,549</u>	<u>\$ 22</u>	<u>\$ 10,810</u>

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2019:

<i>(in thousands of dollars)</i>	2019			
	Program Services	Management and General	Fundraising	Total
<b>Operating expenses</b>				
Salaries	\$ 922,902	\$ 138,123	\$ 1,526	\$ 1,062,551
Employee benefits	188,634	73,845	333	262,812
Medical supplies and medications	406,782	1,093	-	407,875
Purchased services and other	212,209	108,783	2,443	323,435
Medicaid enhancement tax	70,061	-	-	70,061
Depreciation and amortization	37,528	50,785	101	88,414
Interest	3,360	22,135	19	25,514
Total operating expenses	<u>\$ 1,841,476</u>	<u>\$ 394,764</u>	<u>\$ 4,422</u>	<u>\$ 2,240,662</u>
<b>Non-operating income</b>				
Employee benefits	\$ 9,651	\$ 1,556	\$ 14	\$ 11,221
Total non-operating income	<u>\$ 9,651</u>	<u>\$ 1,556</u>	<u>\$ 14</u>	<u>\$ 11,221</u>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

#### 15. Liquidity

The Health System is substantially supported by cash generated from operations. In addition, the Health System holds financial assets for specific purposes which are limited as to use. Thus, certain financial assets reported on the accompanying consolidated balance sheet may not be available for general expenditure within one year of the balance sheet date.

The Health System's financial assets available at June 30, 2020 and 2019 to meet cash needs for general expenditures within one year of June 30, 2020 and 2019, are as follows:

<i>(in thousands of dollars)</i>	2020	2019
Cash and cash equivalents	\$ 453,223	\$ 143,587
Patient accounts receivable	183,819	221,125
Assets limited as to use	1,134,526	876,249
Other investments for restricted activities	140,580	134,119
Total financial assets	<u>\$ 1,912,148</u>	<u>\$ 1,375,080</u>
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	54,596	66,082
Investments for restricted activities	140,580	134,119
Bond proceeds held for capital projects	245,484	-
Other investments with liquidity horizons greater than one year	111,408	97,063
Total financial assets available within one year	<u>\$ 1,360,080</u>	<u>\$ 1,077,816</u>

For the years ended June 30, 2020 and June 30, 2019, the Health System generated positive cash flow from operations of approximately \$269,144,000 and \$161,145,000, respectively. In addition, the Health System's liquidity management plan includes investing excess daily cash in intermediate or long term investments based on anticipated liquidity needs. The Health System has an available line of credit of up to \$30,000,000 which it can draw upon as needed to meet its liquidity needs. See Note 13 for further details on the line of credit.

#### 16. Lease Commitments

In February 2016, the FASB issued ASU 2016-02 (Topic 842) "Leases." Topic 842 supersedes the lease requirements in Accounting Standards Codification Topic 840, "Leases." Under Topic 842, lessees are required to recognize assets and liabilities on the balance sheet for most leases and provide enhanced disclosures. Leases will be classified as either finance or operating. D-HH adopted Topic 842 effective July 1, 2019.

D-HH applied Topic 842 to all leases as of July 1, 2019 with comparative periods continuing to be reported under Topic 840. We have elected the practical expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial direct costs for existing leases. We have also elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Notes to Financial Statements

#### June 30, 2020 and 2019

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D-HH determines if an arrangement is or contains a lease at inception of the contract. Right-of-use assets represent our right to use the underlying assets for the lease term and our lease liabilities represent our obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. We use the implicit rate noted within the contract. If not readily available, we use our estimated incremental borrowing rate, which is derived using a collateralized borrowing rate for the same currency and term as the associated lease. A right-of-use asset and lease liability is not recognized for leases with an initial term of 12 months or less and we recognize lease expense for these leases on a straight-line basis over the lease term within lease and rental expense.

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of 5 to 10 years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from 2 to 5 years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

On adoption, the Health System recognized lease liabilities and right-of-use assets of \$60,269,884, respectively.

The components of lease expense for the year ended June 30, 2020 are as follows:

<i>(in thousands of dollars)</i>	<b>12 months ended June 30, 2020</b>
Operating lease cost	8,992
Variable and short term lease cost (a)	1,497
Total lease and rental expense	<u>10,489</u>
Finance lease cost:	
Depreciation of property under finance lease	2,454
Interest on debt of property under finance lease	524
Total finance lease cost	<u>2,978</u>

(a) Includes equipment, month-to-month and leases with a maturity of less than 12 months.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

Supplemental cash flow information related to leases for the year ended June 30, 2020 are as follows:

<i>(in thousands of dollars)</i>	<b>12 months ended June 30, 2020</b>
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	8,755
Operating cash flows from finance leases	542
Financing cash flows from finance leases	2,429
	<u>\$ 11,726</u>

Supplemental balance sheet information related to leases as of June 30, 2020 are as follows:

<i>(in thousands of dollars)</i>	<b>12 months ended June 30, 2020</b>
<b>Operating Leases</b>	
Right of use assets - operating leases	42,621
Accumulated amortization	(8,425)
Right of use assets - operating leases, net	<u>34,196</u>
Current portion of right of use obligations	9,194
Long-term right of use obligations, excluding current portion	25,308
Total operating lease liabilities	<u>34,502</u>
<b>Finance Leases</b>	
Right of use assets - finance leases	26,076
Accumulated depreciation	(2,687)
Right of use assets - finance leases, net	<u>23,389</u>
Current portion of right of use obligations	2,581
Long-term right of use obligations, excluding current portion	21,148
Total finance lease liabilities	<u>23,729</u>
<b>Weighted Average remaining lease term, years</b>	
Operating leases	4.64
Finance leases	19.39
<b>Weighted Average discount rate</b>	
Operating leases	2.24%
Finance leases	2.22%

Included in the \$42.6 million of right-of-use assets obtained in exchange for operating lease obligations is \$5.6 million of new and modified operating leases entered into during the year ended June 30, 2020. Included in the \$26.1 million of right-of-use assets obtained in exchange for finance lease obligations is \$2.3 million of new and modified operating leases entered into during the year ended June 30, 2020.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Notes to Financial Statements**  
**June 30, 2020 and 2019**

Future maturities of lease liabilities as of June 30, 2020 are as follows:

<i>(in thousands of dollars)</i>	<u>Operating Leases</u>	<u>Finance Leases</u>
Year ending June 30:		
2021	9,852	3,314
2022	8,274	3,003
2023	6,836	2,718
2024	5,650	1,892
2025	3,023	1,109
Thereafter	<u>2,794</u>	<u>17,339</u>
Total lease payments	36,429	29,374
Less: Imputed interest	<u>1,927</u>	<u>5,645</u>
Total lease payments	<u>\$ 34,502</u>	<u>\$ 23,729</u>

Future minimum rental payments under lease commitments with a term of more than one year as of June 30, 2019, prior to our adoption of ASC 842 are as follows:

<i>(in thousands of dollars)</i>	<u>Capital Leases</u>	<u>Operating Leases</u>
Year ending June 30:		
2020	1,706	11,342
2021	1,467	10,469
2022	1,471	7,488
2023	1,494	6,303
2024	1,230	4,127
Thereafter	<u>10,158</u>	<u>5,752</u>
Total lease payments	<u>\$ 17,526</u>	<u>\$ 45,481</u>

The Health System's rental expense totaled approximately \$12,707,000 for the year ended June 30, 2019.

**17. COVID - 19**

In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic and the United States federal government declared COVID-19 a national emergency. The Health System quickly developed and implemented an emergency response to the situation to ensure the safety of its patients and staff across the System. A key decision was made to postpone elective and non-urgent care in mid-March. Several factors drove that decision, including efforts to reduce the spread of COVID-19; conservation of personal protective equipment ("PPE"), which was and remains in critically short supply worldwide; and at the urging of the CDC and U.S. Surgeon General who in March urged all hospitals to reduce the number of elective procedures and visits.

On March 27, 2020, the President of the United States signed into law the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") to provide economic assistance to a wide array of industries to ease the financial impact of COVID-19. As part of the CARES Act, the Centers for Medicare and Medicaid Services ("CMS") expanded its Accelerated and Advance Payment Program which allows participants to receive expedited payments during periods of national emergencies.

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

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

#### **June 30, 2020 and 2019**

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As of June 30, 2020, the Health System has received approximately \$88,877,000 in governmental assistance including funding under the CARES Act. This includes recognition of approximately \$88,725,000 of stimulus revenue recorded as a component of other operating revenue in the consolidated statements of operations and changes in net assets as a result of satisfying the conditions of general and targeted grant funding under the Provider Relief Fund established by the CARES Act. The Health System recognized revenue related to the CARES Act provider relief funding based on information contained in laws and regulations, as well as interpretations issued by the HHS, governing the funding that was publicly available as of June 30, 2020. The Health System recorded approximately \$239,500,000 attributable to the Medicare Accelerated and Advance Payment Program representing working capital financing to be repaid through the provision of future services. These funds are recorded as a contract liability as a payment received before performing services. This amount is reported as a component of estimated third party settlements in the consolidated balance sheet as of June 30, 2020. Subsequent to June 30, 2020, the Health System received additional stimulus funding attributable to a targeted distribution of approximately \$19,700,000 for Safety Net Hospitals and \$2,500,000 for a general distribution.

Additionally, the CARES Act provides for payroll tax relief, including employee retention tax credits and the deferral of all employer Social Security tax payments to help employers in the face of economic hardship related to the COVID-19 pandemic. As of June 30, 2020, the Health System deferred approximately \$13,727,000 attributable to the employer portion of Social Security taxes and \$2,600,000 of employee retention tax credits. D-HH Leadership has also taken advantage of additional Federal and State programs including the Payroll Tax Deferral, Employee Retention Credit, First Responder Support, Front-Line Employees Hazard Pay Grant Program and FEMA funding to help offset some of the incremental costs being incurred to provide comprehensive and safe care during the pandemic.

#### **18. Subsequent Events**

The Health System has assessed the impact of subsequent events through November 17, 2020, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

##### **1. HHS Reporting Requirements for the CARES Act**

In September 2020 and October 2020, HHS issued new reporting requirements for the CARES Act provider relief funding. The new requirements first require Hospitals to identify healthcare-related expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source. If those expenses do not exceed the provider relief funding received, Hospitals will need to demonstrate that the remaining provider relief funds were used to compensate for a negative variance in year over year patient service revenue. HHS is entitled to recoup Provider Relief Funding in excess of the sum of expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source and the decline in calendar year over year patient care revenue. Due to these new reporting requirements there is at least a reasonable possibility that amounts recorded under the CARES Act provider relief fund by the Health System may change in future periods.

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

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

#### **June 30, 2020 and 2019**

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#### **2. Medicare and Medicaid Services ("CMS") expanded Accelerated and Advance Payment Program**

In October 2020, new regulations were issued to revise the recoupment start date from August 2020 to April 2021.

#### **3. Note Payable Amendment**

In October 2020, the note payable issued to TD Bank in May 2020 was amended. Under the amended terms, the interest on the note payable is fixed at a rate of 2.56%, and matures in 2035. Repayment terms are semi-annual, interest only through July 2024, with annual principal payments to begin August 2024. The obligation can be satisfied at any time beforehand, without penalty.

**Consolidating Supplemental Information – Unaudited**

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2020

<i>(in thousands of dollars)</i>	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
<b>Assets</b>											
<b>Current assets</b>											
Cash and cash equivalents	\$ 108,856	\$ 217,352	\$ 43,940	\$ 28,079	\$ 22,874	\$ 14,377	\$ -	\$ 433,478	\$ 19,745	\$ -	\$ 453,223
Patient accounts receivable, net	-	146,886	11,413	8,634	10,200	4,367	-	181,500	2,319	-	183,819
Prepaid expenses and other current assets	25,243	179,432	37,538	3,808	6,105	1,715	(82,822)	171,019	(8,870)	(243)	161,906
<b>Total current assets</b>	134,099	543,670	92,891	38,521	39,179	20,459	(82,822)	785,997	13,194	(243)	798,948
<b>Assets limited as to use</b>											
Notes receivable, related party	344,737	927,207	19,376	13,044	12,768	12,090	(235,568)	1,093,654	40,872	-	1,134,526
Other investments for restricted activities	848,250	593	-	1,211	-	-	(848,843)	1,211	(1,211)	-	-
Property, plant, and equipment, net	-	98,490	6,970	97	3,077	6,286	-	114,900	25,680	-	140,580
Right of use assets	8	466,938	84,803	20,805	43,612	16,823	-	612,989	30,597	-	643,586
Other assets	1,542	32,714	1,822	17,574	621	3,221	-	57,494	91	-	57,585
<b>Total assets</b>	2,242	122,481	1,299	14,748	5,482	4,603	(10,971)	139,884	(2,546)	-	137,338
<b>Liabilities and Net Assets</b>	\$ 1,330,878	\$ 2,192,093	\$ 187,161	\$ 106,000	\$ 104,739	\$ 63,462	\$ (1,178,204)	\$ 2,806,129	\$ 106,677	\$ (243)	\$ 2,912,563
<b>Current liabilities</b>											
Current portion of long-term debt	\$ -	\$ 7,380	\$ 865	\$ 747	\$ 147	\$ 232	\$ -	\$ 9,371	\$ 96	\$ -	\$ 9,467
Current portion of right of use obligations	338	8,752	420	1,316	259	631	-	11,716	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	272,764	126,283	39,845	3,087	4,250	3,406	(318,391)	131,244	(1,985)	(243)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,570	3,875	3,582	-	141,151	1,840	-	142,991
Estimated third-party settlements	-	210,144	34,664	25,421	24,667	6,430	-	301,326	1,199	-	302,525
<b>Total current liabilities</b>	273,102	478,419	83,526	34,141	33,198	14,281	(318,391)	598,276	1,209	(243)	599,242
Notes payable, related party	-	814,525	-	-	27,718	6,600	(848,843)	-	-	-	-
Long-term debt, excluding current portion	1,050,694	37,373	23,617	24,312	147	10,595	(10,970)	1,135,768	2,762	-	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,432	16,429	368	2,698	-	46,420	36	-	46,456
Insurance deposits and related liabilities	-	75,697	475	325	388	220	-	77,105	41	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	-	511	-	324,258	(1)	-	324,257
Other liabilities	-	117,631	1,506	384	2,026	-	-	121,547	22,131	-	143,678
<b>Total liabilities</b>	1,324,999	1,849,842	132,396	75,591	63,845	34,905	(1,178,204)	2,303,374	26,178	(243)	2,329,309
<b>Commitments and contingencies</b>											
<b>Net assets</b>											
Net assets without donor restrictions	5,524	242,824	47,729	29,464	36,158	21,247	-	382,946	48,040	40	431,026
Net assets with donor restrictions	355	99,427	7,036	945	4,736	7,310	-	119,809	32,459	(40)	152,228
<b>Total net assets</b>	5,879	342,251	54,765	30,409	40,894	28,557	-	502,755	80,499	-	583,254
<b>Total liabilities and net assets</b>	\$ 1,330,878	\$ 2,192,093	\$ 187,161	\$ 106,000	\$ 104,739	\$ 63,462	\$ (1,178,204)	\$ 2,806,129	\$ 106,677	\$ (243)	\$ 2,912,563

