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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Lori A. Weaver
 Commissioner

Morissa S. Henn
 Deputy Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
 603-271-9200 1-800-852-3345 Ext. 9200
 Fax: 603-271-4912 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

June 13, 2024

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, Office of the Commissioner, to enter into a **Sole Source** amendment to an existing contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, New Hampshire, to continue the work of evaluating the transformed crisis system, New Hampshire Rapid Response, and increase clinical staff at the Sununu Youth Service Center (SYSC), by increasing the price limitation by \$614,928 from \$9,109,658 to \$9,724,586 with no change to the contract completion date of June 30, 2025, effective upon Governor and Council approval. 53% Federal Funds, 47% General Funds. The original contract was approved by Governor and Council on March 23, 2022, item #10.

Funds are available in the following accounts for State Fiscal Years 2024 and 2025, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

See attached fiscal details.

EXPLANATION

This request is **Sole Source** because MOP 150 requires all amendments to agreements previously approved as sole source to be identified as sole source. This amendment will accomplish two separate deliverables from the Contractor including the completion of an evaluation of the statewide Rapid Response system and an increase in the number of licensed clinicians available to support the residents of the Sununu Youth Services Center (SYSC).

The first purpose of this request is to utilize one-time American Rescue Plan (ARPA) Mental Health Block Grant funds to continue the evaluation of the statewide Rapid Response crisis system. The Contractor will continue to provide recommendations for continuous quality improvement and support the development of the final pillar of the Crisis Now model (Somewhere to Go). Additionally, the Contractor will also finalize data-driven dashboards that could not be completed on the original timetable. The Contractor has worked closely over the past year to validate all data points and has begun mapping the data to produce internal and external dashboards. The Contractor will continue providing system improvement recommendations and technical assistance. Lastly, the Contractor will issue a final report inclusive of final internal and external data dashboards and ongoing quality oversight tools, processes, and recommendations.

The second purpose of this amendment is to provide four (4) licensed clinicians to enhance mental health support and ensure timely and continuous coverage for residents of the Sununu Youth Services Center (SYSC). Comprehensive mental health services at SYSC focus on stabilization, mitigation of risk, and preparing youth for a successful return to the community.

Approximately 40,000 individuals were served by the New Hampshire Rapid Response crisis system during State Fiscal Year 2023 and approximately 10 to 20 youth per month receive mental health services at SYSC.

The Department will monitor contracted services by reviewing recommendations for improvements and sustainability of the rapid response crisis system and by communicating with SYSC around the implementation of additional clinical support and the resulting increases in stability and support of the youth served.

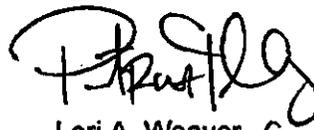
Should the Governor and Council not authorize this request, the Department will have limited ability to continue to evaluate the rapid response crisis system, thereby delaying the implementation of improvement programs.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number #93.958, FAIN #B09SM085371.

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

Respectfully submitted,



Lori A. Weaver
Commissioner

Fiscal Details

SS-2022-OCOM-02-CLINI-01-A01

05-95-95-950010-50000000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT,
COMMISSIONER'S OFFICE, OFFICE OF THE COMMISSIONER, COMMISSIONER'S OFFICE

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	102-500731	Contracts for Prog Svc	95063303	\$148,811	\$0	\$148,811
2023	102-500731	Contracts for Prog Svc	95063303	\$459,358	\$0	\$459,358
			Subtotal	\$608,169	\$0	\$608,169

05-95-47-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT,
DIVISION OF MEDICAID SERVICES, OFFICE OF MEDICAID SERVICES, MEDICAID ADMINISTRATION

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2024	102-500731	Contracts for Prog Svc	47000021	\$472,670	\$0	\$472,670
2025	102-500731	Contracts for Prog Svc	47000021	\$486,381	\$0	\$486,381
			Subtotal	\$959,051	\$0	\$959,051

05-95-42-421510-66430000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
HUMAN SERVICES, SUNUNU YOUTH SERVICE CENTER, SYSC HB2 91:327

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	101-506224	Medical Payments to Providers	42151501	\$279,985	\$0	\$279,985
2023	101-506224	Medical Payments to Providers	42151501	\$864,807	\$0	\$864,807
2024	101-506224	Medical Payments to Providers	42151501	\$890,406	\$0	\$890,406
2025	101-506224	Medical Payments to Providers	42151501	\$916,773	\$289,928	\$1,206,701
			Subtotal	\$2,951,971	\$289,928	\$3,241,899

05-95-92-922010-41170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, CMH PROGRAM SUPPORT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
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2022	102-500731	Contracts for Prog Svc	92204117	\$199,947	\$0	\$199,947
2023	102-500731	Contracts for Prog Svc	92204117	\$616,422	\$0	\$616,422
2024	102-500731	Contracts for Prog Svc	92204117	\$634,191	\$0	\$634,191
2025	102-500731	Contracts for Prog Svc	92204117	\$652,492	\$0	\$652,492
			Subtotal	\$2,103,052	\$0	\$2,103,052

05-95-92-922010-41200000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, MENTAL HEALTH BLOCK GRANT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	102-500731	Contracts for Prog Svc	92254120	\$97,114	\$0	\$97,114
2023	102-500731	Contracts for Prog Svc	92254120	\$286,437	\$0	\$286,437
2024	102-500731	Contracts for Prog Svc	92254120	\$207,564	\$50,000	\$257,564
2025	102-500731	Contracts for Prog Svc	92254120	\$84,041	\$275,000	\$359,041
			Subtotal	\$675,156	\$325,000	\$1,000,156

05-95-48-481010-78720000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DLSS-ELDERLY&ADULT SVCS, GRANTS FOR SOCIAL SVC PROG, ADM ON AGING

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	540-500382	Social Services Contract	48130305	\$13,420	\$0	\$13,420
2023	540-500382	Social Services Contract	48130305	\$41,461	\$0	\$41,461
2024	540-500382	Social Services Contract	48130305	\$42,696	\$0	\$42,696
2025	540-500382	Social Services Contract	48130305	\$43,968	\$0	\$43,968
			Subtotal	\$141,545	\$0	\$141,545

05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DLSS-DEVELOPMENTAL SVCS, DIV OF DEVELOPMENTAL SERVICES, SPECIAL MEDICAL SERVICES

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	561-500911	Specialty Clinics	93001000	\$30,000	\$0	\$30,000
2023	561-500911	Specialty Clinics	93001000	\$30,000	\$0	\$30,000
2024	561-500911	Specialty Clinics	93001000	\$30,000	\$0	\$30,000
2025	561-500911	Specialty Clinics	93001000	\$30,000	\$0	\$30,000

			Subtotal	\$120,000	\$0	\$120,000
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05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DLSS-DEVELOPMENTAL SVCS, DIV OF DEVELOPMENTAL SERVICES, PROGRAM SUPPORT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	561-500911	Specialty Clinics	93005947	\$74,788	\$0	\$74,788
2023	561-500911	Specialty Clinics	93005947	\$293,514	\$0	\$293,514
2024	561-500911	Specialty Clinics	93005947	\$302,938	\$0	\$302,938
2025	561-500911	Specialty Clinics	93005947	\$312,645	\$0	\$312,645
			Subtotal	\$983,885	\$0	\$983,885

05-95-92-920510-19810000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SERVICES, SABG ADDITIONAL

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	102-500731	Contracts for Prog Svc	92055902	\$77,876	\$0	\$77,876
2023	102-500731	Contracts for Prog Svc	92055902	\$231,038	\$0	\$231,038
2024	102-500731	Contracts for Prog Svc	92055902	\$173,875	\$0	\$173,875
2025	102-500731	Contracts for Prog Svc	92055902	\$84,040	\$0	\$84,040
			Subtotal	\$566,829	\$0	\$566,829
			Total	\$9,109,658	\$614,928	\$9,724,586

**State of New Hampshire
Department of Health and Human Services
Amendment #1**

This Amendment to the Clinical and Administrative Services contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Mary Hitchcock Memorial Hospital ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on March 23, 2022 (Item #10), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

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

1. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:
\$9,724,586
2. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:
Robert W. Moore, Director
3. Modify Exhibit B, Scope of Services, Section 1.7.5.1, to read:
 - 1.7.5.1 The Contractor shall provide four (4) licensed Clinicians to provide clinical support and services to SYSC residents in accordance with SYSC policies and protocols. Two (2) of the licensed clinicians shall work Monday through Friday approximately 9:00am to 5:00pm. One (1) of the licensed clinicians shall work Monday through Friday second shift, approximately 12:00pm to 8:00pm. One (1) of the licensed clinicians shall work Friday through Monday, approximately 10:00am to 8:00pm. Services shall include, but are not limited to:
 - 1.7.5.1.1 Individual, group and family therapy;
 - 1.7.5.1.2 Watch assessments;
 - 1.7.5.1.3 Crisis intervention and/or support and processing; and
 - 1.7.5.1.4 Development of youth treatment plans.
4. Modify Exhibit B, Scope of Services, Section 1.7.5.2, to read:
 - 1.7.5.2 The Contractor shall ensure on-call service coverage by either the Staff Psychologist or Clinicians, Monday through Friday from 5:00 p.m. to 7:00 a.m. and weekends.
5. Modify Exhibit B, Scope of Services, Section 1.7.5.5, to read:
 - 1.7.5.5 The Clinicians shall prepare parole and court reports and participate in hearings as necessary.
6. Modify Exhibit B, Scope of Services; Section 1.8.5 title, to read:
 - 1.8.5 Crisis System Transformation Evaluation (Phase 1: Sections 1.8.5.1 – 1.8.5.5 and Phase II: 1.8.5.6 – 1.8.5.7)
7. Modify Exhibit B, Scope of Services; Section 1.8.5.3 title, with no change to the rest of the section, to read:
 - 1.8.5.3 The Contractors must work with the Department to evaluate and inform the

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transformation of NH's crisis system by:

8. Modify Exhibit B, Scope of Services; Section 1.8.5.3 title, with no change to the rest of the section, to read:

1.8.5.4 The Contractors must work with the Department to evaluate and inform the transformation of NH's crisis system by:

9. Modify Exhibit B, Scope of Services; Section 1.8.5.3 title, with no change to the rest of the section, to read:

1.8.5.5 The Contractors must work with the Department to evaluate and inform the transformation of NH's crisis system by:

10. Modify Exhibit B, Scope of Services; Section 1.8.5.6 title, with no change to the rest of the section, to read:

1.8.5.6. The Contractors must work with the Department to support, refine, and guide sustainability of the transformation of NH's crisis system by:

11. Modify Exhibit B, Scope of Services; Section 1.8.5.7, to read:

1.8.5.7. In collaboration with the Department, the Contractor must prepare a public report regarding efficacy and outcomes of the crisis system transformation. The final report shall include, but is not limited to:

1.8.5.7.1. Findings from both quantitative and qualitative data collected at various time points;

1.8.5.7.2. Summary of needed adaptations, if applicable, with rationale and recommendations;

1.8.5.7.3. Summary of any identified crisis system gaps that became evident throughout the analysis;

1.8.5.7.4. Evaluation findings regarding the "fit" of the crisis model to rural settings, staffing capacity, and funding and other resources necessary to meet current and anticipated future needs; and

1.8.5.7.5. Recommendations for crisis system sustainability.

1.8.5.7.6. The final internal and external data dashboards, final quality oversight tools, and processes and recommendations for ongoing oversight and next steps.

12. Modify Exhibit B, Scope of Services; Section 1.8.5.8, to read:

1.8.5.8. Reserved

13. Modify Exhibit C, Payment Terms, Section 1, to read:

1. This Agreement is funded by:

1.1. 30% Federal Funds from:

1.1.1. The Centers for Medicare & Medicaid Services (CMS), Assistance Listing Number (ALN) #93.778, FAIN# 2405NH5ADM;

1.1.2. Health Resources and Services Administration (HRSA), Maternal and Child Health Block Grant, ALN #93.994, FAIN# B0452939;

1.1.3. Administration on Aging, Title III-B Social Services, ALN #93.044, FAIN# 2401NHOASS;

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1.1.4. Substance Abuse & Mental Health Services Administration (SAMHSA), Community Mental Health Block Grant, ALN #93.958, FAIN # B09SM085371; and

1.1.5. SAMHSA, Substance Abuse Block Grant ARPA, ALN #93.959, FAIN# 1B08TI083955.

1.2. 70% General funds.

14. Modify Exhibit C-2, Budget Sheet, by replacing it in its entirety with Exhibit C-2, Budget Sheet, Amendment #1 which is attached hereto and incorporated by reference herein.

15. Modify Exhibit C-5, Budget Sheet, by replacing it in its entirety with Exhibit C-5, Budget Sheet, Amendment #1 which is attached hereto and incorporated by reference herein.

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All terms and conditions of the Contract not modified by this Amendment remain in full force and effect. This Amendment shall be effective upon Governor and Council approval.

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

State of New Hampshire
Department of Health and Human Services

6/10/2024

Date

DocuSigned by:
Katja S. Fox
ED0D06B04C63442

Name: Katja S. Fox
Title: Director

Mary Hitchcock Memorial Hospital

6/9/2024

Date

DocuSigned by:
Edward J. Merrens, MD, MHCDS
8ACA3CECA0CC438

Name: Edward J. Merrens, MD, MHCDS
Title: chief clinical officer

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

OFFICE OF THE ATTORNEY GENERAL

6/10/2024

Date

DocuSigned by:
Robyn Guarino

Name: Robyn Guarino

Title: Attorney

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:

Title:

New Hampshire Department of Health and Human Services Contractor Name: <i>Mary Hitchcock Memorial Hospital</i> <i>Clinical and Administrative Services - Service Area</i> Budget Request for: <i>#3 Behavioral Health</i> Budget Period: <i>SFY22 through SFY25</i> Indirect Cost Rate (if applicable) 15.00%				
Line Item	Program Cost - Funded by DHHS - SFY 22	Program Cost - Funded by DHHS - SFY 23	Program Cost - Funded by DHHS - SFY 24	Program Cost - Funded by DHHS - SFY 25
1. Salary & Wages	\$188,531	\$582,560	\$600,037	\$805,386
2. Fringe Benefits	\$51,601	\$159,446	\$164,229	\$230,419
3. Consultants	\$0	\$0	\$0	\$0
4. Equipment Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.	\$0	\$0	\$0	\$0
5.(a) Supplies - Educational	\$0	\$0	\$0	\$0
5.(b) Supplies - Lab	\$0	\$0	\$0	\$0
5.(c) Supplies - Pharmacy	\$0	\$0	\$0	\$0
5.(d) Supplies - Medical	\$0	\$0	\$0	\$0
5.(e) Supplies - Office	\$0	\$0	\$0	\$0
6. Travel	\$333	\$1,000	\$1,000	\$1,500
7. Software	\$0	\$0	\$0	\$0
8. (a) Other - Marketing/Communications	\$0	\$0	\$0	\$0
8. (b) Other - Education and Training	\$3,000	\$9,000	\$9,000	\$12,000
8. (c) Other - Other (specify below)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
9. Subrecipient Contracts	\$0	\$0	\$0	\$0
Total Direct Costs	\$243,465	\$752,006	\$774,266	\$1,049,305
Total Indirect Costs	\$36,520	\$112,801	\$116,140	\$157,396
Subtotals	\$279,985	\$864,807	\$890,406	\$1,206,701
			TOTAL	\$3,241,899

New Hampshire Department of Health and Human Services Contractor Name: <i>Mary Hitchcock Memorial Hospital</i> <i>Clinical and Administrative Services - Service Area</i> Budget Request for: #3 Behavioral Health Budget Period: SFY22 through SFY25 Indirect Cost Rate (if applicable) 15.00%				
Line Item	Program Cost - Funded by DHHS - SFY 22	Program Cost - Funded by DHHS - SFY 23	Program Cost - Funded by DHHS - SFY 24	Program Cost - Funded by DHHS - SFY 25
1. Salary & Wages	\$11,294	\$34,900	\$23,965	\$13,569
2. Fringe Benefits	\$3,886	\$12,005	\$8,243	\$4,437
3. Consultants	\$0	\$0	\$21,740	\$118,276
4. Equipment Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.	\$0	\$0	\$0	\$0
5.(a) Supplies - Educational	\$0	\$0	\$0	\$0
5.(b) Supplies - Lab	\$0	\$0	\$0	\$0
5.(c) Supplies - Pharmacy	\$0	\$0	\$0	\$0
5.(d) Supplies - Medical	\$0	\$0	\$0	\$0
5.(e) Supplies - Office	\$0	\$0	\$0	\$0
6. Travel	\$0	\$0	\$0	\$0
7. Software	\$0	\$0	\$0	\$0
8. (a) Other - Marketing/Communications	\$0	\$0	\$0	\$0
8. (b) Other - Education and Training	\$0	\$0	\$0	\$0
8. (c) Other - Other (specify below)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
Other (please specify)	\$0	\$0	\$0	\$0
9. Subrecipient Contracts	\$92,970	\$264,532	\$182,185	\$118,276
Total Direct Costs	\$108,150	\$311,437	\$236,133	\$254,558
Total Indirect Costs	\$16,222	\$46,716	\$31,670	\$20,442
Subtotals	\$124,372	\$358,153	\$267,803	\$275,000
			TOTAL \$	1,025,328

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Contractor Initials: 6/7/2024
Date:

State of New Hampshire

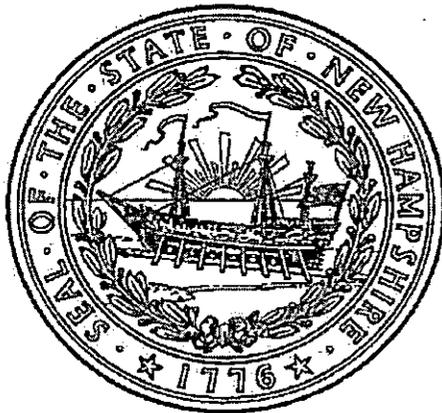
Department of State

CERTIFICATE

I, David M. Scanlan, 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: 0006622917



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 20th day of March A.D. 2024.

A handwritten signature in black ink, appearing to read "David M. Scanlan".

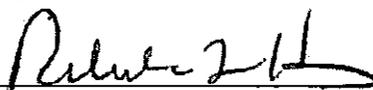
David M. Scanlan
Secretary of State

**CERTIFICATE OF VOTE/AUTHORITY**

I, Roberta L. Hines, MD, do hereby certify that:

1. I am the duly elected Chair of the Boards of Trustees of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic (together, "Dartmouth-Hitchcock").
2. The following is a true and accurate excerpt from the Amended, Restated and Integrated Bylaws of the Dartmouth-Hitchcock Corporations:
 - a. **"ARTICLE II – Section A. Fiduciary Duty. Stewardship over Corporate Assets.** As responsible stewards of tax-exempt, charitable Corporations, members of the Corporations' Boards have the fiduciary duty to oversee, with due care and loyalty, the stewardship of the Corporations' assets and operations in order to create a sustainable health system that is population focused and value-based, and to advance their respective corporate purposes. In exercising this duty, the Boards may, consistent with the respective Corporation's Articles of Agreement and these Bylaws, delegate authority to Board Committees and other bodies, or to various officers, to provide 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 Corporations as may be necessary or desirable in furtherance of their charitable purposes."
3. Pursuant to policy approved and adopted by the Boards of Trustees consistent with the above Bylaws provision, the Chief Clinical Officer, Edward Merrens, MD, has subdelegated signature authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. The foregoing authority shall remain in full force and effect as of the date of the agreement executed or action taken in reliance upon this Certificate. This authority shall remain valid for thirty (30) days from the date of this Certificate and the State of New Hampshire shall be entitled to rely upon same, until written notice of modification, rescission or revocation of same, in whole or in part, has been received by the State of New Hampshire.

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Boards of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 1ST day of June, 2024.



Roberta L. Hines, MD, Board Chair

CERTIFICATE OF INSURANCE

DATE: June 29, 2023

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		0002023-A	7/1/2023	7/1/2024	EACH OCCURRENCE	\$1,000,000
X CLAIMS MADE					DAMAGE TO RENTED PREMISES	\$1,000,000
					MEDICAL EXPENSES	N/A
OCCURRENCE					PERSONAL & ADV INJURY	\$1,000,000
					GENERAL AGGREGATE	\$3,000,000
OTHER					PRODUCTS-COMP/OP AGG	\$1,000,000
PROFESSIONAL LIABILITY		0002023-A	7/1/2023	7/1/2024	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 and 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



ADDITIONAL REMARKS SCHEDULE

AGENCY HUB International New England		License # 1780862	NAMED INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756
POLICY NUMBER SEE PAGE 1			
CARRIER SEE PAGE 1	NAIC CODE SEE P 1	EFFECTIVE DATE: SEE PAGE 1	

ADDITIONAL REMARKS

**THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: ACORD 25 FORM TITLE: Certificate of Liability Insurance**

**Description of Operations/Locations/Vehicles:
Mt. Ascutney Hospital and Health Center
Visiting Nurse Associates and Hospice of Vermont and New Hampshire**

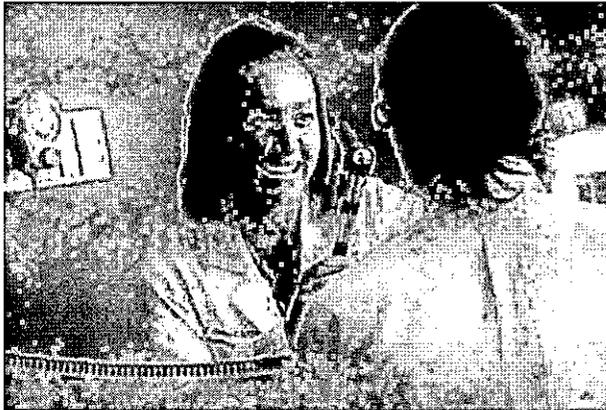
About Dartmouth Hitchcock Medical Center and Dartmouth Hitchcock Clinics

Dartmouth Hitchcock Medical Center and Clinics—members of Dartmouth Health (<https://www.dartmouth-health.org>)—include Dartmouth Hitchcock Medical Center, the state's only academic medical center, and Dartmouth Hitchcock Clinics, which provide primary and specialty care 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.