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2020

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Assets</b>									
<b>Current assets</b>									
Cash and cash equivalents	\$ 108,856	\$ 218,295	\$ 47,642	\$ 22,874	\$ 14,568	\$ 34,072	\$ 6,916	\$ -	\$ 453,223
Patient accounts receivable, net	-	146,887	11,413	10,200	4,439	8,634	2,246	-	183,819
Prepaid expenses and other current assets	25,243	180,137	27,607	6,105	1,737	2,986	1,156	(83,065)	161,906
<b>Total current assets</b>	<b>134,099</b>	<b>545,319</b>	<b>86,662</b>	<b>39,179</b>	<b>20,744</b>	<b>45,692</b>	<b>10,318</b>	<b>(83,065)</b>	<b>798,948</b>
<b>Assets limited as to use</b>	<b>344,737</b>	<b>946,938</b>	<b>18,001</b>	<b>12,768</b>	<b>13,240</b>	<b>13,044</b>	<b>21,366</b>	<b>(235,568)</b>	<b>1,134,526</b>
Notes receivable, related party	848,250	593	-	-	-	-	-	(848,843)	-
Other investments for restricted activities	-	105,869	25,272	3,077	6,265	97	-	-	140,580
Property, plant, and equipment, net	8	469,613	68,374	43,612	18,432	40,126	3,421	-	643,586
Right of use assets	1,542	32,714	1,822	621	3,220	17,574	92	-	57,585
Other assets	2,242	122,647	7,429	5,482	2,152	8,199	158	(10,971)	137,338
<b>Total assets</b>	<b>\$ 1,330,878</b>	<b>\$ 2,223,693</b>	<b>\$ 207,560</b>	<b>\$ 104,739</b>	<b>\$ 64,053</b>	<b>\$ 124,732</b>	<b>\$ 35,355</b>	<b>\$ (1,178,447)</b>	<b>\$ 2,912,563</b>
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
Current portion of long-term debt	\$ -	\$ 7,380	\$ 865	\$ 147	\$ 257	\$ 747	\$ 71	\$ -	\$ 9,467
Current portion of right of use obligations	338	8,752	420	259	631	1,316	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	272,762	126,684	35,117	4,251	3,517	3,528	1,791	(318,634)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,875	3,626	3,883	1,483	-	142,991
Estimated third-party settlements	-	210,143	34,664	24,667	6,430	25,421	1,200	-	302,525
<b>Total current liabilities</b>	<b>273,100</b>	<b>478,819</b>	<b>78,798</b>	<b>33,199</b>	<b>14,461</b>	<b>34,895</b>	<b>4,604</b>	<b>(318,634)</b>	<b>599,242</b>
Notes payable, related party	-	814,525	-	27,718	6,600	-	-	(848,843)	-
Long-term debt, excluding current portion	1,050,694	37,373	23,618	147	10,867	24,312	2,489	(10,970)	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,433	368	2,700	16,429	33	-	46,456
Insurance deposits and related liabilities	-	75,697	475	388	222	325	39	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	510	-	-	-	324,257
Other liabilities	-	117,631	1,506	2,026	-	22,515	-	-	143,678
<b>Total liabilities</b>	<b>1,324,997</b>	<b>1,850,242</b>	<b>127,670</b>	<b>63,846</b>	<b>35,360</b>	<b>98,476</b>	<b>7,165</b>	<b>(1,178,447)</b>	<b>2,329,309</b>
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
Net assets without donor restrictions	5,526	266,327	48,549	36,158	21,385	24,881	28,160	40	431,026
Net assets with donor restrictions	355	107,124	31,341	4,735	7,308	1,375	30	(40)	152,228
<b>Total net assets</b>	<b>5,881</b>	<b>373,451</b>	<b>79,890</b>	<b>40,893</b>	<b>28,693</b>	<b>26,256</b>	<b>28,190</b>	<b>-</b>	<b>583,254</b>
<b>Total liabilities and net assets</b>	<b>\$ 1,330,878</b>	<b>\$ 2,223,693</b>	<b>\$ 207,560</b>	<b>\$ 104,739</b>	<b>\$ 64,053</b>	<b>\$ 124,732</b>	<b>\$ 35,355</b>	<b>\$ (1,178,447)</b>	<b>\$ 2,912,563</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2019

(In thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
<b>Assets</b>											
<b>Current assets</b>											
Cash and cash equivalents	\$ 42,456	\$ 47,455	\$ 9,411	\$ 7,066	\$ 10,462	\$ 8,372	\$ -	\$ 125,232	\$ 18,355	\$ -	\$ 143,587
Patient accounts receivable, net	-	180,938	15,880	7,279	8,960	5,010	-	218,067	3,058	-	221,125
Prepaid expenses and other current assets	14,178	139,034	8,563	2,401	5,587	1,423	(74,083)	97,083	1,421	(3,009)	95,495
<b>Total current assets</b>	<b>56,634</b>	<b>367,437</b>	<b>33,854</b>	<b>16,746</b>	<b>24,989</b>	<b>14,805</b>	<b>(74,083)</b>	<b>440,382</b>	<b>22,834</b>	<b>(3,009)</b>	<b>480,207</b>
<b>Assets limited as to use</b>	<b>92,602</b>	<b>688,485</b>	<b>18,759</b>	<b>12,684</b>	<b>12,427</b>	<b>11,619</b>	<b>-</b>	<b>836,576</b>	<b>39,673</b>	<b>-</b>	<b>876,249</b>
Notes receivable, related party	553,484	752	-	1,406	-	-	(554,236)	1,406	(1,406)	-	-
Other investments for restricted activities	-	91,882	6,970	31	2,973	6,323	-	108,179	25,940	-	134,119
Property, plant, and equipment, net	22	432,277	67,147	30,945	41,946	17,797	-	590,134	31,122	-	621,256
Right of use assets	-	-	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,208	1,279	15,019	6,042	4,358	(10,970)	127,484	(3,013)	-	124,471
<b>Total assets</b>	<b>\$ 706,260</b>	<b>\$ 1,689,041</b>	<b>\$ 128,009</b>	<b>\$ 76,831</b>	<b>\$ 88,377</b>	<b>\$ 54,932</b>	<b>\$ (639,289)</b>	<b>\$ 2,104,161</b>	<b>\$ 115,150</b>	<b>\$ (3,009)</b>	<b>\$ 2,216,302</b>
<b>Liabilities and Net Assets</b>											
<b>Current liabilities</b>											
Current portion of long-term debt	\$ -	\$ 8,226	\$ 830	\$ 954	\$ 547	\$ 262	\$ -	\$ 10,819	\$ 95	\$ -	\$ 10,914
Current portion of right of use obligations	-	-	-	-	-	-	-	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	55,499	99,884	15,620	6,299	3,678	2,778	(74,083)	109,873	6,953	(3,009)	113,817
Accrued compensation and related benefits	-	110,639	5,851	3,694	2,313	4,270	-	126,787	1,641	-	128,408
Estimated third-party settlements	-	28,405	103	1,290	10,851	2,921	-	41,570	-	-	41,570
<b>Total current liabilities</b>	<b>55,499</b>	<b>248,622</b>	<b>22,404</b>	<b>12,237</b>	<b>17,589</b>	<b>10,229</b>	<b>(74,083)</b>	<b>282,497</b>	<b>8,669</b>	<b>(3,009)</b>	<b>288,177</b>
Notes payable, related party	-	528,202	-	-	28,034	-	(554,236)	-	-	-	-
Long-term debt, excluding current portion	643,257	44,820	24,503	35,604	643	11,465	(10,970)	749,322	2,858	-	752,180
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-	-	-
Insurance deposits and related liabilities	-	56,786	440	513	388	240	-	58,367	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	-	4,320	-	281,009	-	-	281,009
Other liabilities	-	98,201	1,104	28	1,585	-	-	100,918	23,218	-	124,136
<b>Total liabilities</b>	<b>698,756</b>	<b>1,241,058</b>	<b>58,713</b>	<b>48,362</b>	<b>48,239</b>	<b>26,254</b>	<b>(639,289)</b>	<b>1,482,113</b>	<b>34,805</b>	<b>(3,009)</b>	<b>1,513,909</b>
<b>Commitments and contingencies</b>											
<b>Net assets</b>											
Net assets without donor restrictions	7,486	356,880	63,051	27,653	35,518	21,242	-	511,830	46,063	40	559,933
Net assets with donor restrictions	18	91,103	6,245	796	4,620	7,436	-	110,218	32,262	(40)	142,480
<b>Total net assets</b>	<b>7,504</b>	<b>447,983</b>	<b>69,296</b>	<b>28,449</b>	<b>40,138</b>	<b>28,678</b>	<b>-</b>	<b>622,048</b>	<b>80,345</b>	<b>-</b>	<b>702,393</b>
<b>Total liabilities and net assets</b>	<b>\$ 706,260</b>	<b>\$ 1,689,041</b>	<b>\$ 128,009</b>	<b>\$ 76,831</b>	<b>\$ 88,377</b>	<b>\$ 54,932</b>	<b>\$ (639,289)</b>	<b>\$ 2,104,161</b>	<b>\$ 115,150</b>	<b>\$ (3,009)</b>	<b>\$ 2,216,302</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2019

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Assets</b>									
<b>Current assets</b>									
Cash and cash equivalents	\$ 42,456	\$ 48,052	\$ 11,952	\$ 11,120	\$ 8,549	\$ 15,772	\$ 5,686	\$ -	\$ 143,587
Patient accounts receivable, net	-	180,938	15,880	8,960	5,060	7,280	3,007	-	221,125
Prepaid expenses and other current assets	14,178	139,832	9,460	5,567	1,401	1,678	471	(77,092)	95,495
<b>Total current assets</b>	<b>56,634</b>	<b>368,822</b>	<b>37,292</b>	<b>25,647</b>	<b>15,010</b>	<b>24,730</b>	<b>9,164</b>	<b>(77,092)</b>	<b>460,207</b>
Assets limited as to use	92,602	707,597	17,383	12,427	12,738	12,685	20,817	-	876,249
Notes receivable, related party	553,484	752	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	99,807	24,985	2,973	6,323	31	-	-	134,119
Property, plant, and equipment, net	22	434,953	70,846	42,423	19,435	50,338	3,239	-	621,256
Right of use assets	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,366	7,388	5,476	1,931	8,688	74	(10,970)	124,471
<b>Total assets</b>	<b>\$ 706,260</b>	<b>\$ 1,720,297</b>	<b>\$ 157,894</b>	<b>\$ 88,946</b>	<b>\$ 55,437</b>	<b>\$ 96,472</b>	<b>\$ 33,294</b>	<b>\$ (642,298)</b>	<b>\$ 2,216,302</b>
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
Current portion of long-term debt	\$ -	\$ 8,226	\$ 830	\$ 547	\$ 288	\$ 954	\$ 69	\$ -	\$ 10,914
Current portion of right of use obligations	-	-	-	-	-	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,499	100,441	19,356	3,879	2,856	6,704	2,174	(77,092)	113,817
Accrued compensation and related benefits	-	110,639	5,851	2,313	4,314	4,192	1,099	-	128,408
Estimated third-party settlements	-	26,405	103	10,851	2,921	1,290	-	-	41,570
<b>Total current liabilities</b>	<b>55,499</b>	<b>249,179</b>	<b>26,140</b>	<b>17,590</b>	<b>10,379</b>	<b>13,140</b>	<b>3,342</b>	<b>(77,092)</b>	<b>298,177</b>
Notes payable, related party	-	526,202	-	28,034	-	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	24,503	643	11,763	35,604	2,560	(10,970)	752,180
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-
Insurance deposits and related liabilities	-	56,786	440	388	240	513	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	4,320	-	-	-	281,009
Other liabilities	-	98,201	1,115	1,585	-	23,235	-	-	124,136
<b>Total liabilities</b>	<b>698,756</b>	<b>1,241,615</b>	<b>62,460</b>	<b>48,240</b>	<b>26,702</b>	<b>72,492</b>	<b>5,942</b>	<b>(642,298)</b>	<b>1,513,909</b>
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
Net assets without donor restrictions	7,486	379,498	65,873	36,087	21,300	22,327	27,322	40	559,933
Net assets with donor restrictions	18	99,184	29,561	4,819	7,435	1,653	30	(40)	142,460
<b>Total net assets</b>	<b>7,504</b>	<b>478,682</b>	<b>95,434</b>	<b>40,706</b>	<b>28,735</b>	<b>23,980</b>	<b>27,352</b>	<b>-</b>	<b>702,393</b>
<b>Total liabilities and net assets</b>	<b>\$ 706,260</b>	<b>\$ 1,720,297</b>	<b>\$ 157,894</b>	<b>\$ 88,946</b>	<b>\$ 55,437</b>	<b>\$ 96,472</b>	<b>\$ 33,294</b>	<b>\$ (642,298)</b>	<b>\$ 2,216,302</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2020

<i>(in thousands of dollars)</i>	Dartmouth- Hitchcock Health	Dartmouth- Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non- Oblig Group Affiliates	Eliminations	Health System Consolidated
<b>Operating revenue and other support</b>											
Patient service revenue	\$ -	\$ 1,490,516	\$ 207,416	\$ 65,496	\$ 53,943	\$ 41,349	\$ -	\$ 1,858,720	\$ 21,305	\$ -	\$ 1,880,025
Contracted revenue	5,369	114,906	400	-	10	7,427	(54,543)	73,569	498	(39)	74,028
Other operating revenue	26,349	321,028	16,406	7,179	10,185	7,847	(28,972)	360,022	15,128	(528)	374,622
Net assets released from restrictions	409	13,013	1,315	162	160	84	-	15,143	1,117	-	16,260
<b>Total operating revenue and other support</b>	<b>32,127</b>	<b>1,939,463</b>	<b>225,537</b>	<b>72,837</b>	<b>64,298</b>	<b>56,707</b>	<b>(83,515)</b>	<b>2,307,454</b>	<b>38,048</b>	<b>(587)</b>	<b>2,344,935</b>
<b>Operating expenses</b>											
Salaries	-	947,275	115,777	37,596	33,073	27,600	(34,706)	1,126,615	17,007	1,201	1,144,823
Employee benefits	-	227,138	26,979	6,214	6,741	6,344	(4,864)	268,552	4,009	311	272,872
Medications and medical supplies	-	401,165	36,313	8,390	5,140	2,944	-	453,952	1,429	-	455,381
Purchased services and other	13,615	284,714	31,864	11,639	14,311	13,351	(20,942)	348,552	13,943	(1,999)	360,496
Medicaid enhancement tax	-	59,708	8,476	3,228	2,853	1,747	-	76,010	-	-	76,010
Depreciation and amortization	14	71,108	9,351	3,361	3,601	2,475	-	89,910	2,254	-	92,164
Interest	25,780	23,431	953	906	1,097	252	(25,412)	27,007	315	-	27,322
<b>Total operating expenses</b>	<b>39,409</b>	<b>2,014,539</b>	<b>229,713</b>	<b>71,332</b>	<b>66,816</b>	<b>54,713</b>	<b>(85,924)</b>	<b>2,390,598</b>	<b>38,957</b>	<b>(487)</b>	<b>2,429,068</b>
<b>Operating (loss) margin</b>	<b>(7,282)</b>	<b>(75,076)</b>	<b>(4,176)</b>	<b>1,505</b>	<b>(2,518)</b>	<b>1,994</b>	<b>2,409</b>	<b>(83,144)</b>	<b>(909)</b>	<b>(80)</b>	<b>(84,133)</b>
<b>Non-operating gains (losses)</b>											
Investment income (losses), net	4,877	18,522	714	292	359	433	(198)	24,999	2,048	-	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	-	134	-	10,810	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(205)	544	4,317	(2,211)	(3,133)	346	80	(2,707)
<b>Total non-operating gains (losses), net</b>	<b>945</b>	<b>26,238</b>	<b>2,028</b>	<b>87</b>	<b>903</b>	<b>4,884</b>	<b>(2,409)</b>	<b>32,676</b>	<b>2,394</b>	<b>80</b>	<b>35,150</b>
(Deficiency) excess of revenue over expenses	(6,337)	(48,838)	(2,148)	1,592	(1,615)	6,878	-	(50,468)	1,485	-	(48,983)
<b>Net assets without donor restrictions</b>											
Net assets released from restrictions for capital	-	564	179	-	344	300	-	1,387	27	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	-	(7,188)	-	(79,022)	-	-	(79,022)
Net assets transferred to (from) affiliates	4,375	(7,269)	(32)	219	1,911	15	-	(781)	781	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	(2,316)	-	(2,316)
<b>Increase in net assets without donor restrictions</b>	<b>\$ (1,962)</b>	<b>\$ (114,056)</b>	<b>\$ (15,322)</b>	<b>\$ 1,811</b>	<b>\$ 640</b>	<b>\$ 5</b>	<b>\$ -</b>	<b>\$ (128,884)</b>	<b>\$ (23)</b>	<b>\$ -</b>	<b>\$ (128,907)</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2020

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Operating revenue and other support</b>									
Patient service revenue	\$ -	\$ 1,490,516	\$ 207,416	\$ 53,943	\$ 41,348	\$ 65,496	\$ 21,306	\$ -	\$ 1,880,025
Contracted revenue	5,369	115,403	400	10	7,427	-	-	(54,581)	74,028
Other operating revenue	26,349	323,151	16,472	10,185	9,482	16,726	1,757	(29,500)	374,622
Net assets released from restrictions	409	13,660	1,335	160	83	613	-	-	16,260
<b>Total operating revenue and other support</b>	<b>32,127</b>	<b>1,942,730</b>	<b>225,623</b>	<b>64,298</b>	<b>58,340</b>	<b>82,835</b>	<b>23,063</b>	<b>(84,081)</b>	<b>2,344,935</b>
<b>Operating expenses</b>									
Salaries	-	947,275	115,809	33,073	28,477	41,085	12,608	(33,504)	1,144,823
Employee benefits	-	227,138	26,988	6,741	6,517	7,123	2,918	(4,553)	272,872
Medications and medical supplies	-	401,165	36,313	5,140	2,941	8,401	1,421	-	455,381
Purchased services and other	13,615	287,948	32,099	14,311	13,767	14,589	7,108	(22,941)	360,496
Medicaid enhancement tax	-	59,708	8,476	2,853	1,747	3,226	-	-	76,010
Depreciation and amortization	14	71,109	9,480	3,601	2,596	5,004	360	-	92,164
Interest	25,780	23,431	953	1,097	252	1,159	62	(25,412)	27,322
<b>Total operating expenses</b>	<b>39,409</b>	<b>2,017,774</b>	<b>230,118</b>	<b>66,816</b>	<b>56,297</b>	<b>80,587</b>	<b>24,477</b>	<b>(86,410)</b>	<b>2,429,068</b>
<b>Operating (loss) margin</b>	<b>(7,282)</b>	<b>(75,044)</b>	<b>(4,495)</b>	<b>(2,518)</b>	<b>2,043</b>	<b>2,248</b>	<b>(1,414)</b>	<b>2,329</b>	<b>(84,133)</b>
<b>Non-operating gains (losses)</b>									
Investment income (losses), net	4,877	19,361	1,305	359	463	292	588	(198)	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	134	-	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(25)	4,318	(205)	914	(2,131)	(2,707)
<b>Total non-operating gains (losses), net</b>	<b>945</b>	<b>27,077</b>	<b>2,619</b>	<b>334</b>	<b>4,915</b>	<b>87</b>	<b>1,502</b>	<b>(2,329)</b>	<b>35,150</b>
<b>(Deficiency) excess of revenue over expenses</b>	<b>(6,337)</b>	<b>(47,967)</b>	<b>(1,876)</b>	<b>(2,184)</b>	<b>6,958</b>	<b>2,335</b>	<b>88</b>	<b>-</b>	<b>(48,983)</b>
<b>Net assets without donor restrictions</b>									
Net assets released from restrictions for capital	-	591	179	344	300	-	-	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	(7,188)	-	-	-	(79,022)
Net assets transferred to (from) affiliates	4,377	(7,282)	10	1,911	15	219	750	-	-
Other changes in net assets	-	-	(2,316)	-	-	-	-	-	(2,316)
<b>Increase in net assets without donor restrictions</b>	<b>\$ (1,960)</b>	<b>\$ (113,171)</b>	<b>\$ (17,324)</b>	<b>\$ 71</b>	<b>\$ 85</b>	<b>\$ 2,554</b>	<b>\$ 838</b>	<b>\$ -</b>	<b>\$ (128,907)</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2019

<i>(in thousands of dollars)</i>	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
<b>Operating revenue and other support</b>											
Patient service revenue	\$ -	\$ 1,580,552	\$ 220,255	\$ 69,794	\$ 60,166	\$ 46,029	\$ -	\$ 1,976,796	\$ 22,527	\$ -	\$ 1,999,323
Contracted revenue	5,011	109,051	355	-	-	5,902	(46,100)	74,219	790	8	75,017
Other operating revenue	21,128	186,852	3,407	1,748	4,261	2,289	(22,076)	197,609	13,386	(297)	210,698
Net assets released from restrictions	369	11,556	732	137	177	24	-	12,995	1,110	-	14,105
<b>Total operating revenue and other support</b>	<b>26,508</b>	<b>1,888,011</b>	<b>224,749</b>	<b>71,679</b>	<b>64,604</b>	<b>54,244</b>	<b>(68,176)</b>	<b>2,261,619</b>	<b>37,813</b>	<b>(289)</b>	<b>2,299,143</b>
<b>Operating expenses</b>											
Salaries	-	868,311	107,671	37,297	30,549	26,514	(24,682)	1,045,660	15,785	1,106	1,062,551
Employee benefits	-	217,623	25,983	6,454	5,434	7,152	(3,763)	258,883	3,642	287	262,812
Medications and medical supplies	-	354,201	34,331	8,634	6,298	3,032	-	406,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,622)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,061	-	-	70,061
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,360	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,961	533	-	25,514
<b>Total operating expenses</b>	<b>32,057</b>	<b>1,828,123</b>	<b>220,108</b>	<b>74,229</b>	<b>63,107</b>	<b>55,012</b>	<b>(70,471)</b>	<b>2,202,165</b>	<b>38,726</b>	<b>(229)</b>	<b>2,240,662</b>
<b>Operating margin (loss)</b>	<b>(5,549)</b>	<b>59,888</b>	<b>4,641</b>	<b>(2,550)</b>	<b>1,497</b>	<b>(768)</b>	<b>2,295</b>	<b>59,454</b>	<b>(913)</b>	<b>(60)</b>	<b>58,481</b>
<b>Non-operating gains (losses)</b>											
Investment income (losses), net	3,929	32,193	227	469	834	623	(198)	38,077	1,975	-	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	-	186	-	11,221	-	-	11,221
Other (losses) income, net	(3,784)	1,586	(187)	30	(240)	279	(2,097)	(4,413)	791	60	(3,562)
Loss on early extinguishment of debt	-	-	-	(87)	-	-	-	(87)	-	-	(87)
<b>Total non-operating gains (losses), net</b>	<b>145</b>	<b>43,056</b>	<b>1,798</b>	<b>412</b>	<b>594</b>	<b>1,088</b>	<b>(2,295)</b>	<b>44,798</b>	<b>2,766</b>	<b>60</b>	<b>47,624</b>
<b>(Deficiency) excess of revenue over expenses</b>	<b>(5,404)</b>	<b>102,944</b>	<b>6,439</b>	<b>(2,138)</b>	<b>2,091</b>	<b>320</b>	<b>-</b>	<b>104,252</b>	<b>1,853</b>	<b>-</b>	<b>106,105</b>
<b>Net assets without donor restrictions</b>											
Net assets released from restrictions for capital	-	419	565	-	402	318	-	1,704	65	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	-	682	-	(72,043)	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,939	8,760	128	110	-	5,054	(5,054)	-	-
<b>Increase in net assets without donor restrictions</b>	<b>\$ 5,073</b>	<b>\$ 21,998</b>	<b>\$ 1,223</b>	<b>\$ 6,622</b>	<b>\$ 2,821</b>	<b>\$ 1,430</b>	<b>\$ -</b>	<b>\$ 38,967</b>	<b>\$ (3,136)</b>	<b>\$ -</b>	<b>\$ 35,831</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2019

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Operating revenue and other support</b>									
Patient service revenue	\$ -	\$ 1,580,552	\$ 220,254	\$ 60,166	\$ 46,029	\$ 69,794	\$ 22,528	\$ -	\$ 1,999,323
Contracted revenue	5,010	109,842	355	-	5,902	-	-	(46,092)	75,017
Other operating revenue	21,128	188,775	3,549	4,260	3,868	10,951	540	(22,373)	210,698
Net assets released from restrictions	371	12,637	732	177	26	162	-	-	14,105
<b>Total operating revenue and other support</b>	<b>26,509</b>	<b>1,891,806</b>	<b>224,890</b>	<b>64,603</b>	<b>55,825</b>	<b>80,907</b>	<b>23,068</b>	<b>(68,465)</b>	<b>2,299,143</b>
<b>Operating expenses</b>									
Salaries	-	868,311	107,706	30,549	27,319	40,731	11,511	(23,576)	1,062,551
Employee benefits	-	217,623	25,993	5,434	7,319	7,218	2,701	(3,476)	262,812
Medications and medical supplies	-	354,201	34,331	6,298	3,035	8,639	1,371	-	407,875
Purchased services and other	11,366	246,101	35,396	13,390	14,371	18,172	7,437	(22,798)	323,435
Medicaid enhancement tax	-	54,954	8,005	2,264	1,776	3,062	-	-	70,061
Depreciation and amortization	14	69,343	8,125	3,920	2,478	4,194	340	-	88,414
Interest	20,678	21,585	1,054	1,119	228	1,637	63	(20,850)	25,514
<b>Total operating expenses</b>	<b>32,058</b>	<b>1,832,118</b>	<b>220,610</b>	<b>62,974</b>	<b>56,526</b>	<b>83,653</b>	<b>23,423</b>	<b>(70,700)</b>	<b>2,240,662</b>
<b>Operating (loss) margin</b>	<b>(5,549)</b>	<b>59,688</b>	<b>4,280</b>	<b>1,629</b>	<b>(701)</b>	<b>(2,746)</b>	<b>(355)</b>	<b>2,235</b>	<b>58,481</b>
<b>Non-operating gains (losses)</b>									
Investment income (losses), net	3,929	33,310	129	785	645	469	983	(198)	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	186	-	-	-	11,221
Other (losses) income, net	(3,784)	1,586	(171)	(240)	288	31	765	(2,037)	(3,562)
Loss on early extinguishment of debt	-	-	-	-	-	(87)	-	-	(87)
<b>Total non-operating gains (losses), net</b>	<b>145</b>	<b>44,173</b>	<b>1,716</b>	<b>545</b>	<b>1,119</b>	<b>413</b>	<b>1,748</b>	<b>(2,235)</b>	<b>47,624</b>
<b>(Deficiency) excess of revenue over expenses</b>	<b>(5,404)</b>	<b>103,861</b>	<b>5,996</b>	<b>2,174</b>	<b>418</b>	<b>(2,333)</b>	<b>1,393</b>	<b>-</b>	<b>106,105</b>
<b>Net assets without donor restrictions</b>									
Net assets released from restrictions for capital	-	484	565	402	318	-	-	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	682	-	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,963	128	118	3,629	45	-	-
<b>Increase (decrease) in net assets without donor restrictions</b>	<b>\$ 5,073</b>	<b>\$ 22,980</b>	<b>\$ 804</b>	<b>\$ 2,704</b>	<b>\$ 1,536</b>	<b>\$ 1,296</b>	<b>\$ 1,438</b>	<b>\$ -</b>	<b>\$ 35,831</b>

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

### **Note to Supplemental Consolidating Information**

#### **June 30, 2020 and 2019**

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#### **1. Basis of Presentation**

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in net assets without donor restrictions of D-HH and its subsidiaries. All intercompany accounts and transactions between D-HH and its subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

**Schedule of Expenditures of Federal Awards**

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Schedule of Expenditures of Federal Awards**  
**Year ended June 30, 2020**