Who are Dartmouth Hitchcock Medical Center and Dartmouth Hitchcock Clinics?

Dartmouth Hitchcock Medical Center



Dartmouth Hitchcock Medical Center is the state's only academic medical center, and the only Level I Adult and Level II 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. In 2022, Dartmouth Hitchcock Medical Center was named the #1 hospital in New Hampshire by U.S. News & World Report (<https://health.usnews.com/best-hospitals/area/nh>), and recognized as high performing in 2 adult specialties, Cancer and Neurology/Neurosurgery, as well as in 12 common adult procedures and conditions.

Dartmouth Hitchcock Clinics



Dartmouth Hitchcock Clinics provide primary and specialty care throughout New Hampshire and Vermont, with major community group practices in Lebanon, Concord, Manchester, Nashua, and Keene, New Hampshire, and Bennington, Vermont.

Children's Hospital at Dartmouth Hitchcock Medical Center

Children's Hospital at Dartmouth Hitchcock Medical Center 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 Dartmouth Hitchcock Medical Center.



Norris Cotton Cancer Care Pavilion Lebanon

Norris Cotton Cancer Care Pavilion Lebanon (<https://cancer.dartmouth.edu/>), one of only 53 NCI-designated Comprehensive Cancer Centers in the nation, is one of the premier facilities for cancer treatment, research, prevention, and education.

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

About Dartmouth Health (<https://www.dartmouth-health.org/>)

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Dartmouth-Hitchcock Health and Subsidiaries

**Consolidated Financial Statements
June 30, 2023 and 2022**

Dartmouth-Hitchcock Health and Subsidiaries
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June 30, 2023 and 2022

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Report of Independent Auditors

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

Opinion

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, 2023 and 2022, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended, including the related notes (collectively referred to as the "consolidated financial statements").

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Health System as of June 30, 2023 and 2022, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Health System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management 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, and for 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.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for one year after the date the consolidated financial statements are issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.



In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit 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, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The accompanying consolidating balance sheets and consolidating statements of operations and changes in net assets without donor restrictions as of and for the years ended June 30, 2023 and 2022 (the "supplemental information") is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. The consolidating information is not intended to present, and we do not express an opinion on, the financial position, results of operations and cash flows of the individual companies. The supplemental 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 supplemental 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 supplemental information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

A handwritten signature in cursive script that reads "PricewaterhouseCoopers LLP".

Boston, Massachusetts
November 17, 2023

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2023 and 2022

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Assets		
Current assets		
Cash and cash equivalents	\$ 115,996	\$ 191,929
Patient accounts receivable, net (Note 4)	289,787	251,250
Prepaid expenses and other current assets	184,104	169,133
Total current assets	<u>589,887</u>	<u>612,312</u>
Assets limited as to use (Notes 5 and 7)	1,071,462	1,181,094
Other investments for restricted activities (Notes 5 and 7)	182,224	175,116
Property, plant, and equipment, net (Note 6)	811,622	764,840
Right-of-use assets, net (Note 16)	55,528	58,925
Other assets	193,333	172,163
Total assets	<u>\$ 2,904,056</u>	<u>\$ 2,964,450</u>
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	\$ 15,236	\$ 6,596
Current portion of right-of-use obligations (Note 16)	11,334	11,319
Line of credit	40,000	-
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,386	3,500
Accounts payable and accrued expenses	146,747	156,572
Accrued compensation and related benefits	137,467	190,560
Estimated third-party settlements (Note 3 and 4)	64,360	134,898
Total current liabilities	<u>418,530</u>	<u>503,445</u>
Long-term debt, excluding current portion (Note 10)	1,098,962	1,117,288
Long-term right-of-use obligations, excluding current portion (Note 16)	45,671	48,824
Insurance deposits and related liabilities (Note 12)	91,349	78,391
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	206,305	228,606
Other liabilities	173,918	154,096
Total liabilities	<u>2,034,735</u>	<u>2,130,650</u>
Commitments and contingencies (Notes 3, 4, 6, 7, 10, 13, and 16)		
Net assets		
Net assets without donor restrictions (Note 9)	658,988	634,297
Net assets with donor restrictions (Notes 8 and 9)	210,333	199,503
Total net assets	<u>869,321</u>	<u>833,800</u>
Total liabilities and net assets	<u>\$ 2,904,056</u>	<u>\$ 2,964,450</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, 2023 and 2022

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Operating revenue and other support		
Net patient service revenue (Note 4)	\$ 2,397,157	\$ 2,243,237
Contracted revenue	84,346	77,666
Other operating revenue (Note 4)	608,875	534,031
Net assets released from restrictions	14,843	15,894
Total operating revenue and other support	<u>3,105,221</u>	<u>2,870,828</u>
Operating expenses		
Salaries	1,423,091	1,315,407
Employee benefits	332,386	322,570
Medications and medical supplies	725,480	649,272
Purchased services and other	458,901	403,862
Medicaid enhancement tax (Note 4)	85,715	82,725
Depreciation and amortization	90,457	86,958
Interest (Note 10)	34,515	32,113
Total operating expenses	<u>3,150,545</u>	<u>2,892,907</u>
Operating loss	<u>(45,324)</u>	<u>(22,079)</u>
Non-operating gains (losses)		
Investment income (loss), net (Note 5)	58,119	(78,744)
Other components of net periodic pension and post retirement benefit income (Note 11 and 14)	(17,691)	13,910
Other losses, net	(8,530)	(6,658)
Total non-operating gains (losses), net	<u>31,898</u>	<u>(71,492)</u>
Deficiency of revenue over expenses	<u>\$ (13,426)</u>	<u>\$ (93,571)</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, 2023 and 2022

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Net assets without donor restrictions		
Deficiency of revenue over expenses	\$ (13,426)	\$ (93,571)
Net assets released from restrictions for capital	3,229	1,573
Change in funded status of pension and other postretirement benefits (Note 11)	34,901	(32,309)
Other changes in net assets	<u>(13)</u>	<u>(23)</u>
Increase (decrease) in net assets without donor restrictions	<u>24,691</u>	<u>(124,330)</u>
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	23,637	39,710
Investment income (loss), net	5,846	(7,010)
Net assets released from restrictions	<u>(18,653)</u>	<u>(17,467)</u>
Increase in net assets with donor restrictions	<u>10,830</u>	<u>15,233</u>
Change in net assets	35,521	(109,097)
Net assets		
Beginning of year	<u>833,800</u>	<u>942,897</u>
End of year	<u>\$ 869,321</u>	<u>\$ 833,800</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, 2023 and 2022

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Cash flows from operating activities		
Change in net assets	\$ 35,521	\$ (109,097)
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	90,806	87,006
Amortization of bond premium, discount, and issuance cost, net	(2,779)	(2,764)
Amortization of right-of-use asset	9,242	9,270
Payments on right-of-use lease obligations - operating	(9,162)	(9,190)
Change in funded status of pension and other postretirement benefits	(34,901)	32,309
Loss (gain) on disposal of fixed assets	(883)	(523)
Net realized gains and change in net unrealized gains on investments	(79,799)	86,652
Restricted contributions and investment earnings	(8,208)	(20,151)
Proceeds from sales of donated securities	3,818	10,665
Changes in assets and liabilities		
Patient accounts receivable, net	(38,537)	(19,089)
Prepaid expenses and other current assets	1,984	(9,915)
Other assets, net	(21,688)	2,517
Accounts payable and accrued expenses	(31,082)	17,104
Accrued compensation and related benefits	(53,093)	8,490
Estimated third-party settlements	(71,907)	(120,117)
Insurance deposits and related liabilities	12,958	(1,583)
Liability for pension and other postretirement benefits	12,486	(28,422)
Other liabilities	21,191	(56,687)
Net cash used in operating activities	<u>(164,033)</u>	<u>(123,525)</u>
Cash flows from investing activities		
Purchase of property, plant, and equipment	(129,321)	(160,855)
Proceeds from sale of property, plant, and equipment	1,214	613
Purchases of investments	(71,410)	(65,286)
Proceeds from maturities and sales of investments	249,684	137,781
Net cash provided by (used in) investing activities	<u>50,167</u>	<u>(87,747)</u>
Cash flows from financing activities		
Proceeds from line of credit	979,500	30,000
Payments on line of credit	(939,500)	(30,000)
Repayment of long-term debt	(81,907)	(9,116)
Proceeds from issuance of debt	75,000	-
Repayment of finance leases	(3,599)	(3,253)
Restricted contributions and investment earnings	8,208	20,151
Net cash provided by financing activities	<u>37,702</u>	<u>7,782</u>
Decrease in cash and cash equivalents	<u>(76,164)</u>	<u>(203,490)</u>
Cash and cash equivalents, beginning of year	<u>193,485</u>	<u>396,975</u>
Cash and cash equivalents, end of year	<u>\$ 117,321</u>	<u>\$ 193,485</u>
Supplemental cash flow information		
Interest paid	\$ 44,362	\$ 42,867
Construction in progress included in accounts payable and accrued expenses	5,105	9,407
Donated securities	3,818	10,665

The following table reconciles cash and cash equivalents on the consolidated balance sheets to cash, cash equivalents and restricted cash on the consolidated statements of cash flows.

	<u>2023</u>	<u>2022</u>
Cash and cash equivalents	\$ 115,996	\$ 191,929
Cash and cash equivalents included in assets limited as to use	-	1,350
Restricted cash and cash equivalents included in other investments for restricted activities	<u>1,325</u>	<u>206</u>
Total of cash, cash equivalents, and restricted cash shown in the consolidated statements of cash flows	<u>\$ 117,321</u>	<u>\$ 193,485</u>

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

Dartmouth-Hitchcock Health and Subsidiaries

Notes to Consolidated Financial Statements

June 30, 2023 and 2022

1. Organization and Community Benefit Commitments

Dartmouth-Hitchcock Health (D-HH), its Members, and their Subsidiaries (the Health System) is a system of hospitals, clinics, and other healthcare service providers across New Hampshire and Vermont. The Health System's mission is to advance health through research, education, clinical practice, and community partnerships, providing each person the best care, in the right place, at the right time, every time. The Health System seeks to achieve the healthiest population possible, leading the transformation of health care in the region and setting the standard for the nation. The Health System's expanding network of services are the fabric of its commitment to serve the region with exceptional medical care.

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of the following entities: Dartmouth-Hitchcock Clinic (DHC) and Subsidiaries, Mary Hitchcock Memorial Hospital (MHMH) and Subsidiaries, (DHC and MHMH together are referred to as D-H), The New London Hospital Association, Inc. (NLH), Windsor Hospital Corporation (d/b/a Mt. Ascutney Hospital and Health Center) (MAHHC) and Subsidiaries, The Cheshire Medical Center (Cheshire) and Subsidiaries, Alice Peck Day Memorial Hospital (APD) and Subsidiary, and Visiting Nurse Association and Hospice of Vermont and New Hampshire (VNH) and 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 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, DHC, MHMH, NLH, Cheshire, and APD are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). MAHHC and VNH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

On December 6, 2022, D-HH entered into an Integration Agreement with Valley Regional Healthcare, Inc. ("VRHC") and its subsidiary Valley Regional Hospital and its affiliates ("VRH"), a critical access hospital located in Claremont, New Hampshire. The parties have submitted the transaction for regulatory review by the New Hampshire Attorney General with a target closing date in early 2024.

Community Benefits

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

Dartmouth-Hitchcock Health and Subsidiaries

Notes to Consolidated Financial Statements

June 30, 2023 and 2022

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 Improvement 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* includes costs, in excess of awards, for numerous health research and service initiatives within the Health System.
- *Cash and In-Kind Contributions* occur outside of the System through various financial contributions of cash, in-kind donations, and grants to local organizations.
- *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.
- *Charity Care* includes losses, at-cost, incurred by providing health care services to persons qualifying for hospital financial assistance programs.
- *The Uncompensated Cost of Care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2022 was approximately \$235,081,000. The 2023 Community Benefits Reports are expected to be filed in February 2024.

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

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, 2022:

(in thousands of dollars)

Uncompensated cost of care for Medicaid	\$ 235,081
Health professional education	43,186
Subsidized health services	21,202
Charity care	16,011
Community health improvement services	15,695
Research	7,254
Cash and In-Kind Contributions	4,001
Community building activities	<u>2,834</u>
Total community benefit value	<u>\$ 345,264</u>

In fiscal years 2023 and 2022, funds received to offset or subsidize charity care costs provided were \$439,000 and \$452,000, respectively.

For fiscal year 2022, Medicare costs exceeding reimbursement totaled \$157,615,000.

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, 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.

Dartmouth-Hitchcock Health and Subsidiaries

Notes to Consolidated Financial Statements

June 30, 2023 and 2022

Deficiency of Revenue over Expenses

The Consolidated Statements of Operations and Changes in Net Assets include the deficiency of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income (loss) on investments of net assets without donor restrictions, which are utilized to provide charity and other operational support. Peripheral activities, including 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 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 qualifying as charity care, they are not reported as revenue.

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

Patient Service Revenue

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

Contracted Revenue

The Health System has various Professional Service Agreements (PSAs), pursuant to which certain organizations purchase services of personnel employed by the Health System and also lease space and equipment. Revenue pursuant to these PSAs, and certain facility and equipment leases and other professional service contracts, have been classified as contracted revenue in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

Other Revenue

The Health System recognizes other revenue, which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue, which consists primarily of revenue from retail pharmacy, specialty pharmacy, and contract pharmacy, is recorded in the amounts to which it expects to be entitled in exchange for the prescriptions. Other revenue also includes Coronavirus Aid, Relief, and Economic Securities Act (CARES Act Provider Relief Funds)

Dartmouth-Hitchcock Health and Subsidiaries

Notes to Consolidated Financial Statements

June 30, 2023 and 2022

from the Department of Health and Human Services (HHS), CARES Act Employee Retention Credit Funds, operating agreements, grant revenue, cafeteria sales, and other support service revenue (Note 3 and 4).

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), which would be considered level 1 investments under the fair value hierarchy. All short-term, highly liquid, investments included within the Health System's endowment and similar investment pools, otherwise qualifying as cash equivalents, are classified as investments at fair value and, therefore, are excluded from cash and cash equivalents in the Consolidated Statements of Cash Flows.

Investments and Investment Income (Loss)

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 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 of revenue over expenses.

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 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.

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

Property, plant, and equipment

Property, plant, and equipment, and other real estate are stated at cost at the time of purchase or fair value at the time of donation, less accumulated depreciation. The Health System's policy is to capitalize expenditures for major improvements and to charge expense for maintenance and repair expenditures which do not extend the lives of the related assets. The provision for depreciation has been determined using the straight-line method at rates which are intended to amortize the cost of assets over their estimated useful lives which range from 10 to 40 years for buildings and improvements, 2 to 20 years for equipment, and the shorter of the lease term, or 5 to 12 years, for leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of capital assets such as land, buildings, or equipment are reported as support, and excluded from the deficiency 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.

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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 \$8,367,000 and \$8,885,000 as intangible assets as of June 30, 2023 and 2022, respectively.

Gifts

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

Recently Issued Accounting Pronouncements

In March 2020, January 2021, and April 2022, the FASB issued standard updates on Reference Rate Reform in response to the planned discontinuation of the London Inter-Bank Offered Rate (LIBOR), a key interbank reference rate. The standard provides accounting relief to contract modifications and optional expedients for applying U.S. GAAP to contracts and other transactions that reference LIBOR or other reference rates that are expected to be discontinued because of rate reform. The Health System is currently in the process of evaluating the impact of adoption of these standards on the financial statements.

3. The COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic resulting in an extraordinary disruption to our nation's healthcare system. In response to COVID-19, the Coronavirus Aid Relief and Economic Security (CARES) Act was enacted which provided different types of economic support to a wide variety of organizations and individuals. The Health System employed several CARES Act provisions, with the most significant impacts summarized below.

Health and Human Services Provider Relief Funds

The Health System received \$1,822,000 and \$100,346,000 in CARES Act Provider Relief Funds for the years ended June 30, 2023 and 2022, respectively.

In July 2020, HHS issued reporting requirements for CARES Act Provider Relief Funds, requiring recipients to identify healthcare-related expenses that remain unreimbursed by another source, attributable to the COVID-19 pandemic. If those expenses do not exceed the funding received, recipients will need to demonstrate that the remaining funds were used to compensate for a negative variance in patient service revenue. HHS is entitled to recoup Provider Relief Funds awarded in excess of expenses attributable to the COVID-19 pandemic that were not reimbursed

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by another source plus losses incurred due to the decline in patient care revenue. There have been no recoupments through June 30, 2023.

Medicare and Medicaid Services (CMS) Accelerated and Advance Payment Program

The Health System received CMS prepayment advances, related to the CARES Act, totaling \$245,200,000. In addition, the Health System accumulated payroll tax deferrals of \$33,100,000. Repayment of funds commenced in April 2021. The balances of CMS prepayment advances and accumulated payroll tax deferrals at June 30, 2022 were \$54,890,000 and \$16,550,000, respectively, and are included in estimated third party settlements and accrued compensation and related benefits on the Consolidated Balance Sheets. The amounts for CMS prepayment advances and payroll tax deferrals were repaid, in full, during the year ended June 30, 2023.

The Health System continues to address the challenges and impacts of the COVID-19 pandemic, including protecting the health and safety of employees and patients, as well as assessing the availability of personal protective equipment and other needed supplies to be better positioned for potential surges. Additionally, the Health System continues to evaluate the impact of new or changes to laws and regulations at the federal, state, and local levels and the potential effect on Health System staffing and operations. At this time, the Health System remains unable to accurately predict the full extent to which the COVID-19 pandemic will affect the Health System's future finances and operations.

4. Net Patient Service Revenue and Accounts Receivable

The Health System reports net 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

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or partially unsatisfied at the end of the reporting period. This generally refers to inpatient services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

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

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

Explicit Pricing Concessions

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

- Inpatient acute care services provided to Medicare program beneficiaries are paid using the prospective payment system (PPS) to determine rates-per-discharge. These rates vary according to a patient classification system (DRG), based on diagnostic, clinical, and other factors. In addition, inpatient capital costs (depreciation and interest) are reimbursed by Medicare on the basis of a prospectively determined rate per discharge. Medicare outpatient services are paid on a prospective payment system, based on a pre-determined amount for each outpatient procedure (APC), subject to various mandated modifications. Retrospectively determined cost-based revenues under these programs, such as indirect medical education, direct graduate medical education, disproportionate share hospital, transplant services, and bad debt reimbursement are based on the hospital's cost reports and are estimated using historical trends and current factors. The Health System's payments for inpatient services rendered to NH and 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.

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- 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 (MCPs) consist primarily of payment terms involving mutually agreed upon rates per diagnosis, discounted fee-for-service rates, or similar contractual arrangements. These revenues are also subject to review and possible audit. The MCPs 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 MCPs 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 Vermont annual net patient revenue. In fiscal years 2023 and 2022, home health provider taxes paid were \$579,000 and \$627,000, respectively.

Implicit Price Concessions

Generally, patients who are covered by third-party payer contracts are responsible for related co-pays, co-insurance, and deductibles, which vary depending on the contractual obligations of patients. The Health System also provides services to uninsured patients and offers those patients a discount from standard charges. The Health System estimates the transaction price for patients with co-pays, co-insurance, and deductibles, and for those who are uninsured, based on historical collection experience and current market conditions. The discount offered to uninsured patients reduces the transaction price at the time of billing. The uninsured and patient responsible accounts, net of discounts recorded, are further reduced through implicit price concessions based on historical collection trends for similar accounts and other known factors that impact the estimation process. Subsequent changes to the estimate of transaction price are generally recorded as adjustments to net patient services revenue in the period of change.

The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Health System expects to collect based on

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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.

For the years ended June 30, 2023 and 2022, additional increases in revenue of \$24,098,000 and \$19,743,000, respectively, were recognized, due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

Net operating revenues 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.

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The table below shows the Health System's sources of total operating revenue and other support presented at the net transaction price for the years ended June 30, 2023 and 2022.

<i>(in thousands of dollars)</i>	2023		
	<u>PPS</u>	<u>CAH</u>	<u>Total</u>
Hospital			
Medicare	\$ 587,377	\$ 106,370	\$ 693,747
Medicaid	168,410	18,824	187,234
Commercial	862,502	88,492	950,994
Self-pay	<u>11,307</u>	<u>802</u>	<u>12,109</u>
Subtotal	1,629,596	214,488	1,844,084
Professional	<u>504,370</u>	<u>35,578</u>	<u>539,948</u>
Subtotal	2,133,966	250,066	2,384,032
Home based care			<u>13,125</u>
Subtotal			2,397,157
Other revenue			706,242
Provider Relief Funds			<u>1,822</u>
Total operating revenue and other support			<u>\$ 3,105,221</u>

<i>(in thousands of dollars)</i>	2022		
	<u>PPS</u>	<u>CAH</u>	<u>Total</u>
Hospital			
Medicare	\$ 542,292	\$ 99,976	\$ 642,268
Medicaid	158,121	15,739	173,860
Commercial	809,736	81,395	891,131
Self-pay	<u>7,027</u>	<u>902</u>	<u>7,929</u>
Subtotal	1,517,176	198,012	1,715,188
Professional	<u>470,559</u>	<u>40,186</u>	<u>510,745</u>
Subtotal	1,987,735	238,198	2,225,933
Home based care			<u>17,304</u>
Subtotal			2,243,237
Other revenue			528,762
Provider Relief Funds			<u>98,829</u>
Total operating revenue and other support			<u>\$ 2,870,828</u>

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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) 2021 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, 2023 and 2022, the Health System received DSH payments of approximately, \$85,853,000 and \$77,488,000, respectively. DSH payments are subject to audit and, therefore, for the years ended June 30, 2023 and 2022, the Health System recognized as revenue DSH receipts of approximately \$83,582,000 and approximately \$75,988,000, respectively.