Federal Program	CFDA	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed to subrecipients
<b>Research and Development Cluster</b>						
<b>Department of Defense</b>						
National Guard Military Operations and Maintenance (O&M) Projects	12.401	W81XWH1820078	Direct		\$ 1,198,830	\$ 681,880
Military Medical Research and Development	12.420	W81XWH1810712	Direct		50,351	19,178
Military Medical Research and Development	12.420	W81XWH1810005	Direct		83,207	-
Military Medical Research and Development	12.420	R1143	Pass-Through	Trustees of Dartmouth College	7,925	-
Subtotal 12.420					121,483	701,058
Total Department of Defense					1,320,313	701,058
<b>Environmental Protection Agency</b>						
Science To Achieve Results (STAR) Research Program	66.509	31220SUB52965	Pass-Through	University of Vermont	9,880	-
Total Environmental Protection Agency					9,880	-
<b>National Science Foundation</b>						
Promotion of the Arts Grants to Organizations and Individuals	47.083	R1253	Pass-Through	Trustees of Dartmouth College	11,153	-
Total National Science Foundation					11,153	-
<b>Department of Health and Human Services</b>						
Innovations in Applied Public Health Research	93.061	1 R01 TS000288	Direct		518,100	177,439
Environmental Health	93.113	6K23ES025781-08	Direct		173,047	14,568
Environmental Health	93.113	R1118	Pass-Through	Trustees of Dartmouth College	67,272	-
Subtotal 93.113					240,319	14,568
NIEHS Superfund Hazardous Substances	93.143	R1099	Pass-Through	Trustees of Dartmouth College	6,457	-
Research Related to Deafness and Communication Disorders	93.173	6R21DC015133-03	Direct		102,885	93,814
Research Related to Deafness and Communication Disorders	93.173	R1294	Pass-Through	Trustees of Dartmouth College	21,722	-
Subtotal 93.173					124,407	93,814
National Research Service Award in Primary Care Medicine	93.188	T32HP32520	Direct		237,176	-
Research and Training in Complementary and Integrative Health	93.213	R1112	Pass-Through	Trustees of Dartmouth College	11,051	-
Research and Training in Complementary and Integrative Health	93.213	R1187	Pass-Through	Trustees of Dartmouth College	22,498	-
Research and Training in Complementary and Integrative Health	93.213	12274	Pass-Through	Palmer College of Chiropractic	28,937	-
Research and Training in Complementary and Integrative Health	93.213	R1325	Pass-Through	Trustees of Dartmouth College	31,924	-
Research and Training in Complementary and Integrative Health	93.213	R1349	Pass-Through	Trustees of Dartmouth College	13,647	-
Research and Training in Complementary and Integrative Health	93.213		Pass-Through	Southern California University of Health	67,464	38,411
Subtotal 93.213					173,521	38,411
Research on Healthcare Costs, Quality and Outcomes	93.226	5P30HS024403	Direct		716,547	108,034
Research on Healthcare Costs, Quality and Outcomes	93.226	R1128	Pass-Through	Trustees of Dartmouth College	9,489	-
Research on Healthcare Costs, Quality and Outcomes	93.226	R1146	Pass-Through	Trustees of Dartmouth College	22,992	-
Research on Healthcare Costs, Quality and Outcomes	93.226	R1110	Pass-Through	Trustees of Dartmouth College	10,125	-
Research on Healthcare Costs, Quality and Outcomes	93.226	41610.04.21.Dartmouth	Pass-Through	Natl Bureau of Economic Research	10,851	-
Subtotal 93.226					769,804	108,034
Mental Health Research Grants	93.242	1K01MH117496-01A1	Direct		115,387	-
Mental Health Research Grants	93.242	1K08MH117347-01A1	Direct		128,134	-
Mental Health Research Grants	93.242	6K23MH116387-02	Direct		161,441	-
Mental Health Research Grants	93.242	6R01MH110985	Direct		271,788	112,983
Mental Health Research Grants	93.242	6T32MH073553-15	Direct		307,005	114,680
Mental Health Research Grants	93.242	6R25MH068502-17	Direct		20,506	-
Mental Health Research Grants	93.242	6R01MH107625-05	Direct		388,647	226,366
Mental Health Research Grants	93.242	4500002825	Pass-Through	Boston University	9,848	-

The accompanying notes to the Schedule of Expenditures of Federal Awards are an integral part of the Schedule.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Schedule of Expenditures of Federal Awards**  
**Year ended June 30, 2020**

Federal Program	CFDA	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed to subrecipients
Mental Health Research Grants	93.242	R1082	Pass-Through	Trustees of Dartmouth College	30,525	-
Mental Health Research Grants	93.242	R1144	Pass-Through	Trustees of Dartmouth College	15,445	-
Mental Health Research Grants	93.242	R1156	Pass-Through	Trustees of Dartmouth College	15,445	-
Subtotal 93.242					<u>1,464,151</u>	<u>454,029</u>
Drug Abuse and Addiction Research Programs	93.279	6R01DA034899-05	Direct		672,965	236,585
Drug Abuse and Addiction Research Programs	93.279	6R01DA041416-04	Direct		244,261	139,969
Drug Abuse and Addiction Research Programs	93.279	6R21DA044501-03	Direct		157,431	-
Drug Abuse and Addiction Research Programs	93.279	19186	Pass-Through	Baystate Medical Center, Inc	36,675	-
Drug Abuse and Addiction Research Programs	93.279	19-A0-S6-003871	Pass-Through	New York University	23,295	-
Drug Abuse and Addiction Research Programs	93.279	R1104	Pass-Through	Trustees of Dartmouth College	6,549	-
Drug Abuse and Addiction Research Programs	93.279	R1105	Pass-Through	Trustees of Dartmouth College	48,332	-
Drug Abuse and Addiction Research Programs	93.279	R1192	Pass-Through	Trustees of Dartmouth College	5,868	-
Subtotal 93.279					<u>1,195,378</u>	<u>376,554</u>
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	6K23EB026507-02	Direct		179,267	393
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	6R21EB021456-03	Direct		8,057	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	7R21EB024771-03	Direct		187,960	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	R1103	Pass-Through	Trustees of Dartmouth College	35,703	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	R1125	Pass-Through	Trustees of Dartmouth College	12,002	-
Subtotal 93.286					<u>422,989</u>	<u>393</u>
Trans-NIH Research Support	93.310	R1122	Pass-Through	Trustees of Dartmouth College	38,308	-
Trans-NIH Research Support	93.310	R1365	Pass-Through	Trustees of Dartmouth College	1,588	-
Subtotal 93.310					<u>39,906</u>	<u>-</u>
National Center for Advancing Translational Sciences	93.350	R1113	Pass-Through	Trustees of Dartmouth College	376,147	-
21st Century Cures Act - Beau Biden Cancer Moonshot	93.353	1204501	Pass-Through	Dana Farber Cancer Institute	241,659	-
Cancer Cause and Prevention Research	93.393	1R01CA225792	Direct		340,427	81,353
Cancer Cause and Prevention Research	93.393	R21CA227776A	Direct		178,152	44,868
Cancer Cause and Prevention Research	93.393	1R21CA230875-01A1	Direct		70,084	32,196
Cancer Cause and Prevention Research	93.393	R1127	Pass-Through	Trustees of Dartmouth College	33,095	-
Cancer Cause and Prevention Research	93.393	R1189	Pass-Through	Trustees of Dartmouth College	14,127	-
Cancer Cause and Prevention Research	93.393	R1109	Pass-Through	Trustees of Dartmouth College	144	-
Cancer Cause and Prevention Research	93.393	DHMCCA222648	Pass-Through	The Pennsylvania State University	29,215	-
Cancer Cause and Prevention Research	93.393	R44CA210810	Pass-Through	Caim Surgical, LLC	112,956	-
Subtotal 93.393					<u>776,200</u>	<u>158,417</u>
Cancer Detection and Diagnosis Research	93.394	4R00CA190890-03	Direct		230,110	-
Cancer Detection and Diagnosis Research	93.394	6R37CA212187-03	Direct		288,375	8,863
Cancer Detection and Diagnosis Research	93.394	6R03CA219445-03	Direct		44,321	20,230
Cancer Detection and Diagnosis Research	93.394	R1079	Pass-Through	Trustees of Dartmouth College	25,795	-

The accompanying notes to the Schedule of Expenditures of Federal Awards are an integral part of the Schedule.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Schedule of Expenditures of Federal Awards**  
**Year ended June 30, 2020**

Federal Program	CFDA	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed to subrecipients
Cancer Detection and Diagnosis Research	93.394	R1080	Pass-Through	Trustees of Dartmouth College	27,250	-
Cancer Detection and Diagnosis Research	93.394	R1086	Pass-Through	Trustees of Dartmouth College	15,437	-
Cancer Detection and Diagnosis Research	93.394	R1096	Pass-Through	Trustees of Dartmouth College	2,113	-
Cancer Detection and Diagnosis Research	93.394	R1124	Pass-Through	Trustees of Dartmouth College	264,698	-
Subtotal 93.394					898,099	29,093
Cancer Treatment Research	93.395	1UG1CA233323-01	Direct		270,623	-
Cancer Treatment Research	93.395	DAC-194321	Pass-Through	Mayo Clinic	3,303	-
Cancer Treatment Research	93.395	DAR-194321-05	Pass-Through	Mayo Clinic	6,057	-
Cancer Treatment Research	93.395	R1087	Pass-Through	Trustees of Dartmouth College	10,051	-
Cancer Treatment Research	93.395	120870	Pass-Through	Brigham and Women's Hospital	39,208	-
Subtotal 93.395					329,242	-
Cancer Centers Support Grants	93.397	R1126	Pass-Through	Trustees of Dartmouth College	208,831	-
Cancer Centers Support Grants	93.397	R1157	Pass-Through	Trustees of Dartmouth College	1,322	-
Subtotal 93.397					210,153	-
Cardiovascular Diseases Research	93.837	1UM1HL147371-01	Direct		550,860	121,316
Cardiovascular Diseases Research	93.837	7K23HL142835-02	Direct		155,222	28,004
Subtotal 93.837					706,082	149,320
Lung Diseases Research	93.838	6R01HL122372-05	Direct		190,672	30,187
Blood Diseases and Resources Research	93.839	R1339	Pass-Through	Trustees of Dartmouth College	977	-
Arthritis, Musculoskeletal and Skin Diseases Research	93.846	6T32AR049710-16	Direct		151	-
Arthritis, Musculoskeletal and Skin Diseases Research	93.846	1R01AR077157-01	Direct		63,854	-
Arthritis, Musculoskeletal and Skin Diseases Research	93.846	R1342	Pass-Through	Trustees of Dartmouth College	3,007	-
Subtotal 93.846					67,012	-
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847	R1098	Pass-Through	Trustees of Dartmouth College	233,586	-
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847	3U01DK104833-04S1	Pass-Through	Medical University of South Carolina	33,915	-
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847	R1363	Pass-Through	Trustees of Dartmouth College	4,727	-
Subtotal 93.847					272,228	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	6R01NS052274-11	Direct		4,459	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	16-210950-04	Direct		11,666	-
Subtotal 93.853					16,125	-
Allergy and Infectious Diseases Research	93.855	R1081	Pass-Through	Trustees of Dartmouth College	7,631	-
Biomedical Research and Research Training	93.859	R1100	Pass-Through	Trustees of Dartmouth College	2,292	-
Biomedical Research and Research Training	93.859	R1141	Pass-Through	Trustees of Dartmouth College	21,015	-
Biomedical Research and Research Training	93.859	R1145	Pass-Through	Trustees of Dartmouth College	19,835	-
Biomedical Research and Research Training	93.859	R1162	Pass-Through	Trustees of Dartmouth College	19,747	-
Subtotal 93.859					62,889	-
Child Health and Human Development Extramural Research	93.865	5P2CHD086841-04	Direct		104,658	13,389
Child Health and Human Development Extramural Research	93.865	6UG1OD024946-03	Direct		652,853	-
Child Health and Human Development Extramural Research	93.865	6R01HD067270	Direct		1,211,026	1,001,208

The accompanying notes to the Schedule of Expenditures of Federal Awards are an integral part of the Schedule.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Schedule of Expenditures of Federal Awards**  
**Year ended June 30, 2020**

Federal Program	CFDA	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed to subrecipients
Child Health and Human Development Extramural Research	93.865	R1119	Pass-Through	Trustees of Dartmouth College	30,991	-
Child Health and Human Development Extramural Research	93.865	51480	Pass-Through	Univ of Arkansas for Medical Sciences	112,107	-
Subtotal 93.865					<u>2,111,633</u>	<u>1,014,597</u>
Aging Research	93.866	6K23AG051681-04	Direct		133,947	1,620
Aging Research	93.866	R1102	Pass-Through	Trustees of Dartmouth College	30,290	-
Subtotal 93.866					<u>164,237</u>	<u>1,620</u>
Vision Research	93.867	6R21EY028677-02	Direct		166,981	107,019
Medical Library Assistance	93.879	R1107	Pass-Through	Trustees of Dartmouth College	16,893	-
Medical Library Assistance	93.879	R1190	Pass-Through	Trustees of Dartmouth College	95,193	-
Medical Library Assistance	93.879	A00-3630-S001	Pass-Through	Medical University of South Carolina	14,647	-
Subtotal 93.879					<u>126,733</u>	<u>-</u>
International Research and Research Training	93.989	R1123	Pass-Through	Trustees of Dartmouth College	7,502	-
International Research and Research Training	93.989	6R25TW007893-09	Pass-Through	Fogarty International Center	274,828	245,016
Subtotal 93.989					<u>282,330</u>	<u>245,016</u>
Total Department of Health and Human Services					<u>12,199,236</u>	<u>3,699,569</u>
Total Research and Development Cluster					<u>13,540,582</u>	<u>3,699,569</u>
Department of Health and Human Services						
Medicaid Cluster						
Medical Assistance Program	93.778	Not Available	Pass-Through	NH Dept of Health and Human Services	4,272,073	-
Medical Assistance Program	93.778	RFP-2017-OCOM-01-PHYSI-01	Pass-Through	NH Dept of Health and Human Services	714,879	-
Medical Assistance Program	93.778	SNHH 2-18-19	Pass-Through	Southern New Hampshire Health	40,729	-
Medical Assistance Program	93.778	03420-08053	Pass-Through	Vermont Department of Health	54,969	-
Medical Assistance Program	93.778	03410-2020-19	Pass-Through	Vermont Agency of Human Services	41,745	-
Medical Assistance Program	93.778	03410-2085-20	Pass-Through	Vermont Agency of Human Services	126,828	-
Total Medicaid Cluster					<u>5,251,223</u>	<u>-</u>
Department of Transportation						
Highway Safety Cluster						
State and Community Highway Safety	20.600	19-266 Youth Operator	Pass-Through	NH Highway Safety Agency	38,094	-
State and Community Highway Safety	20.600	19-266 BUNH	Pass-Through	NH Highway Safety Agency	37,570	-
State and Community Highway Safety	20.600	19-266 Statewide CPS	Pass-Through	NH Highway Safety Agency	54,042	-
Subtotal 20.600					<u>129,706</u>	<u>-</u>
Total Highway Safety Cluster					<u>129,706</u>	<u>-</u>
Other Sponsored Programs						
Department of Justice						
Crime Victim Assistance	16.575	02-20-20-2000010-2601-073	Pass-Through	New Hampshire Department of Justice	17,995	-
Crime Victim Assistance	16.575	2015-VA-GX0007	Pass-Through	New Hampshire Department of Justice	199,879	-
Crime Victim Assistance	16.575	2018-V3-GX-4078	Direct		59,829	12,440
Crime Victim Assistance	16.575	5021-072-500575	Pass-Through	New Hampshire Department of Justice	98,224	-
Subtotal 16.575					<u>375,927</u>	<u>12,440</u>
Total Department of Justice					<u>375,927</u>	<u>12,440</u>
Department of Labor						
Disability Employment Policy Development	17.258	1947RTN01	Pass-Through	Vermont Department of Labor	1,170,987	-
Total Department of Labor					<u>1,170,987</u>	<u>-</u>
National Endowment for the Humanities						
Promotion of the Arts Grants to Organizations and Individuals	45.024	1856102-38-19	Direct	Vermont Dept for Children and Families	15,837	-
Total National Endowment for the Humanities					<u>15,837</u>	<u>-</u>