During the years ended June 30, 2023 and 2022, the Health System recorded \$85,715,000 and \$82,725,000, respectively, of State of NH MET and State of VT provider taxes. The taxes are calculated at 5.4% for NH and 6.0% 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.

Accounts Receivable

The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2023 and 2022:

	<u>2023</u>	<u>2022</u>
Medicare	36%	38%
Medicaid	12%	12%
Commercial	41%	38%
Self Pay	11%	12%
Total	100%	100%

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5. Investments

The composition of investments at June 30, 2023 and 2022 is set forth in the following table:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	\$ 6,988	\$ 31,130
U.S. government securities	80,595	126,222
Domestic corporate debt securities	271,321	234,490
Global debt securities	37,092	68,610
Domestic equities	205,200	198,742
International equities	75,199	63,634
Emerging markets equities	37,080	34,636
Global equities	77,479	73,035
Real Estate Investment Trust	2	2
Private equity funds	141,808	138,605
Hedge funds	44,558	55,069
Subtotal	<u>977,322</u>	<u>1,024,175</u>
Investments held by captive insurance companies (Note 12)		
U.S. government securities	30,366	27,242
Domestic corporate debt securities	13,918	7,902
Global debt securities	13,180	7,595
Domestic equities	13,994	10,091
International equities	5,372	4,692
Subtotal	<u>76,830</u>	<u>57,522</u>
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	17,310	99,397
Total assets limited as to use	<u>1,071,462</u>	<u>1,181,094</u>
Other investments for restricted activities		
Cash and short-term investments	21,243	8,463
U.S. government securities	27,323	27,600
Domestic corporate debt securities	45,864	37,343
Global debt securities	5,282	10,059
Domestic equities	30,754	34,142
International equities	11,054	10,698
Emerging markets equities	5,187	5,587
Global equities	10,281	11,153
Real Estate Investment Trust	18	19
Private equity funds	18,816	21,166
Hedge funds	6,368	8,852
Other	34	34
Total other investments for restricted activities	<u>182,224</u>	<u>175,116</u>
Total investments	<u>\$ 1,253,686</u>	<u>\$ 1,356,210</u>

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Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case-by-case basis. The fair value method is used 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.

The following tables summarize investments by the accounting method utilized as of June 30, 2023 and 2022. 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>	2023		
	<u>Fair Value</u>	<u>Equity</u>	<u>Total</u>
Cash and short-term investments	\$ 45,541	\$ -	\$ 45,541
U.S. government securities	138,284	-	138,284
Domestic corporate debt securities	122,320	208,783	331,103
Global debt securities	55,554	-	55,554
Domestic equities	204,541	45,407	249,948
International equities	57,221	34,404	91,625
Emerging markets equities	267	42,000	42,267
Global equities	-	87,760	87,760
Real Estate Investment Trust	20	-	20
Private equity funds	-	160,624	160,624
Hedge funds	456	50,470	50,926
Other	34	-	34
Total investments	<u>\$ 624,238</u>	<u>\$ 629,448</u>	<u>\$ 1,253,686</u>

<i>(in thousands of dollars)</i>	2022		
	<u>Fair Value</u>	<u>Equity</u>	<u>Total</u>
Cash and short-term investments	\$ 138,990	\$ -	\$ 138,990
U.S. government securities	181,064	-	181,064
Domestic corporate debt securities	118,642	161,093	279,735
Global debt securities	57,558	28,706	86,264
Domestic equities	191,767	51,208	242,975
International equities	47,631	31,393	79,024
Emerging markets equities	298	39,926	40,224
Global equities	-	84,187	84,187
Real Estate Investment Trust	21	-	21
Private equity funds	-	159,771	159,771
Hedge funds	443	63,478	63,921
Other	34	-	34
Total investments	<u>\$ 736,448</u>	<u>\$ 619,762</u>	<u>\$ 1,356,210</u>

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For the years ended June 30, 2023 and 2022, investment income (loss) is reflected in the accompanying Consolidated Statements of Operations and Changes in Net Assets as other operating revenue of approximately \$905,000 and \$857,000, respectively, and as non-operating gains (losses) of approximately \$58,119,000 and (\$78,744,000), respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreements expire. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2023 and 2022, the Health System has outstanding commitments of \$79,753,000 and \$75,070,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment consists of the following at June 30, 2023 and 2022:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Land	\$ 40,749	\$ 40,749
Construction in progress	43,117	163,145
Land improvements	52,054	44,834
Buildings and improvements	1,166,776	984,743
Equipment	<u>1,101,410</u>	<u>1,042,582</u>
Subtotal property, plant, and equipment	2,404,106	2,276,053
Less accumulated depreciation	<u>1,592,484</u>	<u>1,511,213</u>
Total property, plant, and equipment, net	<u>\$ 811,622</u>	<u>\$ 764,840</u>

As of June 30, 2023, construction in progress primarily consists of four projects; the Family and Community Care Clinic located in Keene, NH, the renovation of inpatient wings as part of the Pavilion backfill project located in Lebanon, NH, and two lab software upgrades to the Lebanon campus. The estimated cost to complete the construction in progress is approximately \$10,700,000.

The construction in progress as of June 30, 2022, included the in-patient tower, the emergency department (ED) expansion and the central pharmacy/supply chain facility renovation. All were placed in service during the year ended June 30, 2023.

Capitalized interest of \$59,000 and \$6,853,000 is included in construction in progress as of June 30, 2023 and 2022, respectively.

Depreciation expense included in operating activities was \$87,029,000 and \$83,661,000 for 2023 and 2022, respectively.

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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 and cash which will be used for future investment opportunities.

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).

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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, 2023 and 2022:

<i>(in thousands of dollars)</i>	2023			
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets				
Investments				
Cash and short term investments	\$ 45,541	\$ -	\$ -	\$ 45,541
U.S. government securities	138,284	-	-	138,284
Domestic corporate debt securities	41,351	80,969	-	122,320
Global debt securities	24,429	31,125	-	55,554
Domestic equities	200,252	4,289	-	204,541
International equities	57,221	-	-	57,221
Emerging market equities	267	-	-	267
Real estate investment trust	20	-	-	20
Hedge funds	456	-	-	456
Other	-	34	-	34
Total fair value investments	<u>507,821</u>	<u>116,417</u>	<u>-</u>	<u>624,238</u>
Deferred compensation plan assets				
Cash and short-term investments	11,893	-	-	11,893
U.S. government securities	40	-	-	40
Domestic corporate debt securities	10,453	-	-	10,453
Global debt securities	16	-	-	16
Domestic equities	41,841	-	-	41,841
International equities	5,874	-	-	5,874
Emerging market equities	21	-	-	21
Real estate	14	-	-	14
Multi strategy fund	62,689	-	-	62,689
Total deferred compensation plan assets	<u>132,841</u>	<u>-</u>	<u>-</u>	<u>132,841</u>
Beneficial interest in trusts	-	-	14,875	14,875
Total assets	<u>\$ 640,662</u>	<u>\$ 116,417</u>	<u>\$ 14,875</u>	<u>\$ 771,954</u>

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<i>(in thousands of dollars)</i>	2022			
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets				
Investments				
Cash and short term investments	\$ 138,990	\$ -	\$ -	\$ 138,990
U.S. government securities	181,064	-	-	181,064
Domestic corporate debt securities	1,768	116,874	-	118,642
Global debt securities	24,745	32,813	-	57,558
Domestic equities	187,063	4,704	-	191,767
International equities	47,631	-	-	47,631
Emerging market equities	298	-	-	298
Real estate investment trust	21	-	-	21
Hedge funds	443	-	-	443
Other	-	34	-	34
Total fair value investments	<u>582,023</u>	<u>154,425</u>	<u>-</u>	<u>736,448</u>
Deferred compensation plan assets				
Cash and short-term investments	8,053	-	-	8,053
U.S. government securities	36	-	-	36
Domestic corporate debt securities	10,874	-	-	10,874
Global debt securities	964	-	-	964
Domestic equities	33,742	-	-	33,742
International equities	4,911	-	-	4,911
Emerging market equities	19	-	-	19
Real estate	12	-	-	12
Multi strategy fund	57,964	-	-	57,964
Total deferred compensation plan assets	<u>116,575</u>	<u>-</u>	<u>-</u>	<u>116,575</u>
Beneficial interest in trusts	-	-	16,051	16,051
Total assets	<u>\$ 698,598</u>	<u>\$ 154,425</u>	<u>\$ 16,051</u>	<u>\$ 869,074</u>

There were no transfers into or out of Level 1, 2, or 3 measurements due to changes in valuation methodologies during the years ended June 30, 2023 and 2022.

There were no liquidations of Level 3 measurements during the years ended June 30, 2023 and 2022.

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8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2023 and 2022:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Investments held in perpetuity	\$ 88,926	\$ 84,117
Healthcare services	38,596	36,123
Research	28,176	27,477
Health education	27,374	27,164
Charity care	12,486	12,155
Other	10,825	8,639
Purchase of equipment	3,950	3,828
Total net assets with donor restrictions	<u>\$ 210,333</u>	<u>\$ 199,503</u>

9. Board Designated and Endowment Funds

Net assets include 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 Health System 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

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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, 2023 and 2022.

Endowment net asset composition by type of fund consists of the following at June 30, 2023 and 2022:

	2023		
	Without Donor Restrictions	With Donor Restrictions	Total
<i>(in thousands of dollars)</i>			
Donor-restricted endowment funds	\$ -	\$ 111,843	\$ 111,843
Board-designated endowment funds	28,688	-	28,688
Total endowed net assets	<u>\$ 28,688</u>	<u>\$ 111,843</u>	<u>\$ 140,531</u>
	2022		
	Without Donor Restrictions	With Donor Restrictions	Total
<i>(in thousands of dollars)</i>			
Donor-restricted endowment funds	\$ -	\$ 107,590	\$ 107,590
Board-designated endowment funds	41,344	-	41,344
Total endowed net assets	<u>\$ 41,344</u>	<u>\$ 107,590</u>	<u>\$ 148,934</u>

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Changes in endowment net assets for the years ended June 30, 2023 and 2022 are as follows:

<i>(in thousands of dollars)</i>	2023		
	Without Donor Restrictions	With Donor Restrictions	Total
Beginning of year balances	\$ 41,344	\$ 107,590	\$ 148,934
Net investment return	212	1,305	1,517
Contributions	-	3,201	3,201
Transfers	(12,743)	2,561	(10,182)
Release of appropriated funds	(125)	(2,814)	(2,939)
End of year balances	<u>\$ 28,688</u>	<u>\$ 111,843</u>	<u>\$ 140,531</u>
End of year balances		111,843	
Beneficial interest in perpetual trusts		<u>13,954</u>	
Net assets with donor restrictions		<u>\$ 125,797</u>	

<i>(in thousands of dollars)</i>	2022		
	Without Donor Restrictions	With Donor Restrictions	Total
Beginning of year balances	\$ 41,728	\$ 108,213	\$ 149,941
Net investment return	(1,065)	(3,998)	(5,063)
Contributions	-	12,950	12,950
Transfers	795	(7,105)	(6,310)
Release of appropriated funds	(114)	(2,470)	(2,584)
End of year balances	<u>\$ 41,344</u>	<u>\$ 107,590</u>	<u>\$ 148,934</u>
End of year balances		107,590	
Beneficial interest in perpetual trusts		<u>14,903</u>	
Net assets with donor restrictions		<u>\$ 122,493</u>	

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10. Long-Term Debt

A summary of obligated group debt at June 30, 2023 and 2022 is as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Variable rate issues		
New Hampshire Health and Education Facilities		
Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	\$ 83,355	\$ 83,355
Fixed rate issues		
New Hampshire Health and Education Facilities		
Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2020A, principal maturing in varying annual amounts, through August 2059 (2)	125,000	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	99,165
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	22,860	23,950
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	21,715	22,605
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
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	-	4,810
Note payable		
Note payable to a financial institution due in monthly interest only payments through May 2035 (9)	125,000	125,000
Total obligated group debt	<u>\$ 1,037,932</u>	<u>\$ 1,044,722</u>

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A summary of long-term debt at June 30, 2023 and 2022 is as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Other		
Mortgage note payable to the US Dept of Agriculture; monthly payments of \$10,892 include interest of 2.375% through November 2046	\$ 2,343	\$ 2,417
Note payable to a financial institution with entire principal due June 2034; collateralized by land and building. The note payable is interest free	232	247
Note payable to a financial institution payable in interest free monthly installments through December 2024; collateralized by associated equipment	<u>32</u>	<u>55</u>
Total nonobligated group debt	2,607	2,719
Total obligated group debt	<u>1,037,932</u>	<u>1,044,722</u>
Total long-term debt	1,040,539	1,047,441
Add: Original issue premium and discounts, net	80,112	83,249
Less: Current portion	15,236	6,596
Debt issuance costs, net	<u>6,453</u>	<u>6,806</u>
Total long-term debt, net	<u>\$ 1,098,962</u>	<u>\$ 1,117,288</u>

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

<i>(in thousands of dollars)</i>	<u>2023</u>
2024	\$ 15,236
2025	19,363
2026	20,209
2027	20,915
2028	21,574
Thereafter	<u>943,242</u>
Total	<u>\$ 1,040,539</u>

Dartmouth-Hitchcock Obligated Group (DHOG) Debt

MHMH established the DHOG for the purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group at June 30, 2023 consist of D-HH, MHMH, DHC, NLH, MAHHC, and APD. The members of the obligated group at June 30, 2022 consisted of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and APD. D-HH is designated as the obligated group agent.

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Effective June 26, 2023, after approval from the D-HH Board of Trustees, Cheshire withdrew from the DHOG. The Cheshire Series 2012 bonds and the related obligated group note securing the Cheshire bonds, will remain outstanding and therefore constitute a continuing joint and several obligation of the DHOG.

Revenue bonds, issued by members of the DHOG, are administered through notes registered in the name of the Bond Trustee and in accordance with the terms of a Master Trust Indenture. The Master Trust Indenture contains provisions permitting the addition, withdrawal, or consolidation of members of the DHOG under certain conditions. The notes constitute a joint and several obligation of the members of the DHOG (and any other future members of the DHOG) and are equally and ratably collateralized by a pledge of the members' gross receipts. The DHOG is also subject to certain annual covenants under the Master Trust Indenture, the most restrictive 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 mature in variable amounts through 2037 and were used primarily to refund a portion of Series 2015A and Series 2016A revenue bonds. The Series 2018B revenue bonds mature in variable amounts through 2048, and were used primarily to refund a portion of Series 2015A and Series 2016A revenue bonds, revolving line of credit, Series 2012 bank loan, and the Series 2015A and Series 2016A swap terminations. The interest on the Series 2018A revenue bonds is variable, with a current interest rate of 5.00%. 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 Series 2020A revenue bonds mature in variable amounts through 2059 and the proceeds 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%.

(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 mature in variable amounts through 2040 and were used primarily to refund Series 2009 and Series 2010 revenue bonds. The Series 2017B revenue bonds mature in variable amounts through 2031 and were used to refund Series 2012A and Series 2012B revenue bonds. The interest on the Series 2017A revenue bonds is fixed, with an interest rate of 5.00%. The interest on the Series 2017B revenue bonds is fixed, with an interest rate of 2.54%.

(4) Series 2019A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2019A, in October 2019. The Series 2019A revenue bonds mature in variable amounts through 2043 and were used primarily to

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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%.

(5) Series 2018C Revenue Bonds

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

(6) Series 2012 Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2012, in November 2012. The Series 2012 revenue bonds mature in variable amounts through 2039 and were used to refund 1998 and 2009 Series revenue bonds, finance the settlement cost of the interest rate swap, and finance the purchase of certain equipment and renovations. The revenue bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%).

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

The DHOG issued NHHEFA Revenue Bonds, Series 2014A and Series 2014B, in August 2014. The Series 2014A revenue bonds mature in 2022. The Series 2014B revenue bonds mature at various dates through 2033. The proceeds from the Series 2014A and 2014B revenue bonds were used partially to 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%. Interest on the Series 2014B revenue bonds is fixed, with an interest rate of 4.00%.

(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 mature at various dates through 2045 and were used to finance certain 2016 projects. The Series 2016B is fixed, with an interest rate of 1.78%.

(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 note matures at various dates through 2035 and is fixed, with an interest rate of 2.56%.

Outstanding joint and several indebtedness of the DHOG at June 30, 2023 and 2022 is \$1,037,932,000 and \$1,044,722,000, respectively.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of \$17,310,000 and \$99,397,000 at June 30, 2023 and 2022, respectively, are classified as assets limited as to use in the accompanying Consolidated Balance Sheets (Note 5). In addition, debt service reserves of approximately \$46,000

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and \$6,674,000 at June 30, 2023 and 2022, 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, 2023 and 2022.

For the years ended June 30, 2023 and 2022 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 \$34,515,000 and \$32,113,000, respectively, and other non-operating losses of \$3,782,000 and \$3,782,000, respectively, net of amounts capitalized.

11. Employee Benefits

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

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

Defined Benefit Plans

Net periodic pension expense included in employee benefits expense, in the Consolidated Statements of Operations and Changes in Net Assets, is comprised of the following components for the years ended June 30, 2023 and 2022:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Interest cost on projected benefit obligation	\$ 45,924	\$ 36,722
Expected return on plan assets	(46,071)	(65,917)
Net loss amortization	<u>15,820</u>	<u>13,139</u>
Total net periodic pension expense	<u>\$ 15,673</u>	<u>\$ (16,056)</u>

The following assumptions were used to determine net periodic pension expense as of June 30, 2023 and 2022:

	<u>2023</u>	<u>2022</u>
Discount rates	4.40% - 5.10%	3.30%
Rate of increase in compensation	N/A	N/A
Expected long-term rates of return on plan assets	4.40% - 7.25%	7.50%

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The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2023 and 2022:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Change in benefit obligation		
Benefit obligation, beginning of year	\$ 938,886	\$ 1,140,221
Interest cost	45,924	36,722
Benefits paid	(58,580)	(54,864)
Actuarial loss	(59,480)	(183,193)
Benefit obligation, end of year	<u>866,750</u>	<u>938,886</u>
Change in plan assets		
Fair value of plan assets, beginning of year	747,095	958,864
Actual return on plan assets	1,229	(169,405)
Benefits paid	(58,580)	(54,864)
Employer contributions	-	12,500
Fair value of plan assets, end of year	<u>689,744</u>	<u>747,095</u>
Funded status of the plans	(177,006)	(191,791)
Less: Current portion of liability for pension	-	-
Long-term portion of liability for pension	(177,006)	(191,791)
Liability for pension	<u>\$ (177,006)</u>	<u>\$ (191,791)</u>

As of June 30, 2023 and 2022, 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 \$489,486,000 and \$519,946,000 of net actuarial loss as of June 30, 2023 and 2022, respectively.

The amounts amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2023 for net actuarial losses was \$15,820,000.

The following table sets forth the assumptions used to determine the accumulated benefit obligation at June 30, 2023 and 2022:

	<u>2023</u>	<u>2022</u>
Discount rates	4.85 - 5.90%	4.40 - 5.10%
Rate of increase in compensation	N/A	N/A

The primary investment objective for the defined benefit plans' 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 pension plan's liabilities. As of June 30,

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2023, it is expected that the LDI strategy will hedge approximately 70% of the interest rate risk associated with pension liabilities. As of June 30, 2022, the expected LDI hedge was approximately 70%. To achieve the appreciation and hedging objectives, the pension plans utilize a diversified structure of asset classes. The asset classes are 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	42
Global debt securities	6–26	4
Domestic equities	5–35	17
International equities	5–15	7
Emerging market equities	3–13	4
Global Equities	0–10	6
Real estate investment trust funds	0–5	1
Private equity funds	0–5	0
Hedge funds	5–18	11

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 pension 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 pension plans own interests in both private equity and hedge funds rather than in securities

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underlying each fund and, therefore, the Health System generally considers such investments as Level 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth the Health System's pension plans' investments that were accounted for at fair value as of June 30, 2023 and 2022:

2023						
<i>(in thousands of dollars)</i>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>	<u>Redemption or Liquidation</u>	<u>Days' Notice</u>
Investments						
Cash and short-term investments	\$ -	\$ 10,667	\$ -	\$ 10,667	Daily	1
U.S. government securities	22,919	-	-	22,919	Daily-Monthly	1-15
Domestic debt securities	96,004	250,964	-	346,968	Daily-Monthly	1-15
Global debt securities	-	-	-	-	Daily-Monthly	1-15
Domestic equities	89,391	26,849	-	116,240	Daily-Monthly	1-10
International equities	18,912	22,361	-	41,273	Daily-Monthly	1-11
Emerging market equities	-	26,743	-	26,743	Daily-Monthly	1-17
Global equities	-	52,461	-	52,461	Daily-Monthly	1-17
Private equity funds	-	-	13	13	See Note 5	See Note 5
Hedge funds	-	-	72,460	72,460	Quarterly-Annual	60-96
Total investments	<u>\$ 227,226</u>	<u>\$ 390,045</u>	<u>\$ 72,473</u>	<u>\$ 689,744</u>		

2022						
<i>(in thousands of dollars)</i>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>	<u>Redemption or Liquidation</u>	<u>Days' Notice</u>
Investments						
Cash and short-term investments	\$ -	\$ 16,030	\$ -	\$ 16,030	Daily	1
U.S. government securities	124,686	-	-	124,686	Daily-Monthly	1-15
Domestic debt securities	17,530	226,107	-	243,637	Daily-Monthly	1-15
Global debt securities	-	24,136	-	24,136	Daily-Monthly	1-15
Domestic equities	104,070	31,324	-	135,394	Daily-Monthly	1-10
International equities	15,558	20,406	-	35,964	Daily-Monthly	1-11
Emerging market equities	-	25,487	-	25,487	Daily-Monthly	1-17
Global equities	-	54,787	-	54,787	Daily-Monthly	1-17
Private equity funds	-	-	14	14	See Note 5	See Note 5
Hedge funds	-	-	86,960	86,960	Quarterly-Annual	60-96
Total investments	<u>\$ 261,844</u>	<u>\$ 398,277</u>	<u>\$ 86,974</u>	<u>\$ 747,095</u>		

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The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2023 and 2022:

<i>(in thousands of dollars)</i>	2023		
	Private		Total
	Hedge Funds	Equity Funds	
Beginning of year balances	\$ 86,960	\$ 14	\$ 86,974
Sales	(13,013)	-	(13,013)
Net unrealized losses	(1,487)	(1)	(1,488)
End of year balances	<u>\$ 72,460</u>	<u>\$ 13</u>	<u>\$ 72,473</u>

<i>(in thousands of dollars)</i>	2022		
	Private		Total
	Hedge Funds	Equity Funds	
Beginning of year balances	\$ 15,512	\$ 15	\$ 15,527
Purchases	81,400	-	81,400
Sales	(2,152)	-	(2,152)
Net unrealized losses	(7,800)	(1)	(7,801)
End of year balances	<u>\$ 86,960</u>	<u>\$ 14</u>	<u>\$ 86,974</u>

The total aggregate net unrealized (losses) gains included in the fair value of the Level 3 investments as of June 30, 2023 and 2022 were approximately (\$12,443,000) and (\$543,000), respectively. Hedge funds totaling \$13,013,000 and \$2,152,000 were liquidated in 2023 and 2022, respectively.

There were no transfers into or out of Level 1, 2, or 3 measurements due to changes in valuation methodologies during the years ended June 30, 2023 and 2022.

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The weighted average asset allocation, by asset category, for the Health System's pension plans is as follows at June 30, 2023 and 2022:

	<u>2023</u>	<u>2022</u>
Cash and short-term investments	3 %	2 %
U.S. government securities	5	17
Domestic debt securities	42	33
Global debt securities	4	3
Domestic equities	17	18
International equities	7	5
Emerging market equities	4	3
Global equities	6	7
Hedge funds	12	12
Total	<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 7.25% per annum.

The Health System is expected to contribute approximately \$15,888,000 to the Plans in 2024 however actual contributions may vary from expected amounts.

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

(in thousands of dollars)

2024	\$ 122,722
2025	58,784
2026	59,960
2027	61,029
2028	61,971
2029 - 2033	313,803

The Cheshire Medical Center plan was terminated effective June 30, 2022, pending regulatory approvals. Following regulatory approval, the plan sponsor intends to distribute assets and settle plan obligations through a lump sum offering to active and terminated vested participants and a group annuity contract will be purchased for any participant that doesn't elect the lump sum, along with all participants currently in pay status. The benefit obligation for the plan reflects anticipated disbursement costs and a terminal cash contribution to fully fund benefits will be made at that time. The obligations reflect the cost of providing the lump sums and group annuity, described above, as well as administrative costs and a terminal contribution which will be necessary to fund all of the costs of terminating the plan. It is expected that the obligations will be settled by June 30, 2024 and the plan termination liability will reflect economic conditions, lump sum election rates and annuity pricing at that time. As a result, the final plan termination liability may be different from the amounts shown in this report.

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

Defined Contribution Plans

The Health System has employer-sponsored plans for certain of its members, under which the employer makes contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately \$71,152,000 and \$64,946,000 in 2023 and 2022, respectively, are included in employee benefits expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

Postretirement Medical and Life Insurance Benefits

The Health System has postretirement medical and life insurance 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, 2023 and 2022:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Service cost	\$ 357	\$ 456
Interest cost	1,956	1,394
Net loss amortization	<u>62</u>	<u>752</u>
Total	<u>\$ 2,375</u>	<u>\$ 2,602</u>

The following table sets forth the accumulated postretirement medical and life insurance benefit obligation amounts recognized in the Health System's consolidated financial statements at June 30, 2023 and 2022:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Change in benefit obligation		
Accumulated benefit obligation, beginning of year	\$ 40,315	\$ 46,863
Service cost	357	456
Interest cost	1,956	1,394
Benefits paid	(3,588)	(3,401)
Actuarial loss	(6,355)	(4,964)
Employer contributions	<u>-</u>	<u>(33)</u>
Accumulated benefit obligation, end of year	<u>32,685</u>	<u>40,315</u>
Current portion of liability for postretirement medical and life benefits	\$ (3,386)	\$ (3,500)
Long-term portion of liability for postretirement medical and life benefits	<u>(29,299)</u>	<u>(36,815)</u>
Funded status of the plans and liability for postretirement medical and life benefits	<u>\$ (32,685)</u>	<u>\$ (40,315)</u>

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

As of June 30, 2023 and 2022, the liability for postretirement medical and life insurance 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 income for the postretirement medical and life insurance benefit plans, included in the change in net assets without donor restrictions, are as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Net actuarial (income) loss	<u>(1,970)</u>	<u>4,445</u>
Total	<u>\$ (1,970)</u>	<u>\$ 4,445</u>

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending June 30, 2023 and thereafter:

<i>(in thousands of dollars)</i>	
2024	\$ 3,486
2025	3,424
2026	3,396
2027	3,387
2028	3,227
2029-2033	14,893

In determining the accumulated benefit obligation for the postretirement medical and life insurance plans, the Health System used a discount rates of 6.00 - 6.10% in 2023, and an assumed healthcare cost trend rate of 6.50 - 7.00%, trending down to 5.00% in 2029 and thereafter.

12. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College, Cheshire, NLH, APD, MAHHC, and VNH are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. RRG cedes the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda, and HAC cedes a portion of this risk to a variety of commercial reinsurers. D-H has majority ownership interest in both HAC and RRG. The insurance program provides coverage to the covered institutions, named insureds and their employees 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
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2023 and 2022, are summarized as follows:

	<u>2023</u>		
	<u>HAC</u>	<u>RRG</u>	<u>Total</u>
<i>(in thousands of dollars)</i>			
Assets	\$ 93,777	\$ 2,372	\$ 96,149
Shareholders' equity	13,620	50	13,670
	<u>2022</u>		
	<u>HAC</u>	<u>RRG</u>	<u>Total</u>
<i>(in thousands of dollars)</i>			
Assets	\$ 79,831	\$ 2,245	\$ 82,076
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. 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.

Line of Credit

The Health System has entered into a loan agreement with a financial institution, establishing access to a revolving loan of up to \$100,000,000. Interest is variable and determined using the Bloomberg Short-Term Bank Yield Index or the Wall Street Journal Prime Rate. The loan agreement is due to expire October 3, 2024. The outstanding line of credit balance was \$40,000,000 and \$0 as of June 30, 2023 and 2022, respectively. Interest expense was approximately \$1,200,000 and \$91,000, 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
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2023:

	2023			
<i>(in thousands of dollars)</i>	<u>Program Services</u>	<u>Management and General</u>	<u>Fundraising</u>	<u>Total</u>
Operating expenses				
Salaries	\$ 1,238,158	\$ 183,063	\$ 1,870	\$ 1,423,091
Employee benefits	293,359	38,778	249	332,386
Medical supplies and medications	722,957	2,517	6	725,480
Purchased services and other	305,192	148,439	5,270	458,901
Medicaid enhancement tax	85,715	-	-	85,715
Depreciation and amortization	45,702	44,707	48	90,457
Interest	8,470	26,037	8	34,515
* Total operating expenses	<u>\$ 2,699,553</u>	<u>\$ 443,541</u>	<u>\$ 7,451</u>	<u>\$ 3,150,545</u>
	<u>Program Services</u>	<u>Management and General</u>	<u>Fundraising</u>	<u>Total</u>
Non-operating expense				
Employee benefits	\$ 15,606	\$ 2,077	\$ 8	\$ 17,691
Total non-operating expense	<u>\$ 15,606</u>	<u>\$ 2,077</u>	<u>\$ 8</u>	<u>\$ 17,691</u>

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2022:

	2022			
<i>(in thousands of dollars)</i>	<u>Program Services</u>	<u>Management and General</u>	<u>Fundraising</u>	<u>Total</u>
Operating expenses				
Salaries	\$ 1,129,572	\$ 184,533	\$ 1,302	\$ 1,315,407
Employee benefits	281,455	40,887	228	322,570
Medical supplies and medications	645,437	3,835	-	649,272
Purchased services and other	255,639	142,241	5,982	403,862
Medicaid enhancement tax	82,725	-	-	82,725
Depreciation and amortization	42,227	44,675	56	86,958
Interest	9,116	22,987	10	32,113
Total operating expenses	<u>\$ 2,446,171</u>	<u>\$ 439,158</u>	<u>\$ 7,578</u>	<u>\$ 2,892,907</u>
	<u>Program Services</u>	<u>Management and General</u>	<u>Fundraising</u>	<u>Total</u>
Non-operating income				
Employee benefits	\$ 12,144	\$ 1,755	\$ 11	\$ 13,910
Total non-operating income	<u>\$ 12,144</u>	<u>\$ 1,755</u>	<u>\$ 11</u>	<u>\$ 13,910</u>

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

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 Sheets 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, 2023 and 2022 to meet cash needs for general expenditures within one year of June 30, 2023 and 2022, are as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Cash and cash equivalents	\$ 115,996	\$ 191,929
Patient accounts receivable	289,787	251,250
Assets limited as to use	1,071,462	1,181,094
Other investments for restricted activities	182,224	175,116
Total financial assets	<u>\$ 1,659,469</u>	<u>\$ 1,799,389</u>
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	76,830	57,522
Investments for restricted activities	182,224	175,116
Bond proceeds held for capital projects	17,310	99,397
Other investments with liquidity horizons greater than one year	141,810	159,792
Total financial assets available within one year	<u>\$ 1,241,295</u>	<u>\$ 1,307,562</u>

The Health System used cash flow from operations of approximately \$(164,033,000) and \$(123,525,000) for the years ended June 30, 2023 and June 30, 2022, 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 \$100,000,000 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

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. The Health System uses the implicit rate noted within the contract. If not readily available, the Health System uses an 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, rather the Health System recognizes lease expense for these leases on a straight-line basis, over the lease term, within lease and rental expense.

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

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. Real estate lease agreements typically have initial terms of 3 to 8 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 the Health System's sole discretion. When determining the lease term, management includes options to extend or terminate the lease when it is reasonably certain that the Health System will exercise that option.

Certain lease agreements for real estate include payments based on actual common area maintenance expenses and/or rental payments adjusted periodically for inflation. These variable lease payments are recognized in other occupancy costs in the Consolidated Statements of Operations and Changes in Net Assets, but are not included in the right-of-use asset or liability balances in our Consolidated Balance Sheets. Lease agreements do not contain any material residual value guarantees, restrictions, or covenants.

The components of lease expense for the years ended June 30, 2023 and 2022 are as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Operating lease cost	\$ 9,590	\$ 9,573
Variable and short term lease cost (a)	<u>10,608</u>	<u>10,894</u>
Total lease and rental expense	<u>\$ 20,198</u>	<u>\$ 20,467</u>
Finance lease cost:		
Depreciation of property under finance lease	\$ 3,778	\$ 3,345
Interest on debt of property under finance lease	<u>546</u>	<u>448</u>
Total finance lease cost	<u>\$ 4,324</u>	<u>\$ 3,793</u>

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

Supplemental cash flow information related to leases for the years ended June 30, 2023 and 2022 are as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	\$ 10,067	\$ 9,952
Operating cash flows from finance leases	546	448
Financing cash flows from finance leases	<u>3,599</u>	<u>3,255</u>
Total	<u>\$ 14,212</u>	<u>\$ 13,655</u>

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

Supplemental balance sheet information related to leases as of June 30, 2023 and 2022 are as follows:

<i>(in thousands of dollars)</i>	<u>2023</u>	<u>2022</u>
Operating Leases		
Right-of-use assets - operating leases	\$ 59,258	\$ 61,165
Accumulated amortization	(26,731)	(21,222)
Right-of-use assets - operating leases, net	<u>32,527</u>	<u>39,943</u>
Current portion of right-of-use obligations	7,799	8,314
Long-term right-of-use obligations, excluding current portion	25,386	32,207
Total operating lease liabilities	<u>33,185</u>	<u>40,521</u>
Finance Leases		
Right-of-use assets - finance leases	32,837	27,963
Accumulated depreciation	(9,836)	(8,981)
Right-of-use assets - finance leases, net	<u>23,001</u>	<u>18,982</u>
Current portion of right-of-use obligations	3,535	3,005
Long-term right-of-use obligations, excluding current portion	20,285	16,617
Total finance lease liabilities	<u>\$ 23,820</u>	<u>\$ 19,622</u>
Weighted Average remaining lease term, years		
Operating leases	7.54	7.73
Finance leases	15.73	19.77
Weighted Average discount rate		
Operating leases	2.36%	2.24%
Finance leases	3.46%	2.17%

The System obtained \$3.6 million and \$9.2 million of new and modified operating and financing leases, respectively, during the year ended June 30, 2023.

The System obtained \$8.9 million and \$0.1 million of new and modified operating and financing leases, respectively, during the year ended June 30, 2022.

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Consolidated Financial Statements
June 30, 2023 and 2022

Future maturities of lease liabilities as of June 30, 2023 are as follows:

<i>(in thousands of dollars)</i>	<u>Operating Leases</u>	<u>Finance Leases</u>
Year ending June 30:		
2024	\$ 8,474	\$ 4,265
2025	5,841	3,336
2026	4,311	2,869
2027	3,475	1,900
2028	2,784	1,701
Thereafter	<u>11,340</u>	<u>15,043</u>
Total lease payments	36,225	29,114
Less: Imputed interest	<u>3,040</u>	<u>5,294</u>
Total lease obligations	<u>\$ 33,185</u>	<u>\$ 23,820</u>

17. Subsequent Events

The Health System has assessed the impact of subsequent events through November 17, 2023, 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. On July 3, 2023, D-HH affiliated with Southern Vermont Health Care Corporation and its subsidiaries ("SVHC"), including Southwestern Vermont Medical Center, Inc. ("SVMC"), a 99-bed community hospital located in Bennington, Vermont. Integrating SVHC into the D-HH System gives D-HH an inpatient presence in southwestern Vermont with reach into eastern New York state and northwestern Massachusetts markets.

In October 2023, the Health System issued a note payable in the amount of \$100,000,000 to TD Bank. The note matures at various dates through 2033, and is fixed, with an interest rate of 6.17%.

Consolidating Supplemental Information

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2023

<i>(in thousands of dollars)</i>	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascunteny Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets										
Current assets										
Cash and cash equivalents	\$ 2,375	\$ 202	\$ 40,750	\$ 32,082	\$ 11,462	\$ -	\$ 86,871	\$ 29,125	\$ -	\$ 115,996
Patient accounts receivable, net	-	241,747	10,868	11,022	7,607	-	271,244	18,543	-	289,787
Prepaid expenses and other current assets	19,552	210,275	2,374	2,449	2,009	(36,789)	199,870	2,619	(18,385)	184,104
Total current assets	21,927	452,224	53,992	45,553	21,078	(36,789)	557,985	50,287	(18,385)	589,887
Assets limited as to use										
Notes receivable, related party	136,937	832,895	13,089	17,990	25,786	(16,760)	1,009,937	81,525	-	1,071,482
Other investments for restricted activities	843,946	14,308	588	-	-	(844,777)	14,065	(588)	(13,477)	-
Property, plant, and equipment, net	5	126,671	2,632	3,206	7,208	-	139,722	42,502	-	182,224
Right-of-use assets, net	-	624,394	27,724	44,547	16,260	-	712,925	98,697	-	811,622
Other assets	344	32,819	14,967	286	4,897	-	53,313	2,215	-	55,528
Total assets	\$ 1,005,102	\$ 2,252,047	\$ 126,790	\$ 118,204	\$ 79,917	\$ (898,326)	\$ 2,683,734	\$ 252,184	\$ (31,862)	\$ 2,904,056
Liabilities and Net Assets										
Current liabilities										
Current portion of long-term debt	\$ 13,365	\$ -	\$ 825	\$ 21	\$ 11	\$ -	\$ 14,222	\$ 1,014	\$ -	\$ 15,235
Current portion of right-of-use obligations	204	9,136	758	49	422	-	10,570	764	-	11,334
Line of credit	-	40,000	-	-	-	-	40,000	-	-	40,000
Current portion of liability for pension and other postretirement plan benefits	-	3,386	-	-	-	-	3,386	-	-	3,386
Accounts payable and accrued expenses	23,590	161,473	5,300	3,975	8,173	(53,549)	138,962	26,170	(18,385)	146,747
Accrued compensation and related benefits	-	119,718	3,549	3,192	4,491	-	130,950	6,517	-	137,467
Estimated third-party settlements	-	28,580	12,588	18,245	-	-	59,393	4,967	-	64,360
Total current liabilities	37,159	352,273	23,021	25,482	13,097	(53,549)	397,483	39,432	(18,385)	418,530
Notes payable, related party	-	800,163	-	27,044	17,570	(844,777)	-	13,477	(13,477)	-
Long-term debt, excluding current portion	1,028,666	25,113	21,956	11	(105)	-	1,075,641	23,321	-	1,098,962
Right-of-use obligations, excluding current portion	140	24,333	14,766	243	4,635	-	44,137	1,534	-	45,671
Insurance deposits and related liabilities	-	89,947	322	253	283	-	90,805	544	-	91,349
Liability for pension and other postretirement plan benefits, excluding current portion	-	197,049	-	-	368	-	197,417	8,888	-	206,305
Other liabilities	-	148,553	366	2,065	-	-	150,984	22,934	-	173,918
Total liabilities	1,065,965	1,637,431	60,451	55,088	35,848	(898,326)	1,956,467	110,130	(31,862)	2,034,735
Commitments and contingencies										
Net assets										
Net assets without donor restrictions	(60,873)	476,653	63,708	58,347	35,455	-	573,290	85,658	40	658,988
Net assets with donor restrictions	10	137,963	2,631	4,759	8,614	-	153,977	58,398	(40)	210,333
Total net assets	(60,863)	614,616	66,339	63,106	44,069	-	727,267	142,054	-	869,321
Total liabilities and net assets	\$ 1,005,102	\$ 2,252,047	\$ 126,790	\$ 118,204	\$ 79,917	\$ (898,326)	\$ 2,683,734	\$ 252,184	\$ (31,862)	\$ 2,904,056

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2023

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	\$ 2,375	\$ 1,470	\$ 15,911	\$ 32,082	\$ 11,691	\$ 50,139	\$ 2,328	\$ -	\$ 115,996
Patient accounts receivable, net	-	241,747	17,253	11,022	7,799	10,868	1,098	-	289,787
Prepaid expenses and other current assets	19,552	210,708	1,504	2,449	1,992	2,284	789	(55,174)	184,104
Total current assets	21,927	453,925	34,668	45,553	21,482	63,291	4,215	(55,174)	589,887
Assets limited as to use									
Notes receivable, related party	136,937	850,436	13,376	17,990	27,090	13,089	19,304	(16,760)	1,071,462
Other investments for restricted activities	843,946	14,308	-	-	-	-	-	(858,254)	-
Property, plant, and equipment, net	5	134,091	34,711	3,206	7,209	2,911	91	-	182,224
Right-of-use assets, net	-	627,070	72,289	44,547	17,593	44,435	5,888	-	811,622
Other assets	344	32,819	2,145	286	4,898	14,967	69	-	55,528
Total assets	\$ 1,005,102	\$ 2,291,551	\$ 164,319	\$ 118,204	\$ 80,503	\$ 145,198	\$ 29,357	\$ (930,188)	\$ 2,904,056
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	\$ 13,365	\$ -	\$ 915	\$ 21	\$ 36	\$ 825	\$ 74	\$ -	\$ 15,236
Current portion of right-of-use obligations	204	9,136	735	49	423	759	28	-	11,334
Line of credit	-	40,000	-	-	-	-	-	-	40,000
Current portion of liability for pension and other postretirement plan benefits	-	3,386	-	-	-	-	-	-	3,386
Accounts payable and accrued expenses	23,590	152,515	22,818	3,975	8,312	5,990	1,481	(71,934)	146,747
Accrued compensation and related benefits	-	119,718	5,406	3,192	4,564	3,907	680	-	137,487
Estimated third-party settlements	-	28,560	4,928	18,245	-	12,588	39	-	64,360
Total current liabilities	37,159	353,315	34,802	25,482	13,335	24,069	2,302	(71,934)	418,530
Notes payable, related party	-	800,163	10,477	27,044	17,570	-	3,000	(858,254)	-
Long-term debt, excluding current portion	1,028,666	25,113	20,907	11	89	21,907	2,269	-	1,098,962
Right-of-use obligations, excluding current portion	140	24,333	1,493	243	4,635	14,786	41	-	45,671
Insurance deposits and related liabilities	-	89,947	500	253	283	322	44	-	91,349
Liability for pension and other postretirement plan benefits, excluding current portion	-	197,049	8,888	-	368	-	-	-	206,305
Other liabilities	-	148,553	1,500	2,065	-	21,800	-	-	173,918
Total liabilities	1,065,965	1,638,473	78,567	55,098	36,280	82,884	7,656	(930,188)	2,034,735
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	(60,873)	507,534	37,307	58,347	35,609	59,404	21,620	40	658,988
Net assets with donor restrictions	10	145,544	48,445	4,759	8,614	2,910	91	(40)	210,333
Total net assets	(60,863)	653,078	85,752	63,106	44,223	62,314	21,711	-	869,321
Total liabilities and net assets	\$ 1,005,102	\$ 2,291,551	\$ 164,319	\$ 118,204	\$ 80,503	\$ 145,198	\$ 29,357	\$ (930,188)	\$ 2,904,056