The accompanying notes to the Schedule of Expenditures of Federal Awards are an integral part of the Schedule.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Schedule of Expenditures of Federal Awards**  
**Year ended June 30, 2020**

Federal Program	CFDA	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed to subrecipients
<b>Department of Health and Human Services</b>						
Blood Disorder Program: Prevention, Surveillance, and Research	93.080	GENFD0001568485	Pass-Through	Boston Children's Hospital	17,530	-
Maternal and Child Health Federal Consolidated Programs	93.110	6 T73MC323930101	Direct		72,142	43,292
Maternal and Child Health Federal Consolidated Programs	93.110	0253-6548-4609	Pass-Through	Icahn School of Medicine at Mount Sinai	22,007	-
Subtotal 93.110					<u>94,149</u>	<u>43,292</u>
Emergency Medical Services for Children	93.127	7 H33MC323950100	Direct		132,270	-
Centers for Research and Demonstration for Health Promotion and Disease Prevention	93.135	R1140	Pass-Through	Trustees of Dartmouth College	207,617	-
Injury Prevention and Control Research and State and Community Based Programs	93.136	03420-08225	Pass-Through	Vermont Agency of Human Services	3,871	-
Coordinated Services and Access to Research for Women, Infants, Children	93.153	5H12HA31112-03-00	Direct		398,842	-
Coordinated Services and Access to Research for Women, Infants, Children	93.153	H12HA31112	Direct		18,419	-
Coordinated Services and Access to Research for Women, Infants, Children	93.153	H1XHA37020-01	Direct		3,987	-
Subtotal 93.153					<u>421,228</u>	<u>-</u>
State Rural Hospital Flexibility Program	93.241	03420-08324	Pass-Through	Vermont Department of Health	1,141	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	1H79SM082302-01	Direct		391,954	23,981
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	1H79TI026146-01	Pass-Through	Vermont Department of Health	740	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	7H79SM063584-01	Direct		109,616	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	03420-07993	Pass-Through	Vermont Department of Health	113,895	-
Subtotal 93.243					<u>616,405</u>	<u>23,981</u>
Drug Free Communities Support Program Grants	93.276	5H79SP020382	Direct		24,427	-
Drug Free Communities Support Program Grants	93.276	2H79SP020382-06	Direct		71,578	-
Subtotal 93.276					<u>96,005</u>	<u>-</u>
<b>University Centers for Excellence in Developmental Disabilities</b>						
Education, Research, and Service	93.632	19-029	Pass-Through	University of New Hampshire	183	-
Adoption Opportunities	93.652	AWD00009303	Direct		51,281	-
Adoption Opportunities	93.652	Not Available	Pass-Through	NH Dept of Health and Human Services	84,051	-
Subtotal 93.652					<u>135,332</u>	<u>-</u>
<b>University Centers for Excellence in Developmental Disabilities</b>						
Education, Research, and Service	93.781	90FPSG0019	Direct		186,045	-
Opioid STR	93.788	2019-BDAS-05-ACCES-04	Pass-Through	NH Dept of Health and Human Services	1,474,457	-
Opioid STR	93.788	05-95-82-920510-7040-5007	Pass-Through	NH Dept of Health and Human Services	197,861	-
Opioid STR	93.788	05-95-47-470010-52010000	Pass-Through	NH Dept of Health and Human Services	606,635	-
Opioid STR	93.788	03420-08055	Pass-Through	Vermont Agency of Human Services	326,779	-
Subtotal 93.788					<u>2,605,732</u>	<u>-</u>
Organized Approaches to Increase Colorectal Cancer Screening	93.800	5 NU58DP006086	Direct		697,244	-
Organized Approaches to Increase Colorectal Cancer Screening	93.800	5NU58DP006086-05-00	Pass-Through	NH Dept of Health and Human Services	524,929	38,855
Subtotal 93.800					<u>1,222,173</u>	<u>38,855</u>
<b>Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities</b>						
Maternal, Infant and Early Childhood Home Visiting Grant	93.817	03420-8755S	Pass-Through	Vermont Department of Health	14,232	-
Maternal, Infant and Early Childhood Home Visiting Grant	93.870	03420-08175	Pass-Through	Vermont Department of Health	191,501	-
Maternal, Infant and Early Childhood Home Visiting Grant	93.870	03420-07623	Pass-Through	Vermont Department of Health	69,478	-
Subtotal 93.870					<u>260,979</u>	<u>-</u>
<b>Rural Health Care Services Outreach, Rural Health Network Development And Small Health Care Provider Quality Improvement</b>						
Rural Health Care Services Outreach, Rural Health Network Development And Small Health Care Provider Quality Improvement	93.912	Not Available	Pass-Through	County of Cheshire	4,753	-
Rural Health Care Services Outreach, Rural Health Network Development And Small Health Care Provider Quality Improvement	93.912	D06RH31057	Direct		142,657	-
Subtotal 93.912					<u>147,410</u>	<u>-</u>

The accompanying notes to the Schedule of Expenditures of Federal Awards are an integral part of the Schedule.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Schedule of Expenditures of Federal Awards**  
**Year ended June 30, 2020**

Federal Program	CFDA	Award number/pass-through Identification number	Funding source	Pass-through entity	Total expenditures	Amount passed to subrecipients
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	1 H7BHA31654-01-00	Direct		338,296	-
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	H7CHA37245-01	Direct		11,920	-
Subtotal 93.918					<u>348,216</u>	<u>-</u>
Block Grants for Community Mental Health Services	93.958	9224120	Pass-Through	NH Dept of Health and Human Services	301,407	106,293
Block Grants for Community Mental Health Services	93.958	RFP-2017-DBH-05-FIRSTE	Pass-Through	NH Dept of Health and Human Services	1,898	-
Subtotal 93.958					<u>303,305</u>	<u>106,293</u>
Block Grants for Prevention and Treatment of Substance Abuse	93.959	03420-08011	Pass-Through	Vermont Department of Health	36,049	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	05-95-49-491510-2990	Pass-Through	Foundation for Healthy Communities	9,990	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	T1010035-15	Pass-Through	Foundation for Healthy Communities	2,300	-
Subtotal 93.959					<u>48,339</u>	<u>-</u>
PPHF Geriatric Education Centers	93.969	2 U1QHP32519-02-00	Direct		666,499	-
PPHF Geriatric Education Centers	93.969	U1QHP32519	Direct		47,441	-
Subtotal 93.969					<u>733,940</u>	<u>-</u>
Total Department of Health and Human Services					<u>7,598,202</u>	<u>212,421</u>
Corporation for National and Community Service AmeriCorps	94.006	17ACHNH0010001	Pass-Through	Volunteer NH	31,079	-
Total Corporation for National and Community Service					<u>31,079</u>	<u>-</u>
Various	Multiple		Pass-Through	County of Cheshire	227,640	-
Greater Monadnock Regional Public Health Network Services					227,640	-
Total Various					<u>14,798,602</u>	<u>224,861</u>
Total Federal Other Sponsored Programs						
Total Expenditures of Federal Awards					<u>\$ 28,339,184</u>	<u>\$ 3,924,430</u>

The accompanying notes to the Schedule of Expenditures of Federal Awards are an integral part of the Schedule.

## **Dartmouth-Hitchcock Health and Subsidiaries Notes to Schedule of Expenditures of Federal Awards Year Ended June 30, 2020**

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### **1. Basis of Presentation**

The accompanying schedule of expenditures of federal awards (the "Schedule") presents the activity of federal award programs administered by Dartmouth-Hitchcock Health and Subsidiaries (the "Health System") as defined in the notes to the consolidated financial statements and is presented on an accrual basis. The purpose of this Schedule is to present a summary of those activities of the Health System for the year ended June 30, 2020 which have been financed by the United States government ("federal awards"). For purposes of this Schedule, federal awards include all federal assistance entered into directly between the Health System and the federal government and subawards from nonfederal organizations made under federally sponsored agreements. The information in this Schedule is presented in accordance with the requirements of the Uniform Guidance. Pass-through entity identification numbers and CFDA numbers have been provided where available.

Visiting Nurse and Hospice of NH and VT ("VNH") received a Community Facilities Loan, CFDA #10.766, of which the proceeds were expended in 2018. The VNH had an outstanding balance of \$2,696,512 as of June 30, 2020. As this loan was related to a project that was completed in the prior audit period and the terms and conditions do not impose continued compliance requirements other than to repay the loan, we have properly excluded the outstanding loan balance from the Schedule.

### **2. Indirect Expenses**

Indirect costs are charged to certain federal grants and contracts at a federally approved predetermined indirect rate, negotiated with the Division of Cost Allocation and therefore we do not use the de minimus 10% rate. The predetermined rate provided for the year ended June 30, 2020 was 29.3%. Indirect costs are included in the reported federal expenditures.

### **3. Related Party Transactions**

The Health System has an affiliation agreement with Dartmouth College dated June 4, 1996 in which the Health System and the Geisel School of Medicine at Dartmouth College affirm their mutual commitment to providing high quality medical care, medical education and medical research at both organizations. Pursuant to this affiliation agreement, certain clinical faculty of the Health System participate in federal research programs administered by Dartmouth College. During the fiscal year ended June 30, 2020, Health System expenditures, which Dartmouth College reimbursed, totaled \$32,413. Based on the nature of these transactions, the Health System and Dartmouth College do not view these arrangements to be subrecipient transactions but rather view them as Dartmouth College activity. Accordingly, this activity does not appear in the Health System's schedule of expenditures of federal awards for the year ended June 30, 2020.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Schedule of Expenditures of Federal Awards**  
**Year Ended June 30, 2020**

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**4. Greater Monadnock Regional Public Health Network Services**

Cheshire Medical Center received a pass-through award from the County of Cheshire, who were themselves a pass-through entity for their award from the New Hampshire Department of Health and Human Services. Per the award contract between County of Cheshire and NH DHHS, the award was funded from the following Federal Agencies, programs, and CFDA's, with no dollar amount provided:

<b>AGENCY</b>	<b>PROGRAM</b>	<b>CFDA</b>
US Centers for Disease Control & Prevention	Preventative Health Services	93.991
US Centers for Disease Control & Prevention	Public Health Emergency Preparedness Program	93.074
US Centers for Disease Control & Prevention	Public Health Emergency Preparedness Program	93.069
US Centers for Disease Control & Prevention	Immunization Cooperative Agreements	93.268
US Department of Health & Human Services	Substance Abuse Prevention and Treatment Block Grant	93.959
US Department of Health & Human Services	Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243
US Department of Health & Human Services	Public Health Emergency Preparedness Program	93.074
US Department of Health & Human Services	Public Health Emergency Preparedness Program	93.889
US Department of Health & Human Services	Childhood Lead Poisoning Prevention & Surveillance Program	93.197
US Department of Health & Human Services	Environmental Public Health and Emergency Response	93.070



**Part II**  
**Reports on Internal Control and Compliance**



**Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards**

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

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheet as of June 30, 2020, and the related consolidated statements of operations and changes in net assets and of cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 17, 2020, which included an emphasis of a matter paragraph related to the Health System changing the manner in which it presents the net periodic pension costs in 2020 as discussed in note 2 of the consolidated financial statements.

**Internal Control Over Financial Reporting**

In planning and performing our audit of the financial statements, we considered the Health System's internal control over financial reporting ("internal control") as a basis for designing the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

*A deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

### **Compliance and Other Matters**

As part of obtaining reasonable assurance about whether the Health System's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

### **Purpose of this Report**

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

*Priscilla Susan Cooper LLP*

Boston, Massachusetts  
November 17, 2020



**Report of Independent Auditors on Compliance with Requirements  
That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over  
Compliance in Accordance with the Uniform Guidance**

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

**Report on Compliance for Each Major Federal Program**

We have audited Dartmouth-Hitchcock Health and its subsidiaries' (the "Health System") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of Health System's major federal programs for the year ended June 30, 2020, the Health System's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

***Management's Responsibility***

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

***Auditors' Responsibility***

Our responsibility is to express an opinion on compliance for each of the Health System's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Health System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of Health System's compliance.

***Opinion on Each Major Federal Program***

In our opinion, Dartmouth-Hitchcock Health and its subsidiaries complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2020.

## Report on Internal Control Over Compliance

Management of the Health System are responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered Health System's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Health System's internal control over compliance.

*A deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

*PricewaterhouseCoopers LLP*

Boston, Massachusetts  
September 30, 2021

**Part III**  
**Findings and Questioned Costs**

**Dartmouth-Hitchcock and Subsidiaries  
 Schedule of Findings and Questioned Costs  
 Year Ended June 30, 2020**

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**I. Summary of Auditor's Results**

**Financial Statements**

Type of auditor's report issued	Unmodified opinion
Internal control over financial reporting	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Noncompliance material to financial statements	No

**Federal Awards**

Internal control over major programs	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Type of auditor's report issued on compliance for major programs	Unmodified opinion
Audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	No

**Identification of major programs**

<b>CFDA Number</b>	<b>Name of Federal Program or Cluster</b>
93.778	Medical Assistance Program
17.258	Workforce Innovation and Opportunity Act Adult Program
93.969	Prevention and Public Health Fund Geriatric Education Centers
Dollar threshold used to distinguish between Type A and Type B programs	\$850,176
Auditee qualified as low-risk auditee?	Yes

**II. Financial Statement Findings**

None Noted

**III. Federal Award Findings and Questioned Costs**

None Noted

**Dartmouth-Hitchcock and Subsidiaries**  
**Summary Schedule of Prior Audit Findings and Status**  
**Year Ended June 30, 2020**

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There are no findings from prior years that require an update in this report.