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2022

<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
Assets											
Current assets											
Cash and cash equivalents	\$ 2,056	\$ 66,827	\$ 20,165	\$ 38,416	\$ 28,467	\$ 11,327	\$ -	\$ 167,258	\$ 24,671	\$ -	\$ 191,929
Patient accounts receivable, net	-	206,400	18,106	9,817	9,175	5,350	-	248,858	2,392	-	251,250
Prepaid expenses and other current assets	23,561	161,262	19,580	3,522	4,452	1,472	(31,119)	182,730	(11,372)	(2,225)	169,133
Total current assets	25,617	434,489	57,851	51,755	42,094	18,159	(31,119)	598,846	15,691	(2,225)	612,312
Assets limited as to use											
Notes receivable, related party	301,000	858,919	12,665	14,680	16,005	25,753	(98,848)	1,130,174	50,920	-	1,181,094
Other investments for restricted activities	842,052	11,557	-	803	-	-	(853,609)	803	(803)	-	-
Property, plant, and equipment, net	490	118,082	16,422	727	3,925	6,846	-	146,492	28,624	-	175,116
Right-of-use assets	-	585,064	63,067	24,757	45,973	15,526	-	734,387	30,453	-	764,840
Other assets	1,362	35,321	1,830	14,892	166	5,249	-	58,820	105	-	58,925
	681	146,516	1,187	14,391	6,573	4,983	-	174,331	(2,168)	-	172,163
Total assets	\$ 1,171,202	\$ 2,189,948	\$ 153,022	\$ 122,005	\$ 114,736	\$ 76,516	\$ (983,576)	\$ 2,843,853	\$ 122,822	\$ (2,225)	\$ 2,964,450
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	\$ -	\$ 4,810	\$ 865	\$ 800	\$ 23	\$ -	\$ -	\$ 6,498	\$ 98	\$ -	\$ 6,596
Current portion of right-of-use obligations	559	8,514	689	852	172	473	-	11,259	80	-	11,319
Current portion of liability for pension and other postretirement plan benefits	-	3,500	-	-	-	-	-	3,500	-	-	3,500
Accounts payable and accrued expenses	147,626	100,110	16,507	4,883	4,843	8,693	(129,967)	152,795	6,002	(2,225)	156,572
Accrued compensation and related benefits	-	169,194	6,817	4,431	4,507	4,434	-	169,383	1,177	-	170,560
Estimated third-party settlements	3,002	68,876	22,999	17,488	21,886	647	-	134,658	-	-	134,898
Total current liabilities	151,187	355,004	47,977	28,454	31,431	14,247	(129,967)	498,333	7,337	(2,225)	503,445
Notes payable, related party	-	808,602	-	-	27,437	17,570	(853,609)	-	-	-	-
Long-term debt, excluding current portion	1,044,845	25,084	21,667	23,060	32	(110)	-	1,114,778	2,510	-	1,117,288
Right-of-use obligations, excluding current portion	803	27,359	1,233	14,499	-	4,885	-	48,779	45	-	48,824
Insurance deposits and related liabilities	-	76,678	623	373	401	250	-	78,325	66	-	78,391
Liability for pension and other postretirement plan benefits, excluding current portion	-	220,350	7,774	-	-	481	-	228,605	1	-	228,606
Other liabilities	-	129,082	1,109	300	1,749	-	-	132,250	21,846	-	154,096
Total liabilities	1,196,835	1,642,169	80,583	66,686	61,050	37,323	(983,576)	2,101,070	31,805	(2,225)	2,130,650
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	(25,638)	418,255	53,846	54,590	48,974	31,078	-	560,905	53,352	40	634,297
Net assets with donor restrictions	5	129,524	18,793	729	4,712	8,115	-	161,878	37,665	(40)	199,503
Total net assets	(25,633)	547,779	72,439	55,319	53,686	39,193	-	742,783	91,017	-	833,800
Total liabilities and net assets	\$ 1,171,202	\$ 2,189,948	\$ 153,022	\$ 122,005	\$ 114,736	\$ 76,516	\$ (983,576)	\$ 2,843,853	\$ 122,822	\$ (2,225)	\$ 2,964,450

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2022

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	\$ 2,056	\$ 68,075	\$ 32,500	\$ 28,467	\$ 11,631	\$ 47,894	\$ 1,306	\$ -	\$ 191,929
Patient accounts receivable, net	-	206,400	16,106	9,175	5,431	9,817	2,321	-	251,250
Prepaid expenses and other current assets	23,561	161,508	8,296	4,452	1,499	2,678	483	(33,344)	169,133
Total current assets	25,617	435,983	56,902	42,094	18,561	60,389	4,110	(33,344)	612,312
Assets limited as to use									
Notes receivable, related party	301,000	884,007	13,183	16,005	26,979	14,680	24,088	(98,848)	1,181,094
Other investments for restricted activities	842,052	11,557	-	-	-	-	-	(853,609)	-
Property, plant, and equipment, net	490	125,614	37,124	3,925	6,846	1,031	86	-	175,116
Right-of-use assets, net	-	587,739	66,385	45,973	16,947	42,436	5,360	-	764,840
Other assets	1,362	35,321	1,830	166	5,248	14,892	106	-	58,925
Total assets	\$ 1,171,202	\$ 2,226,920	\$ 185,740	\$ 114,736	\$ 77,107	\$ 140,720	\$ 33,826	\$ (985,801)	\$ 2,964,450
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	\$ -	\$ 4,810	\$ 865	\$ 23	\$ 26	\$ 800	\$ 72	\$ -	\$ 6,596
Current portion of right-of-use obligations	559	8,514	689	172	472	852	61	-	11,319
Current portion of liability for pension and other postretirement plan benefits	-	3,500	-	-	-	-	-	-	3,500
Accounts payable and accrued expenses	147,626	100,617	16,726	4,843	8,831	5,481	4,640	(132,192)	156,572
Accrued compensation and related benefits	-	169,194	6,817	4,507	4,490	4,735	817	-	190,560
Estimated third-party settlements	3,002	68,876	22,959	21,866	647	17,498	-	-	134,898
Total current liabilities	151,187	355,511	48,096	31,431	14,466	29,356	5,590	(132,192)	503,445
Notes payable, related party	-	808,602	-	27,437	17,570	-	-	(853,609)	-
Long-term debt, excluding current portion	1,044,845	25,084	21,867	32	110	23,005	2,345	-	1,117,288
Right-of-use obligations, excluding current portion	803	27,359	1,233	-	4,885	14,499	45	-	48,824
Insurance deposits and related liabilities	-	76,678	623	401	250	373	66	-	78,391
Liability for pension and other postretirement plan benefits, excluding current portion	-	220,350	7,774	-	482	-	-	-	228,606
Other liabilities	-	129,092	1,109	1,749	-	22,146	-	-	154,096
Total liabilities	1,196,835	1,642,676	80,702	61,050	37,763	89,379	8,046	(985,801)	2,130,650
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	(25,638)	447,013	56,674	48,974	31,231	50,308	25,695	40	634,297
Net assets with donor restrictions	5	137,231	48,364	4,712	8,113	1,033	85	(40)	199,503
Total net assets	(25,633)	584,244	105,038	53,686	39,344	51,341	25,780	-	833,800
Total liabilities and net assets	\$ 1,171,202	\$ 2,226,920	\$ 185,740	\$ 114,736	\$ 77,107	\$ 140,720	\$ 33,826	\$ (985,801)	\$ 2,964,450

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2023

<i>(in thousands of dollars)</i>	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support										
Patient service revenue	\$ -	\$ 1,888,079	\$ 98,605	\$ 87,855	\$ 63,606	\$ -	\$ 2,138,145	\$ 259,012	\$ -	\$ 2,397,157
Contracted revenue	3,834	141,562	149	51	3,657	(799)	148,454	336	(64,444)	84,346
Other operating revenue	36,756	578,955	4,264	6,485	2,134	(43,983)	584,621	31,811	(7,557)	608,875
Net assets released from restrictions	-	12,763	100	316	284	-	13,463	1,380	-	14,843
Total operating revenue and other support	40,590	2,621,369	103,118	94,707	69,681	(44,782)	2,884,683	292,539	(72,001)	3,105,221
Operating expenses										
Salaries	-	1,183,341	49,062	46,198	28,947	486	1,308,034	162,896	(47,839)	1,423,091
Employee benefits	-	276,506	9,020	8,321	8,278	1,697	303,822	36,910	(8,346)	332,386
Medications and medical supplies	-	650,157	13,130	11,852	4,379	-	679,518	45,962	-	725,480
Purchased services and other	20,277	366,903	15,821	11,834	21,278	(18,642)	417,471	56,691	(15,261)	458,901
Medicaid enhancement tax	-	65,805	4,426	3,366	2,273	-	75,870	9,845	-	85,715
Depreciation and amortization	1	68,566	3,372	4,775	2,311	-	79,025	11,432	-	90,457
Interest	33,194	28,101	805	1,064	479	(30,386)	33,257	1,544	(286)	34,515
Total operating expenses	53,472	2,639,379	95,636	87,410	67,945	(46,845)	2,896,997	325,280	(71,732)	3,150,545
Operating (loss) margin	(12,882)	(18,010)	7,482	7,297	1,736	2,063	(12,314)	(32,741)	(269)	(45,324)
Non-operating gains (losses)										
Investment gains (losses), net	1,373	48,094	881	1,113	915	(252)	52,124	6,067	(72)	58,119
Other components of net periodic pension and post retirement benefit income	-	(16,269)	-	-	-	-	(16,269)	(1,422)	-	(17,691)
Other (losses) income, net	(10,643)	250	-	509	387	(1,811)	(11,308)	2,437	341	(8,530)
Total non-operating (losses) gains, net	(9,270)	32,075	881	1,622	1,302	(2,063)	24,547	7,082	269	31,898
(Deficiency) excess of revenue over expenses	(22,152)	14,065	8,363	8,919	3,038	-	12,233	(25,659)	-	(13,426)
Net assets without donor restrictions										
Net assets released from restrictions for capital	-	2,139	56	26	233	-	2,454	775	-	3,229
Change in funded status of pension and other postretirement benefits	-	37,322	-	-	114	-	37,436	(2,535)	-	34,901
Net assets transferred to (from) affiliates	(13,083)	4,881	703	428	992	-	(6,079)	6,079	-	-
Other changes in net assets	-	(9)	(4)	-	-	-	(13)	-	-	(13)
(Decrease) increase in net assets without donor restrictions	\$ (35,235)	\$ 58,398	\$ 9,118	\$ 9,373	\$ 4,377	\$ -	\$ 46,031	\$ (21,340)	\$ -	\$ 24,691

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2023

<i>(in thousands of dollars)</i>	Dartmouth- Hitchcock Health	D-H and Subsidiaries	Choshiro and Subsidiaries	NLH	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	\$ -	\$ 1,888,079	\$ 245,887	\$ 87,855	\$ 63,606	\$ 98,605	\$ 13,125	\$ -	\$ 2,397,157
Contracted revenue	3,834	141,815	84	51	3,656	149	-	(65,243)	84,346
Other operating revenue	36,756	581,102	15,548	6,485	3,974	14,641	1,909	(51,540)	608,875
Net assets released from restrictions	-	13,358	747	316	293	129	-	-	14,843
Total operating revenue and other support	40,590	2,624,354	262,268	94,707	71,529	113,524	15,034	(116,783)	3,105,221
Operating expenses									
Salaries	-	1,183,341	144,785	46,198	29,820	63,203	13,097	(47,353)	1,423,091
Employee benefits	-	276,506	33,677	8,321	8,435	10,002	2,095	(6,650)	332,386
Medications and medical supplies	-	650,157	45,073	11,852	4,382	13,149	872	(5)	725,480
Purchased services and other	20,277	369,991	44,961	11,834	22,074	19,196	4,471	(33,903)	458,901
Medicaid enhancement tax	-	65,805	9,844	3,366	2,274	4,426	-	-	85,715
Depreciation and amortization	1	68,566	8,945	4,775	2,425	5,203	542	-	90,457
Interest	33,194	28,101	1,031	1,064	480	1,115	201	(30,671)	34,515
Total operating expenses	53,472	2,642,467	288,316	87,410	69,890	106,294	21,278	(118,582)	3,150,545
Operating (loss) margin	(12,882)	(18,113)	(26,050)	7,297	1,639	7,230	(6,244)	1,799	(45,324)
Non-operating gains (losses)									
Investment gains (losses), net	1,373	50,245	2,389	1,113	997	1,111	1,220	(329)	58,119
Other components of net periodic pension and post retirement benefit income	-	(16,269)	(1,422)	-	-	-	-	-	(17,691)
Other (losses) income, net	(10,643)	250	2,361	509	403	-	60	(1,470)	(8,530)
Total non-operating gains (losses), net	(9,270)	34,226	3,328	1,622	1,400	1,111	1,280	(1,799)	31,898
(Deficiency) excess of revenue over expenses	(22,152)	16,113	(22,722)	8,919	3,039	8,341	(4,964)	-	(13,426)
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	2,223	691	26	233	56	-	-	3,229
Change in funded status of pension and other postretirement benefits	-	37,322	(2,535)	-	114	-	-	-	34,901
Net assets transferred to (from) affiliates	(13,083)	4,872	5,199	428	992	703	889	-	-
Other changes in net assets	-	(9)	-	-	-	(4)	-	-	(13)
(Decrease) increase in net assets without donor restrictions	\$ (35,235)	\$ 60,521	\$ (19,367)	\$ 9,373	\$ 4,378	\$ 9,066	\$ (4,075)	\$ -	\$ 24,691

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2022

<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
Operating revenue and other support											
Patient service revenue	\$ -	\$ 1,751,093	\$ 236,645	\$ 99,403	\$ 79,754	\$ 59,040	\$ -	\$ 2,225,935	\$ 17,302	\$ -	\$ 2,243,237
Contracted revenue	209	133,928	165	21	22	3,521	(50,573)	77,293	458	(95)	77,666
Other operating revenue	38,568	492,455	23,736	4,146	7,527	2,754	(50,711)	518,475	16,731	(1,175)	534,031
Net assets released from restrictions	249	13,299	779	435	190	204	-	15,156	738	-	15,894
Total operating revenue and other support	<u>39,026</u>	<u>2,390,775</u>	<u>261,325</u>	<u>104,005</u>	<u>87,493</u>	<u>65,519</u>	<u>(111,284)</u>	<u>2,838,859</u>	<u>35,229</u>	<u>(1,260)</u>	<u>2,870,828</u>
Operating expenses											
Salaries	-	1,091,601	135,063	43,266	40,219	28,960	(45,229)	1,293,900	20,422	1,085	1,315,407
Employee benefits	-	268,795	31,761	10,302	7,537	8,240	(5,842)	318,793	3,514	283	322,570
Medications and medical supplies	-	578,581	43,203	12,266	9,946	4,127	-	648,123	1,149	-	649,272
Purchased services and other	25,638	312,373	42,723	15,951	13,068	17,383	(32,862)	364,274	11,398	(1,810)	403,862
Medicaid enhancement tax	-	64,036	9,468	3,980	2,834	2,407	-	82,725	-	-	82,725
Depreciation and amortization	-	64,643	8,771	3,519	4,819	2,359	-	84,111	2,847	-	86,958
Interest	32,536	25,355	914	876	1,073	493	(29,530)	31,727	385	-	32,113
Total operating expenses	<u>58,174</u>	<u>2,408,394</u>	<u>271,923</u>	<u>90,160</u>	<u>79,496</u>	<u>63,969</u>	<u>(113,453)</u>	<u>2,853,653</u>	<u>39,716</u>	<u>(482)</u>	<u>2,892,907</u>
Operating (loss) margin	<u>(19,148)</u>	<u>(12,619)</u>	<u>(10,598)</u>	<u>13,845</u>	<u>7,997</u>	<u>1,550</u>	<u>2,179</u>	<u>(16,794)</u>	<u>(4,487)</u>	<u>(798)</u>	<u>(22,079)</u>
Non-operating gains (losses)											
Investment income (losses), net	(8,026)	(58,973)	(2,068)	(795)	(1,114)	(1,555)	(210)	(72,741)	(6,003)	-	(78,744)
Other components of net periodic pension and post retirement benefit income	-	11,902	2,008	-	-	-	-	13,910	-	-	13,910
Other (losses) income, net	(3,540)	(1,641)	(542)	-	1	169	(1,969)	(7,522)	66	798	(6,538)
Total non-operating (losses) gains, net	<u>(11,566)</u>	<u>(48,712)</u>	<u>(602)</u>	<u>(795)</u>	<u>(1,113)</u>	<u>(1,386)</u>	<u>(2,179)</u>	<u>(66,353)</u>	<u>(5,937)</u>	<u>798</u>	<u>(71,492)</u>
(Deficiency) excess of revenue over expenses	<u>(30,714)</u>	<u>(61,331)</u>	<u>(11,200)</u>	<u>13,050</u>	<u>6,884</u>	<u>164</u>	<u>-</u>	<u>(83,147)</u>	<u>(10,424)</u>	<u>-</u>	<u>(93,571)</u>
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	678	52	-	450	233	-	1,423	150	-	1,573
Change in funded status of pension and other postretirement benefits	-	(27,860)	(4,496)	-	-	48	-	(32,308)	(1)	-	(32,309)
Net assets transferred to (from) affiliates	7,600	(19,385)	4,066	2,571	2,096	795	-	(2,257)	2,257	-	-
Other changes in net assets	-	-	-	-	(23)	-	-	(23)	-	-	(23)
(Decrease) increase in net assets without donor restrictions	<u>\$ (23,114)</u>	<u>\$ (107,898)</u>	<u>\$ (11,578)</u>	<u>\$ 15,621</u>	<u>\$ 9,417</u>	<u>\$ 1,240</u>	<u>\$ -</u>	<u>\$ (116,312)</u>	<u>\$ (8,016)</u>	<u>\$ -</u>	<u>\$ (124,330)</u>

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2022

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Hoath System Consolidated
Operating revenue and other support									
Patient service revenue	\$ -	\$ 1,751,093	\$ 236,645	\$ 79,754	\$ 59,041	\$ 99,403	\$ 17,301	\$ -	\$ 2,243,237
Contracted revenue	209	134,388	165	21	3,521	21	-	(50,659)	77,666
Other operating revenue	38,568	494,363	23,794	7,527	4,370	14,587	2,708	(51,886)	534,031
Net assets released from restrictions	249	13,873	821	190	204	548	9	-	15,894
Total operating revenue and other support	39,026	2,393,717	261,425	87,492	67,136	114,559	20,018	(112,545)	2,870,828
Operating expenses									
Salaries	-	1,091,601	135,116	40,219	29,729	47,352	15,534	(44,144)	1,315,407
Employee benefits	-	266,795	31,770	7,537	8,361	11,169	2,517	(5,579)	322,570
Medications and medical supplies	-	578,581	43,203	9,946	4,126	12,297	1,123	(4)	649,272
Purchased services and other	25,638	315,589	42,938	13,067	18,072	18,915	4,313	(34,670)	403,862
Medicaid enhancement tax	-	64,036	9,469	2,834	2,406	3,980	-	-	82,725
Depreciation and amortization	-	64,643	8,895	4,819	2,483	5,595	523	-	86,958
Interest	32,536	25,355	914	1,073	493	1,204	58	(29,530)	32,113
Total operating expenses	58,174	2,406,610	272,305	79,495	65,670	100,512	24,068	(113,927)	2,892,907
Operating (loss) margin	(19,148)	(12,893)	(10,880)	7,997	1,466	14,047	(4,050)	1,382	(22,079)
Non-operating gains (losses)									
Investment income (losses), net	(8,026)	(61,039)	(2,163)	(1,114)	(1,663)	(1,373)	(3,155)	(211)	(78,744)
Other components of net periodic pension and post retirement benefit income	-	11,902	2,008	-	-	-	-	-	13,910
Other (losses) income, net	(3,540)	(1,641)	(542)	1	179	-	56	(1,171)	(6,658)
Total non-operating (losses) gains, net	(11,566)	(50,778)	(697)	(1,113)	(1,484)	(1,373)	(3,099)	(1,382)	(71,492)
(Deficiency) excess of revenue over expenses	(30,714)	(63,671)	(11,577)	6,884	(18)	12,674	(7,149)	-	(93,571)
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	834	53	460	226	-	-	-	1,573
Change in funded status of pension and other postretirement benefits	-	(27,860)	(4,495)	-	47	-	-	-	(32,309)
Net assets transferred to (from) affiliates	7,600	(19,391)	4,108	2,096	795	2,571	2,221	-	-
Other changes in net assets	-	-	-	(23)	-	-	-	-	(23)
(Decrease) increase in net assets without donor restrictions	\$ (23,114)	\$ (110,088)	\$ (11,912)	\$ 9,417	\$ 1,050	\$ 15,245	\$ (4,928)	\$ -	\$ (124,330)

Dartmouth-Hitchcock Health and Subsidiaries
Note to Supplemental Consolidating Information
June 30, 2023 and 2022

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 significant 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.

MARY HITCHCOCK MEMORIAL HOSPITAL (MHMH)/
DARTMOUTH HITCHCOCK CLINIC (DHC) \ Combined as DARTMOUTH-HITCHCOCK

BOARDS OF TRUSTEES AND OFFICERS

Effective: January 1, 2024

DARTMOUTH-HITCHCOCK

<p>M. Elyse Allan, MBA <i>Retired President and Chief Executive Officer of General Electric Canada Company, Inc.</i></p>
<p>Geraldine "Polly" Bednash, PhD, RN, FAAN <i>Adjunct Professor, Australian Catholic University</i></p>
<p>Laura M. Chiang, MD <i>Assistant Professor of Anesthesiology and Critical Care; Vice Chair for Education, Dept. of Anesthesiology and Co-Medical Director, Surgical Intensive Care Unit</i></p>
<p>Marcus P. Coe, MD, MS <i>Associate Professor, Residency Director, Department of Orthopaedic Surgery, Dartmouth Hitchcock Medical Center and Geisel School of Medicine</i></p>
<p>Duane A. Compton, PhD <i>Ex-Officio: Dean, Geisel School of Medicine at Dartmouth</i></p>
<p>Joanne M. Conroy, MD <i>Ex-Officio: CEO & President, Dartmouth-Hitchcock/Dartmouth Health</i></p>
<p>Gary V. Desir, MD <i>Yale School of Medicine: Paul B. Beeson Professor of Medicine; Chair, Internal Medicine at Yale School of Medicine and Yale New Haven Hospital; Vice Provost for Faculty Development and Diversity, Yale University</i></p>

<p>Celestina "Tina" M. Dooley-Jones, PhD <i>Retired Senior Foreign Service Officer</i></p>
<p>Nancy M. Dunbar, MD <i>Medical Director, Blood Bank Department of Pathology and Laboratory Medicine</i></p>
<p>Roberta L. Hines, MD MHMH/DHC Boards' Chair <i>Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine</i></p>
<p>Keith J. Loud, MD - beginning in March 2024 <i>Chair, Department of Pediatrics and Adolescent Medicine</i></p>
<p>Jennifer L. Moyer, MBA <i>Managing Director & CAO, White Mountains Insurance Group, Ltd</i></p>
<p>Sherri C. Oberg, MBA <i>CEO and Co-Founder of Particles for Humanity, PBC</i></p>
<p>David P. Paul, MBA MHMH/DHC Boards' Secretary & Treasurer <i>Retired President & COO, JBG SMITH</i></p>
<p>Mark S. Speers, MBA <i>Co-founder & Senior Advisor, Health Advances, LLC</i></p>

Jonathan B. Thyng, MD
Medical Director, Dartmouth Hitchcock Clinics Nashua

DARTMOUTH HEALTH

Mark W. Begor, MBA Chief
Executive Officer, Equifax

Joanne M. Conroy, MD
Ex-Officio: CEO & President, Dartmouth-Hitchcock/Dartmouth Health

Thomas P. Glynn, PhD
Adjunct Lecturer, Harvard Kennedy School of Government

Charles G. Plimpton, MBA
*Dartmouth Health Board Treasurer & Secretary
Retired Investment Banker*

Richard J. Powell, MD
Section Chief, Vascular Surgery; Professor of Surgery and Radiology

Thomas Raffio, MBA, FLMI *President
& CEO, Northeast Delta Dental*

Edward Howe Stansfield, III, MA
*Dartmouth Health Board Chair
Retired Senior Financial Advisor, Resident Director, of Bank of America/Merrill Lynch*

Paul A. Taheri, MD, MBA

Clinical Partner – Welsh Carson Anderson and Stowe

Pamela Austin Thompson, MS, RN, CENP, FAAN

*Chief executive officer emeritus of the American
Organization of Nurse Executives (AONE)*

Exec/Governance Oversight:

Kimberley A. Gibbs (603/650-8779)

Director, Executive Administration and Exec/Governance

One Medical Center Drive, Lebanon, NH 03756

kimberley.a.gibbs@hitchcock.org

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Claire M. Lillie (603/650-5244)

Exec. Coordinator for Exec/Governance & Leadership

claire.m.lillie@hitchcock.org

Laura K. Rondeau (603/650-5706)

Exec. Coordinator for Exec/Governance & Leadership

laura.k.rondeau@hitchcock.org

ARUN KRISHNAN MD

EDUCATION:

Brookdale Hospital and Medical Center	
* Child and Adolescent Psychiatry Fellowship	Jul 2014- Jun 2016
Brookdale Hospital and Medical Center	
* Residency in Adult Psychiatry (categorical)	Jul 2011- Jun 2014
Medical College Thiruvananthapuram, India	
MBBS (Bachelor of Medicine & Bachelor of Surgery)	Sep 2000- 2006

PROFESSIONAL EXPERIENCE:

Child And Adolescent Psychiatrist	(Dec 2018 – present)
Sunnu Youth Service Center/ Dartmouth Hitchcock Medical Center	
1056 N. River Road, Manchester, NH 03104	

Psychiatrist	(Aug 2018- present)
Counseling Center of New England	
15 trafalgar Sq, Suite 202, Nashua, NH 03063	

Psychiatrist	(Jul 2016- present)
Elliot Hospital	
1 Elliot way, Manchester, NH 03103	

Child Psychiatry Fellowship Training	(Jul 2014 – Jun 2016)
Brookdale UHospital and Medical Center, Brooklyn, NY	

Adult Psychiatry Residency Training	(Jul 2011 - Jun 2014)
Brookdale Hospital and Medical Center, Brooklyn, NY	

VOLUNTEER ACTIVITIES

Research:	Voluntary research assistant	(Apr 2009- Sep 2010)
	Geriatric Psychiatry fellowship program, SUNY Downstate Medical Center, Brooklyn, NY	

- Data collection and interviewing patient’s with memory problems and their family.
- Assisted fellows in making posters and in research.

PROFESSIONAL MEMBERSHIPS

- | | | |
|---|-----|--------------|
| • | AMA | 2019-present |
| • | APA | 2011- 2021 |

ACTIVITIES:

- Chief resident for Adult Psychiatry resident July 2013- June 2014.
- Member of House Staff safety council in Brookdale hospital
- Received scholarship to attend Telluride Patient Safety Summer Camp in July 2015.
- Presented poster " Working together to create change:- House staff safety council that create change " as a part of House Staff safety Council at GNYHA Conference Center NY during Symposium on Engaging Residents in Health Care Transformation in January 2016.
- Presented poster in Brookdale health week in October, 2015 on "Patient Safety Event Reporting in Child & Adolescent Psychiatry".
- Delegate for CIR (Committee for Interns and Residents), advocated in using patient care fund for audio video equipment, attending national CIR conference during training.
- Coordinator for QI project aimed at increasing patient compliance to medication by discussing about sexual side effect of medication.
- Attending hospital resident's forum, GME meeting and Departmental meeting and advocated for residents and patient's safety.
- Attended various GMEC meeting and open residents forum in Brookdale Hospital.
- Actively involved in CLER visit in 2013 and 2015 and represented residents.

CERTIFICATION:

- | | |
|--|----------------|
| • Board certified in Adult Psychiatry | 2015- present |
| • Board certified in Child and Adolescent Psychiatry | 2016- present |
| • Medical License in Connecticut medical board | 2015 -2017 |
| • DEA | 2016 - present |
| • Medical License in New Hampshire medical board | 2016 - present |
| • Medical License in Massachusetts | 2017 - present |

Samantha L. Morin, Ph.D.

Curriculum Vitae

EDUCATION/LICENSES

- 03/06/20 **Licensed by the NH Board of Registration of Psychologists**
NH Psychologist License Number: 1483
- 08/15/19 **Licensed by the MA Board of Registration of Psychologists**
MA Psychologist License Number: 11130
- 08/11 to 08/17 **Doctor of Philosophy, Fordham University**
Major: Clinical Psychology (APA-Accredited Program)
Concentration: Forensic Psychology
Dissertation: Determining treatment needs and recidivism risk of juveniles with sexual offense adjudications.
Advisor: Keith Cruise, Ph.D., M.L.S.
- 08/07 to 05/09 **Master of Arts, Roger Williams University**
Major: Forensic Psychology (APA-Accredited Program)
Thesis: Understanding perceptions of hypnotically-recovered memories in a civil sexual abuse case.
Advisor: Judith Platania, Ph.D.
- 08/03 to 05/07 **Bachelor of Arts, Saint Anselm College**
Major: Psychology; Minor/Certificate: Forensics
Honors Thesis: Critical incident stress debriefing (CISD): A comparison of law enforcement/arson professionals and college students seeking careers in arson/ law enforcement.
Advisor: Paul Finn, Ph.D.

CLINICAL EXPERIENCE

- 03/20 to present **Licensed Clinical Psychologist/Supervisor of Clinical Services**
Dartmouth-Hitchcock Medical Center, Department of Psychiatry; Contracted position at Sununu Youth Services Center (SYSC), Manchester, NH
Dartmouth Supervisor: William Torrey, MD; SYSC Director of Operations: Rhonda Chasse, MPA
Experiences:
- Contracted by Dartmouth Hitchcock Department of Psychiatry as the facility psychologist and supervisor of clinical services at SYSC, the sole juvenile secure treatment facility in the state of NH. Member of the SYSC Leadership team alongside the Director of Operations, Administrator II, and Residential Supervisor VI.
 - Provide clinical supervision and treatment planning oversight to the clinical services team, including three to four Masters-level clinicians. This includes: weekly supervision with each clinician, biweekly clinical team meetings,

Morin

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assignment of cases to clinicians, review of all clinical documentation (DAP notes, psychosocial assessments, treatment plans, court and parole reports, coaching/safety plans, assessments, etc.), and participation in all treatment plan meetings.

- Provide clinical consultation regarding youth placed at the facility to clinical services team, as well as other facility departments (e.g., medical, school, residential services staff, supervisors), including twice weekly case review meetings open to all staff.
- Responsible for evaluating current treatment programming (groups, milieu, individual and family therapy, assessments, etc.), as well as the development and implementation of facility-wide evidence-based treatment programming.
- Lead a multidisciplinary team of staff in the development of revised, evidence-based behavioral management programming for the facility including the development and implementation of positive behavioral interventions and supports (PBIS).
- Participate in parole hearings and court hearings, as needed/requested.
- Oversee research initiatives within the facility.
- Active participant on several juvenile justice workgroups for the State of NH aimed at improving juvenile justice policies and procedures, as well as promoting positive youth development models in the state.

Population Served:

- Diverse population of justice-involved male and female adolescents, ages 13 to 17, detained or committed by the court. Many of the youth present with significant trauma and/or mental health and substance use difficulties.

09/19 to present

Forensic Evaluator (per diem)

Office of the Forensic Examiner, Concord, NH

Supervisor: Shannon Bader, PhD, ABPP

Experiences:

- Conduct court-ordered evaluations of competence to stand trial.
- Write comprehensive reports for the court addressing competence to stand trial.
- Provide testimony as requested.
- Participate in weekly team meetings/peer consultation.

Population Served:

- Diverse population of male and female adult defendants, aged 18 and older, referred for a court-ordered evaluation in the state of NH.

09/18 to 03/20

Psychologist II, Adolescent Continuing Care Unit (ACCU) E2

University of Massachusetts (UMass) Medical School/Worcester Recovery Center and Hospital (WRCH), Worcester, MA

Program Director: Brian Denietolis, PsyD

Experiences:

- Conducted trauma-informed and developmentally appropriate individual and family psychotherapy with adolescents on the unit and their families.
- Managed and conducted initial psychology intake assessments (e.g., psychological diagnostic evaluation, trauma assessment, substance use assessment, specialized

risk assessment form) with each youth admitted to the unit within first 10 days of admission.

- Managed and conducted risk assessments for youth meeting hospital thresholds (e.g., suicide risk, violence risk, fire-setting risk, elopement risk, problem sexual behavior risk) including record review, youth interview, collateral contact, and composing risk assessment reports.
- Managed, conducted, and supervised psychological testing evaluations for youth indicated by clinical team as in need of evaluation; evaluations typically included self-report and evaluator-administered measures of intelligence, cognition, achievement, and personality. Completed comprehensive evaluation reports including diagnostic information and detailed recommendations were provided to team.
- Provided weekly clinical and testing supervision to psychology graduate student trainees completing practicum at WRCH. Worked collaboratively on cases with trainees. Supervised trainees in conducting and writing initial intake assessments, risk assessments, and psychological evaluation reports.
- Worked collaboratively with other treatment providers including psychiatrists, social workers, psychology trainees and interns, medical students, nurses, occupational and recreational therapists, and mental health counselors for optimal treatment planning.
- Attended and participated in daily unit rounds, weekly unit treatment team meetings, and weekly psychology department meetings.

Population Served:

- Diverse population of male and female adolescents, ages 13 to 18, with significant trauma and/or persistent mental illness. Four beds are allocated to youth admitted from the courts for forensic evaluations.

08/17 to 08/18

Clinical Psychology Postdoctoral Fellow, Adolescent Risk Assessment/Safety Net
Cambridge Health Alliance (CHA)/Harvard Medical School (HMS), Cambridge, MA
Training Director: Marla Eby, Ph.D.

Primary Supervisor: James Barrett, Ph.D.

Secondary Supervisors: David Stewart, Ph.D.; Dan Sanford, Psy.D.; William Pollack, Ph.D.

Safety Net Program Experiences:

- Attended Safety Net collaborative meetings twice per month with professionals and representatives from the Cambridge Police Department, Cambridge Public Schools, CHA, and Department of Human Services-Youth Programs.
- Provided outpatient psychological services (e.g., intake evaluation, individual psychotherapy, referrals) to adolescents referred from the Safety Net program to CHA.
- Provided consultation to partners in the Safety Net collaborative on issues related to adolescent mental health and treatment.
- Collaborated with other Safety Net partners on research projects investigating the effectiveness of the diversion program.

Population Served:

- Racially/ethnically diverse population of male and female adolescents participating in pre-complaint police diversion program and presenting with several risk

indicators (e.g., disruptive family life, mental illness, low school achievement, negative peer relations).

School-Based Assessment Experiences:

- Conducted safety, risk, and psychological assessments for the Cambridge Public Schools.
- Consulted with school personnel regarding recommendations for students referred for assessment.

Population Served:

- Racially/ethnically diverse population of male and female adolescents attending school in the Cambridge Public School system and presenting with risk indicators (e.g., externalizing behaviors, aggression, mental illness, school truancy, low school achievement, negative peer relations) referred to the School-Based Services program.

CHA Child/Adolescent Outpatient Clinic Experiences:

- Conducted intake evaluations with adolescents referred to CHA or the Cambridge-Rindge Latin School (CRLS) Teen Health Center for individual psychotherapy.
- Provided outpatient individual and family psychotherapy with adolescents and their parent(s)/guardian(s) at CHA or CRLS.

Population Served:

- Racially/ethnically diverse population of male and female adolescents referred for psychological services at CHA or CRLS and presenting with a range of mental health difficulties (e.g., depression, substance use, anger, anxiety, PTSD, etc.).

Juvenile Court Clinic Experiences:

- Conducted court-ordered evaluations with adolescents and their parent(s)/guardian(s) including Child Requiring Assistance (CRA) petitions, and shadowed Competency to Stand Trial (CST) evaluations, Criminal Responsibility (CR) evaluations, and Section 35 (substance abuse) evaluations.

Population Served:

- Racially/ethnically diverse population of male and female youthful offenders referred for court-ordered evaluations at the Lowell Juvenile Court Clinic.

08/16 to 08/17

Clinical Psychology Pre-Doctoral Intern, Forensic Track

UMass Medical School/WRCH, Worcester, MA

Training Director/Primary Supervisor: Jack Terry, Ph.D.

Secondary Supervisors: Andrea Dinsmore, PsyD.; Ashley Murray, Ph.D.; Phoebe Moore, Ph.D.; Brian Dessureau, Ph.D.; Jeanna Spanning, Ph.D.; Brian Denietolis, Psy.D.

Forensic Service (First Major Rotation, 09/16 to 03/17) Experiences:

- Assisted in conducting forensic evaluations under supervision of a Designated Forensic Psychologist (DFP) including competency to stand trial, criminal responsibility, risk assessment, and need for care and treatment.
- Completed written shadow reports for each forensic evaluation including record review, interview data, testing (when indicated), mental status, clinical opinion of the legal question, and need for care and treatment.
- Conducted testing for court-ordered forensic evaluations including administration and documentation of personality, symptom validity/malingering, and intellectual

measures (e.g., PAI, Structured Interview of Reported Symptoms, Validity Indicator Profile, Wechsler Abbreviated Scale of Intelligence- 2nd edition).

Population Served:

- Racially/ethnically diverse population of male and female offenders with severe mental illness (e.g., psychotic disorders, bipolar disorder, depression, substance abuse disorders) admitted to the forensic inpatient unit for court-ordered evaluation and psychiatric stabilization.

Pediatric Anxiety Clinic (Minor Rotation, 12 months) Experiences:

- Conducted anxiety and obsessive-compulsive disorder (OCD)-specific intake evaluations utilizing structured interviewing procedures.
- Conducted empirically supported cognitive-behavioral therapy (CBT) for pediatric anxiety and related disorders, using both family and individual approaches.

Population Served:

- Diverse population of children and adolescents with anxiety, OCD, and related disorders (e.g., generalized anxiety disorder, social anxiety, specific phobias) in a subspecialty outpatient clinic.

Outpatient Neuropsychology (Minor Rotation, 12 months) Experiences:

- Conducted outpatient neuropsychological assessments with patients referred from throughout UMass Memorial Center and outside clinics.
- Completed scoring, interpretation, and writing of reports for full neuropsychological test batteries.

Population Served:

- Racially/ethnically diverse population of children, young adults, and adults with a broad spectrum of neurological, medical, and psychiatric disorders.

Primary Care/Behavioral Medicine (Minor Rotation, 12 months) Experiences:

- Conducted consultation, rapid assessment, and behaviorally-oriented brief psychotherapy to patients in a primary care medical setting.
- Facilitated referrals to internal and external providers (e.g., psychiatric evaluations, long-term psychotherapy, group psychotherapy).

Population Served:

- Racially/ethnically diverse population of young adults and adults presenting at the Primary Care clinic with various comorbid medical (e.g., chronic pain, insomnia, hypertension) and mental health concerns (e.g., anxiety disorders, depression, substance abuse, personality disorders).

Adolescent Inpatient (Second Major Rotation, 03/17 to 08/17) Experiences:

- Conducted trauma-informed and developmentally appropriate individual and family psychotherapy with adolescents on the unit and their families.
- Enhanced and utilized skills in assessment and milieu management, including differential diagnosis, risk management, and the child service delivery system.
- Worked collaboratively with other treatment providers including psychiatrists, social workers, nurses, occupational and recreational therapists, and mental health counselors for optimal treatment planning.

Population Served:

- Diverse population of male and female adolescents, ages 13 to 18, with significant trauma and/or persistent mental illness. Four beds are allocated to youth admitted from the courts for forensic evaluations.

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09/15 to 03/16

Clinical Psychology Extern, Day Treatment Program

New York City Children's Center- Queens Campus, Bellerose, NY

Supervisors: Diana Miley, Psy.D. (treatment); Amy Daley, Ph.D. (assessment)

Experiences:

- Conducted individual, group, play, and family therapy (e.g., CBT, DBT, behavioral modification) in a fully integrated clinical and educational program.
- Conducted crisis interventions when indicated.
- Completed comprehensive psychological assessments.
- Managed treatment and discharge planning of cases.
- Participated in treatment team activities and attended grand rounds, diagnostic conferences, case conferences, and training lectures.

Population Served:

- Racially/ethnically diverse population of children and adolescents, ages 5 to 14, with severe emotional and behavioral disorders (e.g., ADHD, ODD, Autism Spectrum Disorder, DMDD, Bipolar disorder, Psychosis), and their parents/guardians.

09/14 to 08/15

Clinical Psychology Extern, Psychological Assessment

Bronx Lebanon Hospital Center, Bronx, NY

Supervisors: Ali Khadivi, Ph.D. (adult) & Wen Gu, Ph.D. (child/adolescent)

Experiences:

- Conducted individual psychological assessments including record review, clinical interview, and administration of psychological tests, and developed integrated assessment reports for treatment teams.
- Gained experience with various psychological tests including cognitive (e.g., Montreal Cognitive Assessment), intellectual (e.g., WISC-IV, WAIS-IV), personality (e.g., Rorschach, PAI), among others.
- Attended case conferences and grand rounds.

Populations Served:

- Diverse urban population of children, adolescents, and adults with severe mental illness (e.g., depression, schizophrenia, bipolar disorder, disruptive mood dysregulation disorder) admitted to the inpatient psychiatric units.
- Racially/ethnically diverse population of adolescents and adults with severe mental illness (e.g., bipolar disorder, schizophrenia) attending treatment in the outpatient clinic.

08/14 to 06/15

Forensic Psychology Fellowship

Fordham University Law Clinic, New York, NY

Supervisor: Barry Rosenfeld, Ph.D., A.B.P.P.

Experiences:

- Conducted psychological assessments (e.g., risk assessment, diagnostic clarification) and prepared reports for the legal team.
- Consulted with Fordham Law School Professors and Students on Criminal and Federal Litigation cases involving a mental health component.
- Assisted in writing legal briefs involving mental health issues presented in a given case.

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- Attended weekly Criminal Defense Clinic and Federal Litigation Clinic seminars, as well as weekly rounds.

Population served:

- Racially/ethnically diverse population of adult criminal defendants and inmates with mental illness (e.g., mood disorders, PTSD, substance abuse disorders).

07/13 to 06/14

Clinical Psychology Extern, Inpatient Assessment/Treatment

Bellevue Hospital Center, Forensic Track, New York, NY

Supervisors: Elizabeth Arias, Ph.D.; Melanie Farkas, Ph.D.; Marilyn Chen, Ph.D.

Experiences:

- Conducted intake assessments, and group (e.g., emotion regulation) and individual psychotherapy (e.g., CBT for psychosis, psychodynamic, behavioral modification, mindfulness, DBT skills) on the inpatient forensic unit.
- Conducted comprehensive psychological assessments (e.g., psychodiagnostic, malingering measures, cognitive testing).
- Attended weekly didactic seminars/case conferences and presented one treatment case.