**DARTMOUTH-HITCHCOCK (D-H) | DARTMOUTH-HITCHCOCK HEALTH (D-HH)  
BOARDS OF TRUSTEES AND OFFICERS**

**Effective: January 1, 2021**

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<b>Paul P. Danos, PhD</b> MHMH/DHC/D-HH Trustee <i>Dean Emeritus; Laurence F. Whittmore Professor of Business Administration, Tuck School of Business at Dartmouth</i>	<b>Richard J. Powell, MD</b> D-HH Trustee <i>Section Chief, Vascular Surgery; Professor of Surgery and Radiology</i>
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<b>Gary L. Freed, Jr., MD, PharmD</b> MHMH/DHC Trustee <i>Plastic Surgeon, DHMC and Assistant Professor of Surgery for Geisel School of Medicine at Dartmouth</i>	<b>Edward Howe Stansfield, III, MA</b> MHMH/DHC/D-HH Boards' Chair <i>Senior VP, Resident Director for the Hanover, NH Bank of America/Merrill Lynch Office</i>
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<b>Roberta L. Hines, MD</b> MHMH/DHC Trustee <i>Surgeon-in-Chief, The Johns Hopkins Hospital</i>	

## CURRICULUM VITAE

Date Prepared: September 27, 2021

NAME: Sarah Pratt, Ph.D.

ADDRESS: OFFICE

## I. EDUCATION

<u>DATES</u>	<u>INSTITUTION</u>	<u>DEGREE</u>
1994-2000	Fordham University	Ph.D. (Clinical Psychology)
1985-1989	Connecticut College	BA

## II. POSTDOCTORAL TRAINING

<u>DATES</u>	<u>INSTITUTION</u>	<u>SPECIALTY</u>
2000-2001	Dartmouth College	Postdoctoral Fellowship (Clinical Psychology)
1999-2000	Dartmouth College	Clinical Psychology/Neuropsychology Internship

## III. PROFESSIONAL DEVELOPMENT ACTIVITIES

<u>DATE</u>	<u>INSTITUTION</u>	<u>TITLE</u>	<u>CREDITS</u>
2014	Geisel School of Medicine	The Science and Practice of Leading Yourself	N/A
2013-2014	The Dartmouth Institute	Advanced Statistics for Healthcare Research	N/A
2012-2013	Dartmouth Psychiatric Research Center	Statistics Seminar	N/A
2011-2012	Dartmouth Psychiatric Research Center	Statistics Seminar	N/A
2010	Wellcoaches Corporation	Introduction to Core Coaching Competencies in Health, Fitness, and Wellness	N/A
2009	The Dartmouth Institute	Studying Patients' Decision Making ECS 120	N/A

## IV. ACADEMIC APPOINTMENTS

<u>DATE</u>	<u>INSTITUTION</u>	<u>TITLE</u>
2019-present	Geisel School of Medicine at Dartmouth	Associate Professor
2019-present	The Dartmouth Institute	Associate Professor
2009-2019	The Dartmouth Institute	Assistant Professor
2005-2019	Geisel School of Medicine at Dartmouth	Assistant Professor in Psychiatry
2004-2005	Geisel School of Medicine at	Research Assistant Professor in Psychiatry

## Dartmouth

**V. INSTITUTIONAL LEADERSHIP ROLES**

<u>DATE</u>	<u>INSTITUTION</u>	<u>TITLE</u>
2002-2004	Dartmouth Psychiatric Research Center	Member, Executive Committee
2010-2012	Geisel School of Medicine at Dartmouth	Member, PCIR Committee for CTSA ("SYNERGY")
2011-2012	Geisel School of Medicine at Dartmouth	Member, Curriculum Planning Committee Faculty Leadership Program
2011-2018	Department of Psychiatry, Geisel School of Medicine at Dartmouth	Member, Research Committee
2012-2018	Geisel School of Medicine at Dartmouth	Coordinator and Member, Leadership Tutorial Sponsored by the Dean of the Geisel School of Medicine
2013-2018	Geisel School of Medicine at Dartmouth	Member, SYNERGY Clinical Research Unit Steering Committee
2018-present	Department of Psychiatry, Dartmouth-Hitchcock	Co-Chair, Research Committee

**VI. LICENSURE AND CERTIFICATION**

N/A

**VII. HOSPITAL APPOINTMENTS:**

<u>DATE</u>	<u>INSTITUTION</u>	<u>POSITION/TITLE</u>
2000-2001	New Hampshire Hospital	Postdoctoral Fellow
1999-2000	New Hampshire Hospital	Psychology/Neuropsychology Intern
1996-1997	White Plains Hospital	Psychology Extern
1995-1996	Rockland Children's Psychiatric Center	Psychology Extern

**VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH):**

<u>DATE</u>	<u>INSTITUTION</u>	<u>POSITION/TITLE</u>
2000	Department of Veteran's Affairs, Manchester, NH	Clinical Consultant
1998-1999	Fordham University	Senior Teaching Fellow
1997-1999	New York Hospital Cornell Medical Center	Research Coordinator
1997-1998	Riverdale Community Residence	Counselor
1996-1998	Fordham University	Teaching Fellow
1995-1996	Fordham University	Teaching Assistant
1994-1995	Fordham University	Graduate Assistant

1991-1994	Sugarman, Rogers, Barshak, & Cohen	Paralegal
1989-1991	Hill & Barlow	Paralegal

**IX. TEACHING ACTIVITIES****A. UNDERGRADUATE (COLLEGE) EDUCATION**

<b>DATES</b>	<b>INSTITUTION</b>	<b>COURSE TITLE</b>	<b>ROLE</b>	<b>HOURS</b>
1996-1997	Fordham University	Introduction to Clinical Psychology	Instructor	3 credit hours
1996-1997	Fordham University	Introduction to Statistics	Instructor	3 credit hours
1996-1997	Fordham University	Abnormal Psychology	Instructor	3 credit hours
1997-1998	Fordham University	Introduction to Clinical Psychology	Instructor	3 credit hours
1997-1998	Fordham University	Child Clinical Psychology	Instructor	3 credit hours
1997-1998	Fordham University	Substance Abuse	Instructor	3 credit hours

**B. GRADUATE EDUCATION**

<b>DATES</b>	<b>INSTITUTION</b>	<b>COURSE TITLE</b>	<b>ROLE</b>	<b>HOURS</b>
1995-1996	Fordham University	Personality Assessment (MMPI)	Teaching Asst	4 credit hours
1995-1996	Fordham University	Personality Assessment (Rorschach)	Teaching Asst	4 credit hours

**C. UNDERGRADUATE MEDICAL EDUCATION**

N/A

**D. GRADUATE MEDICAL EDUCATION**

<b>DATES</b>	<b>INSTITUTION</b>	<b>COURSE TITLE</b>	<b>ROLE</b>	<b>HOURS</b>
2020	Dartmouth-Hitchcock	Research Methods	Instructor	7-week course for PGY-3

**E. OTHER CLINICAL EDUCATION**

N/A

**X. ADVISING/MENTORING****A. UNDERGRADUATE STUDENTS**

<b><u>DATES</u></b>	<b><u>STUDENT'S NAME</u></b>	<b><u>PROGRAM</u></b>
2008-10	Meghan Driscoll	Massachusetts School of Professional Psychology PhD
2016-present	Cynthia Bianco	Riviere University Psychology Master's Program

**XI. RESEARCH TEACHING/MENTORING****A. UNDERGRADUATE STUDENTS**

<b><u>DATES</u></b>	<b><u>STUDENT'S NAME</u></b>	<b><u>PROGRAM</u></b>
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2021	Arya Kadakia	Dartmouth College Psychology Department
2020	Alexis Caldwell	St. Anselm College Psychology Department
2016	Celeste Beaulieu	St. Anselm College Psychology Department
2015	Mackenzie Wild	St. Anselm College Psychology Department
2015	Haley Heinrich	St. Anselm College Psychology Department
2014	Hannah Mason	St. Anselm College Psychology Department
2014	Lucas Daniels	Wheaton College Psychology Department
2013	Zachary Wormell	St. Anselm College Psychology Department
2013	Ian Hancock	University of New Hampshire Psychology Department
2011	Vivian Fitzgerald	St. Anselm College Psychology Department
2010	April Theroux	St. Anselm College Psychology Department
2009	Anoosh Nahikian	Riviere University Psychology Department
2008	Amanda Hapenny	St. Anselm College Psychology Department
2008	Melissa Stuart	Endicott College Psychology Department
2007	Joanna Kierska	St. Anselm College Psychology Department

**B. GRADUATE STUDENTS**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM</u>
2021-22	Jordan French	William James College Clinical Psychology PhD
2021-22	Jacquelyn Pack	William James College Clinical Psychology PhD
2020-21	Max Salazar	William James College Clinical Psychology PhD
2020-21	Sarah Schultze	University of New Hampshire Master's in Social Work
2019-20	Misty Brisiel	University of New Hampshire Master's in Social Work
2018-19	Ashley Williams	University of New Hampshire Master's in Social Work
2017-18	Karen Gowell	University of New Hampshire Master's in Social Work
2016-17	Megan Greenberg	University of New Hampshire Master's in Social Work
2016-17	Cameron Holmes	University of New Hampshire Master's in Social Work
2016	Christine McGovern	University of New Hampshire Master's in Social Work
2015-16	Jennifer Carr	University of New Hampshire Master's in Social Work
2014-16	Gail DeMasi	University of New Hampshire Master's in Social Work
2014-15	Jennifer Daler	University of New Hampshire Master's in Social Work
2011-12	Bryan Wilkinson	University of New Hampshire Master's in Social Work
2011-12	Erica Placencia	Southern New Hampshire University Master's in Community Mental Health
2011-12	Marissa Romanovich	University of New Hampshire Master's in Social Work
2010-2011	Melissa Gregg	University of New Hampshire Master's in Social Work

**C. MEDICAL STUDENTS**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM</u>
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20015-16	Rachel Kandath	Geisel School of Medicine at Dartmouth
2005	Laura Wheeler	Start MH at Dartmouth

**D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>SPECIALTY</u>
2008-present	Rosemarie Wolfe, MS	Data Management and Statistics
2011-2014	Laura Barre, MD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry
2010-13	Daniel Jimenez, PhD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry
2007-09	Erica O'Neal, MD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry
2006-08	Alice Andrews, PhD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry

**E. FACULTY**

<u>DATES</u>	<u>MENTEE'S NAME</u>	<u>SPECIALTY</u>
2019-2020	Erin Miers, PhD	Psychiatry
2014-present	Laura Barre, MD	Nutritional Sciences
2009-2014	Kelly Aschbrenner, PhD	Psychiatry

**XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT**

<u>DATES</u>	<u>INSTITUTION</u>	<u>COURSE/ACTIVITY TITLE</u>	<u>ROLE</u>	<u>HOURS/YEAR</u>
2020	The Center for Health Care Services	Training in Integrated Illness Management and Recovery (Standard & Train the Trainer)	Trainer	4-Day Training
2020	Fordham University	Training in SWITCH-IT	Trainer	2-Day Training
2020	Various Community Mental Health Centers	Training in In SHAPE	Trainer	2-Day Training
2020	Centerstone Tennessee, Seven Counties Services	Training in COVID-19	Trainer	1-Day Training
2019	Centerstone Kentucky	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2019	Various Community Mental Health Centers	Training in In SHAPE	Trainer	2-Day Training
2019	Centerstone Tennessee	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2019	Brattleboro Retreat	Training in Tele-Friend	Trainer	1-Day Training
2018	Mental Health	Training in HOPES-I	Trainer	2-Day Training

	Association of New York City			
2018	Riverbend Mental Health Center	Training in Integrated Illness Management and Recovery	Trainer	1-Day Training
2018	Citizens Advocates	Training in In SHAPE	Trainer	1-day Training
2017	Porter-Starke Services	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2017	Gandara Mental Health Center	Training in In SHAPE	Trainer	1-Day Training
2017	Mental Health Association of New York City	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2016	NHS Human Services	Training in In SHAPE	Trainer	1-Day Training
2016	Network 180	Training in Heinrichs Quality of Life	Trainer	1-Day Training
2016	Massachusetts Mental Health Association of New York City	Training in In SHAPE	Trainer	1-Day Training
2015	Mental Health Association of New York City	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2015	Mental Health Association of New York City	Training in HOPES	Trainer	2-Day Training
2015	Glenclyff Home for the Elderly	HOPES	Trainer	2-Day Training
2015	Bosch Healthcare Telehealth Leadership Series	Using Telehealth to Improve the Care and Outcomes of People Living with Mental Illness and Chronic Medical Conditions	Presenter	Webinar
2014	North Carolina Psychiatric Research Center	Integrated Illness Management and Recovery	Trainer	2-Day Training
2014	Minnesota Center for Mental Health	Integrated Illness Management and Recovery	Trainer	2-Day Training
2013	Lakes Region Mental Health/Mental Retardation Center	Training in In SHAPE	Trainer	1-Day Training

2013	Bronx-Lebanon Hospital	Integrated Illness Management and Recovery	Trainer	2-Day Training
2013	Vinfen Corp & MA Department of Mental Health	Innovations in Health and Wellness for Individuals with Psychiatric Disabilities	Presenter	Workshop
2013	Southwest Counseling Solutions	Training in In SHAPE	Trainer	1-Day Training
2013	Family Services Inc.	Training in Integrated Illness Management and Recovery	Trainer	1-Day Training
2013	Weight Watchers	Managing and Responding to Challenging Behaviors	Lecturer	Webinar
2012	Open Minds	Telehealth at a Community Mental Center	Lecturer	Webinar
2012	Vinfen Corp.	Training in Integrated Illness Management and Recovery	Trainer	4-Day Training
2012	Austin Travis County Integral Care	Training in In SHAPE	Trainer	2-Day Training
2012	Vinfen Corp & MA Department of Mental Health	Innovative Approaches to Health Behavior Change in Psychiatric Disabilities	Presenter	Workshop
2011	Mercy Behavioral Health	Training in In SHAPE	Trainer	1-Day Training
2010	Dartmouth College Summer Research Institute	Balancing Work and Life	Lecturer	Lecture
2010	NH Mental Health & Substance Abuse Coalition	Smoking Cessation and Relapse Prevention for People with Schizophrenia	Presenter	Presentation
2010	Lapeer County Community Mental Health Services Board	Training in In SHAPE	Trainer	2-Day Training
2010	Center for Aging Research at Dartmouth	Developing a Research Career in Mental Health Research: Example of a Path	Lecturer	Lecture
2010	Community Rehabilitation Center	Basics of Skills Training and HOPES	Trainer	3-Day Training
2009	Medispin Med-Ed	Research Interviewers/Data Collectors: Hiring, Training, and On-going Supervision	Lecturer	Webinar
2009	St. Anselm College	Research on Interventions for	Presenter	Presentation

		a Lecture Health Disparity Population: Psychosocial Programs for People with SMI		
2008	Medispin Med-Ed	Developing Your Research Materials: Strategies for Developing Effective Intervention Manuals	Presenter	Webinar
2005	Focus on Forensics Annual Conference	Skills Training Using Cognitive Behavioral Techniques	Trainer	2-Day Workshop