Population Served:

- Diverse urban population of male offenders with severe mental illness (e.g., psychotic disorders, bipolar disorder, depression, substance abuse disorders) admitted to the forensic inpatient unit for psychiatric stabilization.

08/12 to 05/13

Clinical Psychology Extern, Outpatient Psychotherapy

Hunter College Counseling Center, New York, NY

Supervisor: Ariella Soffer, Ph.D.

Experiences:

- Conducted brief individual psychodynamic psychotherapy.
- Conducted comprehensive intake assessments and completed intake reports.
- Conducted mental health screenings for students on campus.
- Facilitated referrals and collaborated with community services.
- Participated in weekly didactic seminars/case conferences and presented five treatment cases.

Population Served:

- Racially/ethnically diverse population of college students including adolescents, young adults, and adults presenting at the counseling center with various mental health concerns (e.g., anxiety disorders, depression, substance abuse, personality disorders).

10/11 to 09/12

Study Therapist

Project SHARP, New York, NY

Supervisors: Michelle Galietta, Ph.D. & Barry Rosenfeld, Ph.D., A.B.P.P.

Experiences:

- Conducted CBT-based anger management intervention.

Population Served:

- Diverse urban population of male offenders referred for anger management by the NYC courts and Department of Probation.

CLINICAL SUPERVISION EXPERIENCE

- 09/18 to 03/20 **Trainee Supervisor**, Adolescent Continuing Care Unit, Worcester Recovery Center and Hospital (WRCH)
- Provided weekly clinical and testing supervision to psychology graduate student trainees completing practicum at WRCH.
- 11/16 to 05/17 **Trainee Supervisor**: Department of Psychology, WRCH
- Provided weekly clinical supervision to third-year graduate student completing externship at WRCH as part of the UMass Medical School/WRCH Clinical Psychology Predoctoral Internship Program.
- 08/14 to 05/15 **Peer Supervisor**: Department of Psychology, Fordham University
- Provided weekly clinical supervision to second-year graduate student as part of the Clinical Supervision and Consultation course (PSYC 8222/8223)

OTHER CLINICAL EXPERIENCE

- 08/08 to 05/09 **Psychology Extern, Outpatient Psychotherapy**
 Arbour Counseling Services, Fall River, MA
Supervisors: Janine Gendreau, M.A. & Donald Whitworth, Ph.D.
Experiences:
- Conducted individual psychotherapy (e.g., supportive, CBT, psychodynamic) and co-led group psychotherapy (e.g., DBT).
 - Completed initial clinical evaluations.
 - Developed and implemented individual treatment plans.
- Population Served*:
- Racially/ethnically diverse population of adolescents and adults with various mental health concerns (e.g., depression, anxiety disorders, substance abuse, relationship issues, anger management issues, eating disorders, bereavement) attending psychotherapy at an outpatient community clinic.
- 08/07 to 08/08 **Support Staff**
 L.I.F.E. Inc., Bristol, RI
Experiences:
- Provided therapeutic and emotional support and guidance with decision-making.
 - Utilized behavioral management techniques.
 - Assisted with daily living activities.
- Population Served*:
- Developmentally and physically disabled adults living in a residential group home.

RESEARCH EXPERIENCE

- 08/11 to 08/16 **Research Assistant**
 Fordham University, Clinical Psychology Ph.D. Program
Project: Adolescent and Parent Perspectives on Teen Risk-Taking Behaviors: Exploring Associations and Ethical Issues (Fordham University Undergraduate Research Grant)
Principal Investigators: Keith Cruise, Ph.D., M.L.S. & Georgia Gaveras, D.O.

Experiences:

- Conducted comprehensive assessments (e.g., Peer Conflict Scale, Inventory of Callous-Unemotional Traits, BASC-2, FASM, UCLA PTSD Index, SASSI-A2, MAYSI-2) with adolescents participating in an outpatient day treatment program for youth with co-occurring mental health and substance abuse disorders, and their parent/guardian.

Project: Initial Validation of the Short-Term Assessment of Risk and Treatability Present Adolescent Version (START-AV) (Fordham University Faculty Research Grant)

Principal Investigator: Keith Cruise, Ph.D., M.L.S.

Experiences:

- Conducted comprehensive structured interviews and assessments (e.g., START-AV, MAYSI-2, SASSI-A2) with juvenile offenders on probation in Bridgeport, CT for the purposed of validating the START-AV.

05/12 to 08/12

Research Assistant

Fordham University, Clinical Psychology Ph.D. Program, Bronx, NY

Project: Differentiating Real versus Feigned Posttraumatic Stress Disorder in a Sample of West African Torture Survivors

Principal Investigators: Rebecca Weiss, M.A. & Barry Rosenfeld, Ph.D., A.B.P.P.

Experiences:

- Conducted comprehensive assessments with adults from West Africa seeking asylum through the Program for Survivors of Torture (PSOT) at Bellevue Hospital. The purpose of the study was to validate measures of malingering (e.g., M-FAST, TOMM, Dot Counting Test, TSI-2) in this population.

06/10 to 09/11

Research Assistant

UMASS Medical School, Department of Psychiatry, Worcester, MA

Project: Women's Risk and Treatment for Intimate Partner Violence (Psychiatry Research Fellowship Award)

Principal Investigator: Laura S. Guy, Ph.D.

Experiences:

- Conducted comprehensive assessments (e.g., PAI, URICA) with female perpetrators of intimate partner violence prior to and following the completion of a group therapy intervention.

10/09 to 08/11

Research Coordinator II

UMASS Medical School, Department of Psychiatry, Worcester, MA

National Youth Screening and Assessment Project

Supervisors: Thomas Grisso, Ph.D. & Valerie Williams, M.A., M.S.

Experiences:

- Provided technical assistance and training on mental health and risk screening and assessment practices to targeted sites in all four states participating in the MacArthur Foundation's "Models for Change" (MfC) Initiative (Pennsylvania, Washington, Illinois, and Louisiana).

- Assisted juvenile justice programs with the registration, implementation and ongoing use of the Massachusetts Youth Screening Instrument- Version 2 (MAYSI-2).
- Provided technical support to users of MAYSIWARE, the electronic version of the MAYSI-2.

Project: Youth Risk/Needs Assessment for Recidivism: Implementation and Effectiveness Study (John D. & Catherine T. MacArthur Foundation Grant)

Principal Investigator: Gina Vincent, Ph.D.

Co-Investigator: Laura Guy, Ph.D.

Experiences:

- Conducted phone interviews with juvenile probation officers in two states (Louisiana and Pennsylvania) at time points following the implementation of valid risk/needs assessment tools.
- Coded juvenile probation officer interview transcripts according to an established codebook in order to qualitatively examine the outcomes of implementation.

TEACHING EXPERIENCE

01/14 to 05/16 **Instructor:** Department of Psychology, Fordham University

Undergraduate Courses:

Forensic Psychology (PSYC 3820)

Law and Psychology (PSYC 4340)

Graduate Courses:

Clinical Diagnosis Laboratory (PSYC 7121)

09/11 to 05/12 **Teaching Assistant:** Department of Psychology, Fordham University

Undergraduate Courses:

Foundations of Psychology Lab, Three sections (PSYC 1200)

HONORS AND AWARDS

2017 **Outstanding Student Presentation in Corrections Research**

American Psychology-Law Society 2017 Conference Award

2017 **GSA Professional Development Grant**

Fordham University

2017 **GSAS Research Support Grant**

Fordham University

2012, 2013, 2014 **GSA Travel Award**

Fordham University

2008, 2009 **Provost Fund Grant**

Roger Williams University

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- 2007 to 2009 **Master of Arts in Forensic Psychology Grant**
Roger Williams University
- 2003 to 2007 **Psi Chi National Honor Society in Psychology**
Saint Anselm College
- 2003 to 2007 **Presidential Scholar Academic Scholarship**
Saint Anselm College
- 2003 to 2007 **Elks Regional Scholar Academic Scholarship**
Elks Club, Worcester, MA
- 2003 to 2007 **Dean's List 8/8 semesters**
Saint Anselm College

PROFESSIONAL SERVICE

National

- 2015 to Present **Student Reviewer/Reviewer**
Child and Youth Care Forum
- 2012 to Present **Student Reviewer/Reviewer**
International Journal of Forensic Mental Health
- 2010 to 2015 **Student Reviewer**
American Psychology- Law Society Annual Conference
Areas: Risk assessment, developmental/juvenile justice, risk assessment
- 2010 to 2013 **Student Reviewer**
American Psychological Association Annual Conference
Areas: Jury decision making, expert testimony, division 41 proposals
- 2010 **Committee Reviewer**
MacArthur Models for Change 5th Annual Working Conference
Reviewed 35 proposals submitted for inclusion

Departmental

- 2012 to 2014 **Student Interviewer**
Fordham University, Department of Psychology
- 2012 to 2013 **Class Representative**
Fordham University, Department of Psychology

ADDITIONAL TRAININGS

- 2016 **Psychopathy and the Psychopathy Checklist-Revised (PCL-R)**
Worcester Recovery Center and Hospital, Forensic Service, Worcester, MA
Instructor: Ashley Murray, Ph.D.

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- 2015 **Juvenile Competence Workshop**
Summer Training Institute, John Jay College, NY, NY
Instructor: Ivan Kruh, Ph.D.
- 2014 **HCR-20 Training**
Fordham University, NY, NY
Instructor: Barry Rosenfeld, Ph.D., A.B.P.P.
- 2013 **MMPI-2-RF Workshop**
Fordham University, NY, NY
Instructor: Yossef Ben-Porath, Ph.D.
- 2009 **Use of the Psychopathy Checklist-Revised, 2nd Edition (PCL-R) and the
Psychopathy Checklist-Revised: Screening Version (PCL: SV)**
UMASS Medical School, Worcester, MA
Instructor: Gina Vincent, Ph.D.
- 2009 **The Structured Assessment of Violence Risk for Youth (SAVRY)**
UMASS Medical School, Worcester, MA
Instructors: Gina Vincent, Ph.D. & Laura Guy, Ph.D.

PUBLICATIONS

Peer-Reviewed Journal Articles

1. Janopaul-Naylor, E., **Morin, S. L.**, Mullin, B., Lee, E., & Barrett, J. G. (2019). Promising approaches to police-mental health partnerships to improve service utilization for at-risk youth. *Translational Issues in Psychological Science*, 5(2), 206-215. doi:10.1037/tps0000196
2. Holloway, E. D., Cruise, K. R., **Morin, S. L.**, Hinz, H., & Steele, R. (2018). Juvenile probation officers' evaluation of traumatic event exposures and traumatic stress symptoms as responsivity factors in risk assessment and case planning. *Law and Human Behavior*, 2(4): 369-384. doi:10.1037/lhb0000283
3. **Morin, S. L.**, Cruise, K. R., Hinz, H., Holloway, E. D., & Chapman, J. F. (2015). Content, structure, and usefulness of juvenile predisposition psychological evaluations. *Child & Youth Care Forum*, 44(6), 893-917. doi: 10.1007/s10566-015-9312-3
4. Guy, L. S., Vincent, G. M., Nelson, R., & **Fusco-Morin, S.** (2014). What do juvenile probation officers think of using the SAVRY and YLS/CMI for case management, and do they use the tools properly. *International Journal of Forensic Mental Health Services*, 13(3), 227-241.
5. Vincent, G. M., Guy, L. S., **Fusco, S. L.**, & Gershenson, B. G. (2012). Field Reliability of the SAVRY with Juvenile Probation Officers. *Law and Human Behavior*, 36(3), 225-236.
6. **Fusco, S. L.**, & Platania, J. (2011). Understanding perceptions of hypnotically recovered memories in a civil sexual abuse case. *Journal of Forensic Psychology Practice*, 11(4), 330-350.

Book Chapters and Other Publications

1. Viljoen, J. L., Nicholls, T. L., Cruise, K. R., Beneteau-Douglas, J., Desmarais, S. L., Barone, C. C., Petersen, K., **Morin, S. L.**, & Webster, C. D. (2016). *START: AV knowledge guide: A research compendium on the START:AV strength and vulnerability items*. Burnaby, BC: Simon Fraser University.
2. Cruise, K. R., **Morin, S. L.**, & Affleck, K. (2015). Residential interventions with justice involved youth. In K. Heilbrun, D. DeMatteo, & N. Goldstein (Eds.), *Handbook of psychology and juvenile justice*. Washington, DC: American Psychological Association.
3. Models for Change Juvenile Diversion Workgroup (2011). *Juvenile Diversion Guidebook*. Models for Change: Systems Reform in Juvenile Justice.

CONFERENCE PRESENTATIONS

1. **Morin, S. L.**, Barrett, J. G., & Janopaul-Naylor, E. (2018, March). *Mental health and service use outcomes of a pre-complaint police-based juvenile diversion program*. Paper presented at the 2018 Annual Conference of the American Psychology-Law Society, Memphis, Tennessee.
2. Barrett, J. G., **Morin, S. L.**, & Janopaul-Naylor, E. (2018, March). *Effectiveness of a pre-complaint police-based juvenile diversion program in reducing recidivism*. Poster presented at the 2018 Annual Conference of the American Psychology-Law Society, Memphis, Tennessee.
3. **Morin, S. L.**, & Cruise, K. R. (2017, March). *Determining treatment needs and recidivism risk of juveniles with sexual offense adjudications: Primary and secondary C-U traits*. Poster presented at the 2017 Annual Conference of the American Psychology-Law Society, Seattle, Washington.
4. Holloway, E. D., Cruise, K. R., **Morin, S. L.**, Hinz, H., & Viljoen, J. L. (2017, March). *An application of the adherence checklist for the evaluation and reduction of risk (ACERR) to evaluate case plans developed by juvenile probation officers*. Paper presented at the 2017 Annual Conference of the American Psychology-Law Society, Seattle, Washington.
5. Holloway, E. D., Cruise, K. R., **Morin, S. L.**, Hinz, H., & Steele, R. (2016, June). *Risk assessment and case planning by juvenile probation officers: investigating the role of trauma as a responsivity factor*. Paper presented at the 2016 Annual Conference of the International Association of Forensic Mental Health Services, New York, New York.
6. **Morin (Fusco), S. L.**, Cruise, K. R., Hinz, H., Holloway, E., Chapman, J., & Duran, T. (2014, March). *Content, structure, and usefulness of juvenile predisposition psychological evaluations*. Poster presented at the 2014 Annual Conference of the American Psychology-Law Society, New Orleans, Louisiana.
7. Gamache, K., Weipert, R., & **Morin (Fusco), S. L.** (2014, March). *Active shooters: The predictive utility of critical factors on the magnitude of the event*. Symposium presented at the 2014 Annual Conference of the American Psychology-Law Society, New Orleans, Louisiana.
8. **Fusco, S. L.**, Affleck, K. C., Cruise, K. R., Gaveras, G. (2013, March). *Examining co-occurring mental health/risk management needs in at-risk youth: Do parents and youth agree?* Paper presented at the 2013 Annual Conference of the American Psychology-Law Society, Portland, Oregon.
9. **Fusco, S. L.**, Guy, L. S., Nelson, R., Conti, K., Bennet, M. M., Dowd, L., & Vincent, G. (2012, March). *Female perpetrated aggression: Characteristics and treatment needs of anger management group*

participants. Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.

10. Fusco, S. L., Cook, N. E., & Maney, S. (2012, March). *Mental health symptoms among Hispanic youth in juvenile justice: Language and gender differences*. Symposium presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.
11. Conti, K., Guy, L. S., Nelson, R., & Fusco, S. L. (2012, March). *Investigating the URICA-DV-R among women in anger management group treatment*. Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.
12. Gamache, K., Weipert, R. E., Griffen, K., & Fusco, S. L. (2012, March). *"I don't like Mondays": An explorative look at the characteristics of Active Shooters*. Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.
13. Nelson, R., Guy, L. S., Conti, K., & Fusco, S. L. (2012, March). *Female perpetrated intimate partner violence and treatment attrition*. Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.
14. Guy, L. S., Fusco, S. L., Hilterman, E., & Vincent, G. M. (2011, June). Experiences using the SAVRY in the field: A comparison of Spanish clinicians and American probation officers. In, *SAVRY risk management, one step ahead of risk assessment*. Symposium presented at the 11th Annual Conference of the International Association of Forensic Mental Health Services (IAFMHS), Barcelona, Spain.
15. Fusco, S. L., Perrault, R. T., Paiva, M., Cook, N. E., & Vincent, G. M. (2011, March). *Probation officer perceptions of gender differences in youth offending and implications for practice in the field*. Paper presented at the 2011 meeting of the American-Psychology-Law Society, Miami, FL.
16. Paiva, M., Fusco, S. L., & Vincent, G. M. (2011, March). *Socioeconomic Status: Does it affect juvenile compliance while on probation?* Poster presented at the 2011 meeting of the American-Psychology-Law Society, Miami, FL.
17. Cook, N. E., Fusco, S. L., Guy, L. S., & Vincent, G. M. (2011, March). Decision making and use of risk/needs assessment tools in juvenile probation. In, *Use of the SAVRY and YLS/CMI in Juvenile Probation: Implementation Study*. Symposium presented at the 2011 meeting of the American-Psychology-Law Society, Miami, FL.
18. Guy, L. S., Fusco, S. L., Cook, N. E., & Vincent, G. M. (2010, August). Juvenile probation officers' experiences using risk/needs assessment tools in the field. In, E.P. Mulvey & C.A. Schubert (Chairs), *Empirically Based Approaches for Improving the Juvenile Justice System*. Symposium presented at the 118th meeting of the American Psychological Association, San Diego, CA.
19. Guy, L.S., Fusco, S. L., Cook, N. E., & Vincent, G. M. (2010, May). *Juvenile probation officers' decision-making processes and experiences using risk/needs assessment tools in the field*. Paper presented at the 10th Annual meeting of the International Association of Forensic Mental Health Services, Vancouver, Canada.

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20. Gamache, K., Weipert, R., **Fusco, S. L.**, Rowback, J., & Paiva, M. (2009, August). *"She had it coming": A comparative look at domestic violence blame attributions*. Poster presented at the 117th meeting of the American Psychological Association, Toronto, Canada.
21. **Fusco, S. L.**, & Platania, J. (2009, March). *Understanding perceptions of hypnotically-recovered memories in a civil sexual abuse case*. Poster presented at the meeting of the American Psychology-Law Society, San Antonio, TX.
22. Platania, J., Small, R., **Fusco, S. L.**, Miller, M., & Perrault, R. (2008, August). Investigating legal safeguards against prosecutorial misconduct in closing argument. In V. Stinson (Chair), *Death Penalty*. Paper session conducted at the 116th meeting of the American Psychological Association, Boston, MA.
23. **Fusco, S. L.**, & Finn, P. (2007, March). *Critical incident stress debriefing (CISD): A comparison of law enforcement/arson professionals and college students seeking careers in arson/law enforcement*. Poster presented at the meeting of the Eastern Psychological Association, Philadelphia, PA.

PROFESSIONAL AFFILIATIONS

2013 to Present	Society for a Science of Clinical Psychology (SSCP)
2011 to Present	Association for Psychological Science (APS)
2007 to Present	American Psychological Association (APA): Divisions 12, 41, 53, and 56
2006 to Present	Eastern Psychological Association (EPA)

CURRICULUM VITAE

Name: Erin R. Barnett, Ph. D.