**XIII. RESEARCH FUNDING****A. CURRENT SUPPORT**

<u>DATES</u>	<u>PROJECT TITLE &amp; AWARD NUMBER</u>	<u>ROLE</u>	<u>%EFFORT</u>	<u>SPONSOR</u>	<u>ANNUAL DIRECT COSTS</u>
2020-2021	COVID-Related Enhancement	PI	5%	PCORI	\$481,879
2019-2024	Comparative Effectiveness of Cognitive Enhancement Therapy vs. Social Skills Training in SMI	Co-I	14%	PCORI	\$1,250,000
2019-2024	Integrated Physical and Mental Health Self-Management Compared to Chronic Disease Self-Management	PI	50%	PCORI	\$1,386,128
2018-2023	SM80245 ProHealth NH	Site PI	30%	SAMHSA	\$1,999,998

**B. PAST SUPPORT**

<u>DATES</u>	<u>PROJECT</u>	<u>ROLE</u>	<u>%EFFORT</u>	<u>SPONSOR</u>	<u>ANNUAL DIRECT COSTS</u>
2016-2020	R01DA041416 The Appeal and Impact of E-cigarettes in Smokers with Serious Mental Illness	PI	0%	NIDA	\$499,905
2015-2020	R01MH107625 Automated Telehealth to Improve Psychiatric Symptom Self-Management and Community Tenure	PI	9%	NIMH	\$575,723
2014-2019	R01MH102325 (Bartels, PI)	Co-I	15%	NIMH	\$494,019

RCT of a Learning Collaborative to  
Implement Health Promotion in  
Mental Health

2014-2019	U48DP005018 (Bartels, PI) CDC Health Promotion and Disease Prevention Research Center	Co-PI, Core Project	15%		\$576,552
2014-2019	R01MH104555 (Bartels, PI) Self-Management Training and Automated Telehealth to Improve SMI Health Outcomes	Co-I	15%	NIMH	\$499,228
2016-2017	SYNERGY Adaptation of a Fitness Promotion Program for People with IDD	PI	2%	SYNERGY	\$50,000
2014-2016	Smoking Cessation Care Management Program	Co-I	5%	Mass Attorney General's Office	\$29,043
2011-2016	1B1CMS330880-01-00 New Hampshire Medicaid Wellness Incentive Program	Co-PI	5%	CMS	\$1,170,370
2012-2015	1C1CMS330983-01-00 Community Based Health Homes for Individuals with Serious Mental Illness	Co-I	15%	CMMI	\$3,760,000
2009-2015	R01MH089811 Statewide Intervention to Reduce Early Mortality in Persons with Mental Illness	Co-I	25%	NIMH	\$3,447,146
2009-2014	1U48DP001935-01 Adapting a Health Promotion Intervention for High-Risk Adults: Pilot Project	Co-I	10%	CDC	\$100,000
2010-2012	Evaluation of the Health Buddy Technology in People with Serious Mental Illness	PI	5%	Bosch Healthcare	\$300,000
2008-2010	Evaluation of the Health Buddy Technology in a Community Mental Health Center	Co-I	5%	Endowment for Health	\$114,700
2008-2013	K23MH080021	PI	100%	NIMH	\$861,106

Individually Based Psychosocial Rehabilitation for Older Adults with SMI						
2007-2012	R01DA021245 Smoking Cessation and Relapse Prevention in Patients with Schizophrenia	Site PI	10%	NIDA		\$3,149,167
2007-2012	R01 MH078052 Health Promotion and Fitness for Younger and Older Adults with SMI	Co-I	50%	NIMH		\$3,648,638
2005-2009	R34 MH074786 Integrated Illness Management and Recovery of SMI	Co-I	25%	SAMHSA/ NIMH		\$450,000
2006-2009	R01 DD000140 Promoting Health & Functioning in Persons with SMI	Co-I	50%	CDC		\$565,611
2004-2007	Loan Repayment Grant	PI		NIMH		\$31,805
2004-2006	Evaluation of a Pilot Health Promotion Intervention for Persons with Severe Mental Illness	Co-I	10%	Endowment for Health		\$149,569
2003-2005	Development and Evaluation of a Manualized Medication Adherence Module for Older Adults with Severe Mental Illness	PI	10%	Janssen		\$63,896
2003-2005	An Investigation of Medication Adherence and Use of Memory Strategies in Older Adults With Schizophrenia	PI	10%	NARSAD		\$59,345
2001-2007	R01MH62324 Rehabilitation and Healthcare for Older Adults with SMI	Project Director	80%	NIMH		\$3,674,593
1998-1999	Phase 3 Investigation of Aripiprazole	Coordinator		Otsuka America Pharmaceutical		
1997-1999	Clozapine and Skills Training for Schizophrenia: Longitudinal Assessment of Symptoms and Social Skills	Research Assistant		NIMH		

**C. PENDING SUPPORT**

<u>DATES</u>	<u>PROJECT</u>	<u>ROLE</u>	<u>%EFFORT</u>	<u>SPONSOR</u>	<u>ANNUAL DIRECT COSTS</u>
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N/A

**XIV. PROGRAM DEVELOPMENT**

2020	SWITCH IT (Coaching support for switching from combustible to e-cigarettes)				
2016	TeleFriend Tobacco module (Telehealth program of training on smoking cessation)				
2015-2016	Telefriend (Telehealth program of illness self-management)				
2014	Integrated Illness Management and Recovery ("I-IMR") Curriculum and Manual				
2004-2012	In SHAPE Program and Manual (Fitness promotion for people with SMI)				
2002-2007	Helping Older People Experience Success ("HOPES") Curriculum and Manual				

**XV. ENTREPRENEURIAL ACTIVITIES**

N/A

**XVI. MAJOR COMMITTEE ASSIGNMENTS****National/International**

<u>DATES</u>	<u>COMMITTEE</u>	<u>ROLE</u>	<u>INSITUTION</u>
2016-present	Mental Health Services Research Conference	Ad-hoc Member	National Institutes for Health
2015-present	Loan Repayment Program Review Committee	Ad-hoc Member	Center for Scientific Review National Institutes of Health
2012-present	Pre-Doctoral/Post-Doctoral Awards Committee	Ad-hoc Member	Center for Scientific Review National Institutes of Health
2011	Health Literacy Review Committee	Ad-hoc Member	Center for Scientific Review National Institutes of Health
2010	The Health Research Board	Ad hoc Member	Dublin, Ireland

**Regional**

<u>DATES</u>	<u>COMMITTEE</u>	<u>ROLE</u>	<u>INSITUTION</u>
2002-13	Mental Health and Aging Consumer Advisory Council	Member	New Hampshire Bureau of Behavioral Health
2003-06	Committee for the Protection of Human Subjects	Member	New Hampshire Department of Health and Human Services

**Institutional**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSITUTION</u></b>
2013-2018	Synergy Clinical Research Unit Steering Committee	Member	Geisel School of Medicine
2009-present	Research Review Committee	Member	Department of Psychiatry, Geisel School of Medicine
2010-2012	Participants and Clinical Interactions Resources Committee	Member	Geisel School of Medicine
2003-2006	Executive Committee	Member	Dartmouth Psychiatric Research Center

**XVII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:**

<b><u>DATES</u></b>	<b><u>SOCIETY</u></b>	<b><u>ROLE</u></b>
2015-present	Society for Behavioral Medicine	Member
2015-present	Society for Research on Nicotine and Tobacco	Member
2003-2016	American Association of Geriatric Psychiatry	Affiliate Member
1994-2012	American Psychological Association	Member

**XVIII. EDITORIAL BOARDS**

N/A

**XIX. JOURNAL REFEREE ACTIVITY**

<b><u>DATES</u></b>	<b><u>JOURNAL NAME</u></b>	<b><u>ANNUAL FREQUENCY OF REVIEW</u></b>
2016-present	American Journal on Addictions	0-2
2015-present	Administration and Policy in Mental Health and Mental Health Services Research	0-2
2015-present	Cognitive Behaviour Therapist	0-2
2015-present	Community Development Journal	0-2
2015-present	Journal of Dual Diagnosis	0-2
2014-present	Annals of Behavioral Medicine	0-2
2014-present	Psychiatric Rehabilitation Journal	0-4
2014-present	Psychiatric Services	0-4
2013-present	International Journal of Sport and Exercise Psychology	0-3
2012-present	Journal of Substance Abuse Treatment	0-2
2011	Schizophrenia Bulletin	0-2
2011-present	Bipolar Disorders	0-2
2010-present	European Psychiatry	0-2

2017-present	Community Mental Health Journal	0-4
2007-present	Archives of General Psychiatry	0-2
2006-present	Psychiatry Research	0-2
2003-present	Schizophrenia Research	0-2
2003-present	International Journal of Geriatric Psychiatry	0-2
2002-present	Journal of Mental Health	0-3
2002-present	American Journal of Geriatric Psychiatry	0-2

**XX. AWARDS AND HONORS:**

<u>DATE</u>	<u>AWARD</u>
2002	Summer Research Institute in Geriatric Psychiatry
2000	Institute for Intervention Research on Severe Mental Illness
1994-1999	Presidential Scholarship (Full Tuition)
1989	Member, Phi Beta Kappa
1989	Member, National Collegiate Honorary in Political Science (Pi Sigma Alpha)
1989	Winthrop Scholar
1989	Magna Cum Laude with Distinction in Political Science
1985-1989	Dow Jones Scholar

**XXI. INVITED PRESENTATIONS****International**

<u>DATE</u>	<u>TOPIC/TITLE</u>	<u>ORGANIZATION</u>	<u>LOCATION</u>
2019	*Innovative Strategies to Address Nicotine Addiction in Smokers with Serious Mental Illness	Global Forum on Nicotine	Warsaw, Poland
2018	*^Whole Health for People with Serious Mental Illness	Eyra Fysio	Gothenburg, Sweden
2018	*The Future of Health and Well-Being For People Challenged by Mental Illness	IIMHL Leadership Exchange	Stockholm, Sweden
2017	#Poster Presentation: What's E-cig Got To Do With It? Electronic Cigarette Use in Smokers with Serious Mental Illness	International Society for Research on Nicotine and Tobacco	Florence, Italy
2013	*Symposium: Telehealth for People with Serious Mental Illness	The King's Fund Annual Conference	London, England
2010	#Successfully Improving Psychosocial Functioning in Older People with Serious Mental Illness	World Congress of Behavioral and Cognitive Therapies	Boston, MA

**National**

<b><u>DATE</u></b>	<b><u>TOPIC/TITLE</u></b>	<b><u>ORGANIZATION</u></b>	<b><u>LOCATION</u></b>
2019	*^Preliminary Outcomes of a Randomized Controlled Trial of E-Cigarettes in Serious Mental Illness	10 <sup>th</sup> Annual Thematic Meeting on Addictions	Clearwater, FL
2019	*Strategies to Integrate Physical and Mental Health Care for People with Serious Mental Illness	Santa Cruz County (Grand Rounds)	Santa Cruz, CA
2018	#Poster Presentation: Relationship Between Cognition and Nicotine Dependence in Smokers with Mental Illness	Society for Neuroscience Annual Meeting	San Diego, CA
2017	*^Symposium: An Automated Telehealth Program to Improve Psychiatric Symptoms and Improve Community Tenure in People with SMI	Substance Abuse and Mental Health Services Administration, PBHCI Program National Meeting	Austin, TX
2017	*^Symposium: Integrated Illness Management and Recovery: Training Consumers in Health Self-Management	Substance Abuse and Mental Health Services Administration, PBHCI Program National Meeting	Austin, TX
2016	*^Symposium: Fitness Promotion for People with Serious Mental Illness: NH MIPCD "Healthy Choices, Healthy Changes"	Association for Behavioral and Cognitive Therapies	New York, NY
2016	*^Symposium: Comparing Older and Younger Adults with Serious Mental Illness Engaged in Weight Management and Smoking Cessation	Gerontological Society of America	New Orleans, LA
2015	#Paper Presentation: E-cigarette Substitution for Smokers with Schizophrenia or Bipolar Disorder Who Previously Failed to Quit	Society for Research on Nicotine and Tobacco	Philadelphia, PA
2015	*^Symposium: Exercise Promotion in Community Mental Health Settings: Translating Findings from Clinical Trials	Society for Behavioral Medicine	San Antonio, TX
2014	*^Symposium: Community Picks from the Orchard of Evidence-based Health	National Academy for State Health Policy Annual	Atlanta, GE

	Interventions	State Health Policy	
2013	#^Workshop: Integrated Illness Management and Recovery	Massachusetts Psychiatric Rehabilitation Association	Worcester, MA
2011	*Symposium: Telehealth at a Community Mental Health Center: Evaluation of Feasibility and Acceptability	National Association of Home Care & Hospice	Las Vegas, NV
2010	#^Symposium: Informing and Testing Interventions that Promote Health Behavioral Change in People with Severe Mental Illness	Society for Social Work and Research	Tampa, FL
2009	*^Keynote Address: Growing Old Gracefully: Successful Aging in the 21 <sup>st</sup> Century	Annual Behavioral Health, Aging & Wellness Conference	Fairview Heights, IL
2008	#Symposium: Promoting Health and Fitness in People with Serious Mental Illness: Evaluations of the In SHAPE Program	American Association for Geriatric Psychiatry	Orlando, FL
2007	#Symposium: Effect of Psychosocial Rehabilitation Intervention on the Functioning of Older Persons with SMI: Helping Older People Experience Success	American Association for Geriatric Psychiatry	New Orleans, LA
2006	#Symposium: In SHAPE: A Pilot Evaluation of a Health Promotion Intervention for People with Serious Mental Illness	American Association for Geriatric Psychiatry	San Juan, Puerto Rico
2006	#Symposium: Cognitive and Symptom Correlates of Functioning in Older People with Serious Mental Illness	American Association for Geriatric Psychiatry	San Juan, Puerto Rico
2006	#Symposium: Predictors of Functioning And Treatment of Community Dwelling Older People with Bipolar Disorder	American Psychiatric Association	Toronto, Canada
2005	*Recruitment for Psychosocial Interventions Research	American Association of Geriatric Psychiatry Annual Meeting Workshop	San Diego, CA

2005	#Symposium: Long-term Care, Health Management, and Rehabilitation for Elderly with Schizophrenia	American Psychiatric Association	Atlanta, GE
2005	#Symposium: Medication Adherence in Older Adults with Mental Illness	American Association for Geriatric Psychiatry	San Diego, CA
2005	#Paper Presentation: Clinical Variables Associated with Poor Functioning in Older Adults with Severe Mental Illness	American Association for Geriatric Psychiatry	San Diego, CA
2003	#Poster Presentation: Helping Older People Experience Success: the HOPES Study	American Association for Geriatric Psychiatry	Honolulu, HI

**Regional/Local**

<b><u>DATE</u></b>	<b><u>TOPIC/TITLE</u></b>	<b><u>ORGANIZATION</u></b>	<b><u>LOCATION</u></b>
2020	*^The HOPES Program in Project Success	Maine Medical Center Grand Rounds	Portland, ME
2019	*^The STRIDE Program at NHH	New Hampshire Hospital	Concord, NH
2019	*^ Improvements in Self-Reported Health in Chronic Smokers with SMI Using E-cigs	Norris Cotton Cancer Center	Lebanon, NH
2018	*^Clinical Trial of E-Cigarettes for Smokers with Severe Mental Illness	10 <sup>th</sup> Annual Koop Tobacco Treatment Conference	Lebanon, NH
2018	*^Integrated Illness Management and Recovery: Using Mobile Health to Enhance the Delivery of an Evidence-Based Practice	New Hampshire Hospital Grand Rounds	Concord, NH
2018	*^TeleFriend: A Telehealth Program to Monitor and Improve Self-Management of People with Serious Mental Illness	Vermont Association of Hospitals and Health Systems	Burlington, VT
2018	*^Clinical Trial of E-Cigarettes for Smokers with Serious Mental Illness	Ninth Annual Thematic Meeting on Addictions	Lebanon, NH
2018	*^Evaluating E-cigarette Substitution in Chronic Smokers with SMI: Update on a Clinical Trial	Cancer Control Program	Lebanon, NH

2018	*^TeleFriend Pilot at the Brattleboro Retreat	Vermont Program for Quality in Health Care	Montpelier, VT
2018	*^Electronic Cigarettes: A Potential Harm Reduction Strategy for Chronic Smokers with SMI Who Can't Quit	Center for Technology and Behavioral Health at Dartmouth Research Seminar	Lebanon, NH
2018	*^Tobacco and People with SMI: What's the Harm?	Mental Health Center of Greater Manchester	Manchester, NH
2017	*^Cash to Quit: Rewards for Cessation in a Statewide Medicaid Program for Smokers with Mental Illness	Center for Addiction Medicine, Mass General Grand Rounds	Boston, MA
2017	*Evaluation of the STRIDE Program in an Inpatient Setting	New Hampshire Hospital Journal Club	Concord, NH
2016	*^New Hampshire MIPCD "Healthy Choices, Healthy Changes"	Center for Technology and Behavioral Health at Dartmouth Research Seminar	Lebanon, NH
2016	*Innovative Approaches to Improve the Health and Quality of Life for People with Serious Mental Illness	National Alliance on Mental Illness Regional Meeting	Lebanon, NH
2016	*^The Telefriend Study: "Trials" and Tribulations of an R01 to Evaluate a Telehealth Intervention	Center for Technology and Behavioral Health at Dartmouth Research Seminar	Lebanon, NH
2015	*^Impact of E-Cigarettes Among Smokers with Serious Mental Illness Who Struggle to Quit	Norris Cotton Cancer Center Grand Rounds	Lebanon, NH
2014	*^Feasibility and Acceptability of E-Cigarettes Among Recalcitrant Smokers With Serious Mental Illness: A Pilot Study	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2013	*^The In SHAPE Program for People with SMI: Moving from Professional to Peer-Enhanced Model	Boston University Center for Psychiatric Rehabilitation Research Seminar	Boston, MA
2013	*^Using a Telehealth Device to Improve Psychiatric illness Management: Results of a Pilot Study Project	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH

2012	*^Telehealth and the Treatment of Serious Mental Illness	New Hampshire Hospital Grand Rounds	Concord, NH
2012	*^A New Frontier for Medicaid: Rewarding Beneficiaries for Good Health	New Hampshire Hospital Grand Rounds	Concord, NH
2011	*^Medicaid Incentives for the Prevention of Chronic Diseases: The NH Wellness Incentives Program	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2011	*^Integrated Illness Management and Recovery: Pilot Study Results and Planning an R01 Proposal	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2010	*^Preventing Early Mortality in Serious Mental Illness: Integrated Rehabilitation and Health Care	New Hampshire Hospital Grand Rounds	Concord, NH
2010	*^The Road to a Successful K Award	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2007	*^Approaches to Integrated Rehabilitation and Wellness Self-Management for People with Serious Mental Illness	Boston University School of Continuing Medical Education	Boston, MA
2005	*^Preliminary Results of Medication Adherence in Older People with Severe Mental Illness	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2005	*^Teaching Old Dogs New Tricks: Psychosocial Rehabilitation for Older People with Mental Illness	New Hampshire Hospital Grand Rounds	Concord, NH
2005	*^Findings from the HOPES Study of Rehabilitation and Health Care for the Elderly with SMI and New Directions for Future Grants	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2004	*^Medication Adherence in Older People with Severe Mental Illness	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2003	*^Helping Older Adults Experience Success: An Intervention for Older Adults with Severe Mental Illness	New York Presbyterian Hospital Research Seminar	White Plains, NY

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**A. Peer-reviewed Publications****Original Articles:**

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#### C. Abstracts

- #1. **Pratt, S. I.**, Bartels, S. J., Mueser, K. T., & Forester, B. (2003). Helping Older People Experience Success: the HOPES Study. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.
- #2. Forester, B., Bartels, S., **Pratt, S. I.**, & Mueser, K. T. (2005). Clinical characteristics of schizoaffective disorder in older adults compared to schizophrenia, bipolar disorder, and depression. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.
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- #8. Barre, L. K., **Pratt, S. I.**, & Bartels, S. J. (2010). Identifying frailty in older adults with serious mental illness. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.
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## XII. PERSONAL STATEMENT

During my career, I have been committed to enhancing the functioning and quality of life of people who are challenged by serious mental illness (SMI), improving the quality of clinical care offered by treatment providers, and establishing a team of consistent and productive staff and colleagues to conduct research that positively impacts the field of mental health. I have done this by developing and evaluating interventions focused on improving health, fitness, psychosocial skills, and the illness self-management ability in the vulnerable population of people with SMI. As a full time, fully funded researcher for the past 19 years, I have served as a PI and Co-Investigator continuously on almost 30 separate research studies, developing expertise related to all aspects of clinical research and participating in all phases of research. Many of the interventions I have been involved with have had a significant impact on the field, enhancing the lives of thousands of people living with SMI, augmenting the skills and quality of care provided by hundreds of clinicians working with this population, and training a huge work force of researchers dedicated to the mission of creating an ever-growing base of knowledge about best practices for people with SMI.

My work has impacted and advanced the mental health field in many ways particularly through creation and evaluation of several manualized interventions focused on enhancing the health and functioning of people with SMI, and development of innovative strategies to address some of the most challenging problems facing this group. I have also made contributions in terms of the significant community partnerships I have established and individuals I have mentored.

### *Creation and Evaluation of Manualized Interventions*

I have been the primary author on several manualized interventions that have been used in dozens of community mental health centers (CMHCs) with thousands of people challenged by SMI. For example, I developed a group-based skills training intervention targeting social skills, community living skills and physical health self-management skills, the Helping Older People Experience Success (HOPES) program, one of only 3-4 psychosocial interventions that has ever been created for older people with SMI. As part of my K23 Award, I also developed and evaluated the first individually tailored program of skills training and psychosocial rehabilitation for older people with SMI. As a recognized expert in psychosocial rehabilitation and skills training for people with serious mental illness, I am asked to give lectures and workshops on this topic and have provided trainings in HOPES to several CMHCs across the United States. In collaboration with my long-time mentee, Meghan Santos, MSW, I also created a manualized intervention, Integrated Illness Management and Recovery (I-IMR), to train people with SMI on illness self-management and to teach them about how physical and mental health are related. I-IMR is the only truly integrated curriculum that teaches about the relationship between physical and mental illness and how to better manage them simultaneously; therefore, it has made a unique contribution to the field. I recently received a \$7.5 million contract from the Patient Centered Outcomes Research Institute to evaluate the effectiveness of I-IMR in a large Pragmatic Clinical Trial. I also am approached routinely by community mental health centers across the country with requests for training in I-IMR, which is now offered in 11 US states.

I have been integrally involved in the development and evaluation of what has become the most widely adopted fitness promotion program for people with SMI, "In SHAPE." I also co-wrote the In SHAPE treatment manual and am part of the training team that has instructed 80 mental health agencies across 28 US states in implementation of this intervention. There are several other fitness promotion interventions that have been developed for people with SMI, but no other fitness program has come close to achieving the widespread implementation of In SHAPE. These interventions have impacted the

lives of thousands of people with SMI, improving their psychosocial skills, enhancing their illness self-management abilities, and reducing their risk for cardiovascular disease and premature mortality by increasing their fitness, all of which allows them to pursue meaningful recovery-oriented life goals. Having trained and supervised dozens of clinical providers in the delivery of these interventions, I have also positively impacted the quality of services offered at more than 100 CMHCs across the US.

#### *Development of Innovative Strategies to Address Challenging Problems*

I have been involved in several innovative initiatives that have addressed some of the most challenging problems faced by people with SMI, including tobacco addiction, psychiatric instability, engagement in healthy lifestyle behavior change, and most recently, surviving the COVID-19 pandemic. After spending many years conducting evaluations of smoking cessation interventions tailored for people with SMI, including a study published in JAMA, I embarked on an innovative course of research on the use of electronic cigarettes for harm reduction among chronic smokers with SMI who have tried but are unable or unwilling to quit. When I began this research in 2013, electronic cigarettes were especially controversial and therefore I faced scrutiny, criticism, and disapproval. Nevertheless, after a successful pilot study, in 2015 I received an R01 as PI to evaluate the appeal and health impact of e-cigarettes among people with SMI. I am currently in the final stages of developing a coaching program to help people with mental illness to switch fully to e-cigarettes, which will be tested in a pilot study in the Bronx, NY.

Chronic psychiatric instability leading to use of high intensity mental health services is another vexing problem, causing major disruption in the lives of affected individuals and their families and resulting in high cost to the public mental health system. From 2007-2011, I served as PI on two pilot studies of an innovative technology, remote monitoring of mental illness status, which led to funding of my first R01 as PI in 2014. I developed the psychiatric content for the program as well as innovative telehealth libraries addressing tobacco addiction and obesity. As a result of my work on these initiatives, I am recognized as an expert in the use of e-cigarettes among people with SMI, and the use of automated telehealth to address psychiatric instability in people with SMI.

From 2011-2016, I served as Co-PI on an innovative \$10 million research study funded by the Centers for Medicare and Medicaid to evaluate the impact of incentives on health behavior change in people with SMI. This 5-year project involved engaging leadership at 10 CMHCs across the state of NH to serve as study sites and hiring, training, and supervising over 40 new staff. The study provided fitness-promotion programming to almost 1400 people and tobacco education and smoking cessation programming to over 1400 people with SMI receiving services at the participating CMHCs. This unique project was the largest study of the use of incentives in people with SMI ever conducted, the outcomes of which provide invaluable information about the potential value of incentives and rewards in this population, making a significant contribution to the field of behavioral economics. This project served as the basis for a \$10 million grant recently awarded to the NH Bureau of Behavioral Health by SAMHSA on which I serve as Site PI that will continue to advance the science on using incentives to encourage health behavior change in people with serious mental illness, an important and innovative area of study.

I recently received a COVID-related Enhancement to my PCORI-funded Pragmatic Clinical Trial to develop a 3-session module for people with serious mental illness and underlying medical conditions that will provide education and behavioral coaching to prevent them from catching and spreading COVID-19 and other infectious viral infections. This was one of the first COVID-related projects approved by PCORI and it could have a significant impact on people with serious mental illness and other individuals who are especially at risk of negative outcomes of COVID-19.

### *Mentoring and Establishment of Community Partners*

An important part of my work is mentoring, demonstrating how to work clinically with people challenged by SMI, and providing individuals with the opportunity to learn about how to conduct rigorous research. My mentees have included not only students interested in pursuing advanced degrees in the mental health field, but also professionals with terminal degrees who have dedicated their careers to conducting research aimed at improving the lives of people with serious mental illness. I have supervised and mentored 40 undergraduate psychology students, master's students, and post-doctoral trainees. I have also trained and supervised an army of research staff (more than 130 people over the past 16 years), including research interviewers, research assistants, project coordinators, nurses, certified fitness trainers, and other study interventionists. Every staff person serving as an interventionist on my research studies has played a role in improving the lives of many people challenged by SMI. Combined, this represents thousands of individuals, in NH and across the country. I am especially proud of the dedication, loyalty, and commitment that I have fostered among the members of my research team; most notably, my four primary staff members have worked with me for 9-16 years. I have created a research team that is highly productive and has been extremely successful at obtaining funding and executing research studies.

My track record of establishing and maintaining a large network of community partners, primarily CMHCs, is also one of my greatest achievements. The type of research I do requires partnerships with clinical settings that serve people with SMI, the vast majority of which have no existing research infrastructure or culture of research. Therefore, it is a significant accomplishment that I have been able to establish positive working relationships with over 2 dozen clinical sites in multiple states that have participated eagerly and repeatedly in my research studies, including small agencies serving less than 1,000 clients annually and very large mental health systems serving tens of thousands of clients across several states. Cultivating these partnerships takes attention, effort, and skill.

### *Goals*

I look forward to making further meaningful contributions to clinical psychiatry by conducting intervention and dissemination research; training and mentoring students, junior investigators, and staff; and sharing findings of my work at the institutional, local, national, and international level. I hope that the research I direct will have translational value to improve the health and quality of life for those challenged by SMI, as well as the skills and services offered by clinical providers.

**Updated by: Sarah Pratt**

**Date: 6/26/20**

**CONTRACTOR NAME**

Key Personnel

SFY22 (7/1/21-6/30/22)				
Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Sarah Pratt, PhD	Principal Scientist/Associate Professor	\$148,066.50	30%	\$44,420

SFY23 (7/1/23-6/30/24)				
Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Sarah Pratt, PhD	Principal Scientist/Associate Professor	\$152,508.50	30%	\$45,752

SFY24 (7/1/24-9/29/24)				
Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Sarah Pratt, PhD	Principal Scientist/Associate Professor	\$157,083.76	30%	\$12,688