Address:

DHMC, Department of Psychiatry
One Medical Center Drive
Dartmouth Trauma Interventions Research Center, 46 Centerra, Rm 207
Lebanon, NH 03756

Date prepared: May 21st, 2024

I. Education

- 2008-2009 Clinical Psychology Pre-Doctoral Intern, Dartmouth Medical School
- 2006-2009 University of Missouri-St. Louis Ph.D., Clinical Psychology
- 2004-2006 University of Missouri-St. Louis M.A., Clinical Psychology
- 2000-2004 University of Nebraska-Omaha B.A., Psychology

II. Post-doctoral training

- 2009-2010 Dartmouth Medical School / VA's National Center for PTSD

III. Academic appointments

- 2022-current Departments of Psychiatry and The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, Associate Professor
- 2017-current The Dartmouth Institute for Health Policy and Clinical Practice, Assistant Professor
- 2013-2022 Department of Psychiatry, Geisel School of Medicine at Dartmouth, Assistant Professor

IV. Institutional Leadership Roles NA

V. Licensure and certification

- 2015 Certified Trauma-Focused Cognitive Behavioral Therapy clinician
- 2014 Rostered Child Parent Psychotherapy clinician
- 2010 Licensed clinical psychologist NH #1206

VI. Hospital Appointments

2016-current Psychologist, Dartmouth-Hitchcock Medical Center

VII. Other professional positions

2009-2013 VA's National Center for PTSD Research Psychologist

2009-present West Central Behavioral Health Psychologist/Clinician (15% FTE)

VIII. Professional Development

Completed NIH grant writing workshop, by J. Robertson, 2018

Completed Writing Seminar hosted by TDI, R. Drake, S. Woloshin, L. Schwartz, 2018

IX. Teaching activities**A. Undergraduate Medical Education NA****B. Graduate Education**

2018	Geisel School of Medicine The Dartmouth Institute for Health Policy and Clinical Practice	Master's of Public Health	Co-director, Social and Behavioral Determinants of Health, 55 students
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C. Undergraduate Medical Education NA**D. Graduate Medical Education**

2022-present	Geisel School of Medicine at Dartmouth	Providing best practice in community mental health	Seminar lecturer, 60 min
2019	Geisel School of Medicine at Dartmouth	Building shared decision making in child psychiatry	Seminar lecturer, 60 min
2012-present	Geisel School of Medicine at Dartmouth	Early childhood trauma and attachment	Seminar lecturer, 60 min Annual
2012-present	Geisel School of Medicine at Dartmouth	PTSD in children and adolescents	Seminar lecturer, 60 min Annual
2009-2017	Geisel School of Medicine at Dartmouth	Acceptance and Commitment Therapy	Seminar lecturer, 60 min Annual
2009-present	Geisel School of Medicine	Trauma Seminar for	Facilitator, 90 min weekly

at Dartmouth psychology interns seminar

E. Other Clinical Education

2021-present	CBT supervision Juliette Madan, Psychiatry Fellow	Clinical Supervisor	Bi-monthly supervision
2016-present	Trauma-Informed Early Childhood Services	Developer, Presenter	Nine 6-hour trainings
2013-2017	Trauma-Focused Cognitive Behavioral Therapy	Co-presenter	Four 2-day trainings
2013-2017	Child-Parent Psychotherapy	Co-presenter	Four 2-day trainings
2012-2017	Clinical supervisor, clinical psychology interns (4) and doctoral fellows (1)	Clinical Supervisor	Dept. of Psychiatry, Geisel West- Central Behavioral Health

F. Graduate Teaching

2018	Social Determinants of Health	Co-course director	The Dartmouth Institute MPH residential program
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G. Other Professional/Academic Programs

2010-2011 UNH/ Granite State College, Taught two 12 hour courses and one 6 hour course to foster parents and professionals on child trauma and traumatic stress

X. Primary Research Advising

A. Undergraduate students

2023	Catherine Gorman	Research advisor	Dartmouth College
2023	Emilia Callahan	Research advisor	Dartmouth College
2022	Anna Politi	Research advisor	Dartmouth College
2019	Brendon Lee, BS	Research advisor for summer internship	Carleton College

B. Graduate students

2021-2022	TDI MPH Independent Learning Experience, Accelerated Master's	Thesis Research Advisor	The Dartmouth Institute
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Urvya Iyer

2021	TDI MPH spring intern Philip Hession	Preceptor/ Research Advisor	The Dartmouth Institute
2020	TDI MPH spring intern Kieshan Amarakaran	Preceptor/ Research Advisor	The Dartmouth Institute
2019	TDI MPH spring intern Chibuzo Aguwa	Preceptor/ Research Advisor	The Dartmouth Institute
2018	TDI MPH spring intern Tanya Butt	Preceptor/ Research Advisor	The Dartmouth Institute
2017-2019	TDI MPH student Alissa Trepman	Research Advisor	The Dartmouth Institute
2017-2018	Capstone Research Advisor, TDI MPH program 10 students	Research Advisor (10% FTE)	The Dartmouth Institute

C. Medical students**D. Residents/Fellows**

2023-2025	Julia Najm, T32 post-doctoral fellow	Research Mentor	Dept of Psychiatry, Geisel
2016-2017	Sarah Cleary, post-doctoral fellow	Research Supervisor	Dept of Psychiatry, Geisel
2014-2015	Katrin Neubacher, post-doctoral fellow	Research Supervisor	Dept of Psychiatry, Geisel

XI: Advising/Mentoring**A. Undergraduate**

2021	Joslin Wainwright, BA	Senior spring internship supervisor	Colby-Sawyer College
2016	Aubree Kozié, BA	Senior spring internship supervisor	Bennington College

B. Graduate students**C. Medical students**

D. Residents/Fellows

2020-2021	Christina Moore, MS	pre-doctoral intern Professional development advisor	Dept. of Psychiatry, Geisel
2019-2020	Rachel Herman, MS	pre-doctoral intern Professional development advisor	Dept. of Psychiatry, Geisel

E. Faculty

2021-current	Kaitlyn Ahlers, PhD	Junior faculty Professional development, Named mentor on foundation grant application	Dept. of Psychiatry, Geisel
2020-current	James T. Craig, PhD	Junior faculty Mentored NIH R34 proposal	Dept. of Psychiatry, Geisel

XII. Engagement, Advocacy, Community Service, Community Education

2023	End Child Abuse & Neglect (EndCAN) national coalition, Action Circle member
2022	Dresden School District, School Board Strategic Plan, Student Support Services Subcommittee Member
2021	Presented to The Vermont Collaborative on Adverse Childhood Experiences. The Collaborative is a community-based organization that engages VT middle and high school youth aiming to learn about and prevent substance misuse in themselves and others. 1.5 hours.
2020	Videography interview for <i>TIME</i> documentary, <i>The Opioid Diaries: Born in Withdrawal</i> , with Diane Tsai, producer. 4 hours.
2020	Partnered with NH New Futures child advocate Cheryl Avery to draft and support NH legislative bill, proposed by Rep William Marsh to promote improved oversight around the use of psychotropic medications for NH children in foster care
2018- Current	Invited to present to the Leadership Upper Valley on Adverse Childhood Experiences and the Workplace, Annual. 1 hour.
2019	Content expert for the Public Health Council of the Upper Valley legislative meeting with 30+ bi-state legislators focused on child abuse and neglect, 2 hours
2018	Interviewed for <i>Psychology Today</i> for a piece about over-medication of youth in foster care in NH following release of the DHHS Office of the Inspector General report naming NH as having one of the top 5 highest prescription rates to this population, by Devon Frye. 1 hour

- 2018 Interviewed for *Slate Magazine* for a piece about over-medication of immigrant/refugee children detained at Shiloh treatment center at the border, by D. Engber. 1 hour
- 2018 Led community support initiative at the Claremont Recovery Center through partnership with local church. 2 hours
- 2017 Led community fundraiser for West-Central Behavioral Health Child Claremont Clinic through partnership with local business. 3 hours
- 2017 Panel expert following *Resilience* documentary, with focus on child and community trauma. The Red River Theater, Concord, NH. 3 hours
- 2016 Interviewed for the *Dartmouth Alumni Magazine* for a piece about trauma and PTSD, After the Fire, S. Spencer-Rendahl. 1 hour
- 2009-2010 US DHHS SAMHSA's National Child Traumatic Stress Network, Breakthrough Series Collaborative to improve placement stability for local children in foster care. 34 hours (2 two day meetings; monthly community meetings, bimonthly consultation calls)

XIII. Research Activities**A. Sponsored Activity (Grants and Contracts)****CURRENT****1. Key personnel**

Charles H. Hood Foundation

Elwyn (PI)

4/1/23-3/31/25

Decreasing harms and improving child health: An intervention to reduce inappropriate use of antipsychotics and polypharmacy.

This 2-year project will test the feasibility and acceptability of a psychotropic deprescribing intervention aiming to increase shared decisions and implement a deprescribing protocol to improve the safe and effective use of psychotropics among youth receiving off-label antipsychotics or psychotropic polypharmacy.

Role: Co-Principal Investigator, 10% FTE

\$202,500 annual directs (\$405,000 total directs)

US Department of Health and Human Services, Substance Abuse and Mental Health Administration

1H79SM084710-01

Barnet (PI)

12/31/22-12/30/26

Upstream 2: Increasing mental health and trauma identification and referrals for youth ages 12-18 years.

The *Upstream2* project will provide evidence-based mental health and trauma training and consultation to health, community, and service professionals serving youth ages 12-18 and their families across 6 counties in bordering NH and VT. Our primary goal is to increase the capacity for identification of trauma and mental health needs in youth and link families to needed services.

Role: Principal Investigator, 12% FTE

\$122,000 annual directs (\$464,560 total directs)

US Department of Health and Human Services, Substance Abuse and Mental Health Administration

90CO1099/01

Jankowski and Barnett (co-m/PIs)

10/1/21 – 9/30/26

Improving Care for Children and Youth in NH with Trauma and Intellectual and Developmental Disabilities

Our goal is to improve outcomes for children and youth ages 0-21 with intellectual and developmental disabilities, including autism (IDD) who are affected by trauma, across the state of New Hampshire.

Role: co/m-Principal Investigator, 30% FTE

\$260,000 annual directs (\$1.3 million total directs)

NH Department of Health and Human Services

State contract

Barnett (PI)

3/26/22 - 2/1/24

NH Rapid Response Behavioral Health Crisis Transformation

The primary goal of our work is to evaluate the new state rapid response/mobile crisis system.

Role: Principal Investigator, 20% FTE

US Department of Health and Human Services, Substance Abuse and Mental Health Administration

1H79SM080245-01

Brunette (PI)

10/1/18-9/30/23

ProHealth NH: New Hampshire Partnerships to Improve Health & Wellness for Young People with SED and SMI

Role: Consultant/Trainer, 2.5% FTE

\$398,726 annual directs (\$1.99 million total direct)

US Department of Health and Human Services, Administration for Children Youth and Families Children's Bureau

90CU0109-01-00

Jankowski & Barnett (co/m-PIs) 10/1/19 – 9/30/24

Partners to Promote Safety, Permanency and Well-Being for Families Affected by Substance Use (P2P)

The primary goals of P2P are to improve the safety, permanency, well-being, and family functioning of children 0-18 yrs in or at-risk for being placed outside the home due to parental substance use, and to improve engagement and addiction treatment outcomes for parents and caregivers. The target region for P2P activities spans two

rural neighboring counties (Grafton and Sullivan) of New Hampshire.

Role: Co/Multi Principal Investigator, 25% FTE \$460,000 annual directs (\$2.0 million total direct)

US Department of Health and Human Services, Substance Abuse and Mental Health Administration
1H79SM082302-01 Jankowski (PI) 9/1/19 – 8/30/24

Project Launch Upper Valley: Promoting a Healthy Start for Young Children and their Families

We aim to increase our community's ability to identify, engage and serve at-risk and trauma-affected families with evidence-based early intervention services, with an eventual goal of influencing early childhood policy and practice in two Northern New England states. Project Launch UV will focus activities at four tiered levels by raising public awareness and decrease stigma for young children's BH needs; screening of children 0-8 and their caregivers in six primary care clinics, and providing trauma-informed care training to the workforce (e.g., early education and care, health, BH); providing targeted supports to enhance engagement and increase access to care, and provide expert BH consultation for our professional workforce that serves young children and their caregivers; and building capacity for two evidence-based parenting interventions

Role: Co-investigator, 25% FTE \$524,000 annual directs (\$2.6 million total directs)

PAST

US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
1H79SM081151-01 Barnett (PI) 10/1/18-9/30/21

Upstream Upper Valley: Increasing early childhood mental health and trauma awareness among community health and service providers

The *Upstream* project will provide evidence-based mental health and trauma training and consultation to health, community, and service professionals serving young children and families across 3 counties in NH and VT. Our primary goal is to increase the capacity for identification of trauma and mental health needs in young children and link families to needed services.

Role: Principal Investigator, 20% FTE \$113,000 annual directs (\$342,000 total directs)

US Department of Justice, Office of Justice Programs, Office for Victims of Crime Barnett (PI)
Moving Upstream: Building a Trauma-Informed Community Response for Our Youngest Victims of the Opioid Crisis in Cheshire County
2018-V3-GX-0078 Barnett (PI) 10/1/18-9/30/21

Our overall goal is to enhance our community response to children ages 0-8 years victimized by our opioid crisis through expert training, consultation and coalition activities that implement trauma-sensitive practices across multiple sectors serving young children and families across the county.

Role: Principal Investigator, 15% FTE \$133,000 annual directs (\$366,000 total directs)

Patient-Centered Outcomes Research Institute Barnett (PI) 8/1/17 – 7/31/18
5093717-012

Developing Patient-Driven Research to Improve the Psychiatric Care of Youth in Foster Care

The goal of this PCORI project is to build community engagement and capacity toward the generation of comparative effectiveness research ideas that build and evaluate patient-driven psychiatric practices for youth in foster care.

Pipeline to Proposal: Tier II.

Role: Principal Investigator, 8% FTE \$20,000 directs

DHHS Administration for Children and Families Mullen, Jankowski (co/m-PIs) 10/1/13 – 9/30/18
90C01115/01

The NH Adoption Preparation and Preservation Project

The goal of this 5-year demonstration grant is to improve adoption stability for youth in NH through trauma-

informed workforce development.

Role: co-investigator, 30% FTE \$290,000 annual direct (\$1.5 million total direct)

DHHS Administration for Children and Families Jankowski (PI) 10/1/12 – 9/30/17
90CO1099/01

The Partners for Change Project: Improving Well-Being for Youth in the NH Child Welfare System

The goal of this 5-year demonstration grant is to improve the well-being of children in the NH child welfare and juvenile justice system through trauma-informed workforce development with child welfare and mental health staff.

Role: co-investigator, 30% FTE \$429,000 annual directs (\$2.1 million total directs)

Patient-Centered Outcomes Research Institute Barnett (PI) 8/1/16 – 4/30/17

Developing Patient-Driven Research to Improve the Psychiatric Care of Youth in Foster Care

The goal of this PCORI project is to build community engagement and capacity toward the generation of comparative effectiveness research ideas that build and evaluate patient-driven psychiatric practices for youth in foster care. Pipeline to Proposal: Tier 1.

Role: Principal Investigator, 8% FTE \$12,000 directs

Neil and Louise Tillotson Foundation Barnett (PI) 7/1/16 – 6/30/17

Building a model of coordinated care toward safe and effective psychotropic medications for vulnerable children in Coos County

The goal of the study is to develop and pilot-test a protocol that facilitates team discussions and decisions centered on individual children regarding the use of psychotropic medications and other wellness topics.

Role: Principal Investigator, 20% FTE \$45,000 directs

Gary Tucker Jr Award, Psychiatry, Dartmouth Barnett (PI) 7/1/15 – 6/30/16

Our Minds Our Choice: Developing and Piloting an Option Grid around Interventions for Complex Behavior Problems in Children

The goal of this project was to develop - with parents, clinicians, and stakeholders - and pilot-test a 1 page Option Grid decision aid to improve decision-making related to the use of various classes of medications and therapy for children's complex behavior problems.

Role: Principal Investigator, 8% FTE \$20,000 directs

2. Non-key personnel

NH Innovation Research Ctr, Granite State Tech. Innovation Grant Stanger (PI) 11/1/17 – 6/30/18
UNH 18-014

Integrating Coaches to Promote Engagement with an M-Health Collaborative Care App

The research collaboration seeks to test such a modification of an existing m-health collaborative care app (Proxi) to include Mobile Coaches (MCs) to promote user engagement and maximize its utility for use with youth aging out of foster care.

Role: content expert, 5% FTE \$46,000 directs

B. Pending Submissions

C. Clinical Faculty

2009-present West-Central Behavioral Health, Claremont and Lebanon, NH, child and family clinician, 15% FTE

XIV. Program Development

Vulnerable Children's Research Group, Founding Member. With encouragement and guidance from Drs. R. Drake, S. Woloshin, and L. Schwartz, I was a founding member of the Vulnerable Children's Research Group, anchored in Geisel's TDI. This group was created in 2017 in response to aligning research interests of TDI, Psychiatry, and Pediatrics faculty members around the judicious use of psychotropic medications in children. TDI has a long history of studying over-treatment and quaternary prevention. Psychiatry, too, has had a remarkable history in promoting shared decision making in adults with severe mental illness. However, no research team within Geisel has aligned these two areas of study and applied them to child psychiatry. Even more novel is this group's focus on deprescribing high risk psychotropic medications in children, an area of inquiry that is just taking root in the field, and in which I am leading within the VCRG team. One measure of our progress is in multidisciplinary grant proposals and publications. Our team has written several grant proposals, including a submission to NIH's NICHD (not funded, but highly scored) and to the Hood Foundation (not funded, but invited to the final round). We have published, to date, 4 peer-reviewed papers, with 2 additional papers in progress.

Role: Co-founder with R. Drake (TDI, Geisel), S. Woloshin (TDI, Geisel), L. Schwartz (TDI Geisel), J. McLaren, (Psychiatry, Pediatrics, TDI, Geisel), 2017-present

NH SafeRx: Working together for safe and effective psychotropic medications for NH children, Founding Member. NH SafeRx brought together a multidisciplinary team, anchored within the Dept of Psychiatry and NH DHHS, with the task of providing oversight to children in NH foster care. The goals of our program spanned advocacy, research, and clinical domains. Members of NH SafeRx included leaders within NH DHHS Medicaid, Division of Children Youth and Families, Bureau of Children's Behavioral Health, and Geisel's Dept of Psychiatry. We gathered data about the use of high risk medications and atypical antipsychotic monitoring in NH foster children; developed resources for families and clinicians, including training (with CMEs offered) to prescribing clinicians serving this population and a new NH DHHS webpage to manage these resources. We measured our success by policy and practice changes. Our team instituted a new NH DCYF policy providing safety and monitoring expectations to prescribing clinicians and child welfare workers, and, we established contracts between NH DHHS and the two NH Medicaid MCOs to provide audit and monitoring services.

Role: Co-founder with W. B. Daviss (Psychiatry, Geisel), E. Ungarelli (NH DHHS), M. Donati (NH DHHS), 2012-2018

Creating a Trauma-Informed Mountain, Youth Residential Center and Special Needs School, Co-Developer. I co-developed a train-the-trainer program, with expert training, consultation, and reflective practice groups to develop trauma-informed policies and practices at Crotched Mountain Rehabilitation Center, NH. This educational and research activity included 3 years of policy and practice analysis, leadership collaboration, staff trainings, and staff consultation. We measured our success through policy and practice changes (e.g., requirement of all staff to receive trauma-informed care training) as well as changes in crises, restraints, and seclusions. See Barnett, Yackley, & Licht, 2018.

Role: Co-developer with C. Yackley (Psychiatry, Geisel), 2014-2017

Trauma-Informed Early Childhood Services, Co-Developer. Sponsored by the NH DHHS Maternal and Child Health, I co-developed a state-wide train-the-trainer program and curriculum for early childhood professionals focused on understanding and sensitively providing child care to young children and their families experiencing trauma and attachment disturbances. We measured our success by the number of trainers trained in the curriculum as well as number of child care providers, state-wide, receiving the training.

Role: Co-developer with C. Yackley (Psychiatry, Geisel), 2014-2016

XV. Entrepreneurial activities NA

XVI. Major Committee Assignments

National/international

SAMHSA review committee, SM-20-005, National Child Traumatic Stress Initiative, Category III Site Applications, 2020

SAMHSA review committee, SM-17-009, Resiliency in Communities After Stress and Trauma, 2018

Regional NA

Institutional NA

XVII. Memberships, office and committee assignments in professional societies NA

XVIII. Editorial Boards

2023-present	<i>Frontiers in Psychiatry</i>	Guest Editor for Special Issue
2022-present	<i>Child Abuse & Neglect</i>	Editorial Review Board
2019-present	<i>Psychological Trauma: Theory, Research, and Practice</i>	Editorial Review Board
2004-2006	<i>Society for the Psychology of Women</i>	Assistant Editor

XIX. Journal Referee Activity

2013 – 2022	<i>Child Abuse & Neglect</i>	Ad hoc Reviewer
2019 – present	<i>Child Maltreatment</i>	Ad hoc Reviewer
2013 – present	<i>Child & Adolescent Mental Health</i>	Ad hoc Reviewer
2013 – present	<i>Children & Youth Services Review</i>	Ad hoc Reviewer
2018 – present	<i>Administration and Policy in Mental Health</i>	Ad hoc Reviewer
2018 - present	<i>Journal of Child and Family Studies</i>	Ad hoc Reviewer
2015 – present	<i>Journal of Traumatic Stress</i>	Ad hoc Reviewer
2015 – present	<i>Journal of Clinical Psychology</i>	Ad hoc Reviewer
2007 – present	<i>Psychology of Women Quarterly</i>	Ad hoc Reviewer

XX. Awards and Honors

2019	Co-authored “Article of the Year” for the <i>Child Maltreatment</i> journal
2016	Gary Tucker Junior Investigator Award, Geisel School of Medicine’s Department of Psychiatry, \$20,000
2012	Exceptional Contributions to Research and Education, National Center for PTSD, \$900
2011	Exceptional Contributions to Research and Education, National Center for PTSD, \$1000
2007	Lou Sherman Graduate Student Award, UM–St. Louis, \$2000

XXI. Invited Presentations (selected)

*Indicates personal invitation, # indicates accepted at national meeting or conference,
^ indicates applicable as a CME/CEUs activity

International location:

***Barnett, E. R.,** Concepcion-Zayas, M. T., & McLaren, J. L. (November 2022). Deprescribing psychotropic medications in children. Presented virtually as a brief presentation at the Australian Deprescribing Network Conference.

***Barnett, E.R.** & Seely, L. (October 2020). *Building a Trauma-informed Community Response to our Youngest Victims of the Opioid Crisis*. Presented as a webinar to the Canadian Practice and Research Together (PART) Trauma Informed Care and Trauma-Informed Practice Child Welfare series.

***Barnett, E.R.** (May 2018). Psychotropic Medications for Youth in Child Welfare: Two Tools to Support Shared Decision Making. Presented as a webinar to the Canadian Practice and Research Together (PART) series.

National location:

#**Jankowski, M. K.,** Charlowski, R., Maitland, A., & **Barnett, E. R.** (August 2022). What is typical? Exposing bias at the intersection of neurodiversity and trauma. Presented at the 2022 All Network Conference, SAMHSA's National Child Traumatic Stress Network, Baltimore, MD.

#**Barnett, E. R.,** McLaren, J. L., & Zayas - Concepcion, M. (May 2022). Shared Decision-Making in Child Psychiatry and Beyond: A Close Look at the Practice, Evidence, and Tools. Presented at the 2022 American Psychiatric Association annual conference, New Orleans, LA.

#**Lohr, W. D.,** **Barnett, E. R.,** & Bellonci, C. (March 2020). Deprescribing in child psychiatry. Accepted for the 33rd annual Research and Policy Conference On Child, Adolescent, and Young Adult Behavioral Health, Tampa FL. (Conference cancelled).

***Barnett, E.R.** (April 2019). Supporting shared decision making in child psychiatry. Presented as a webinar for the Excellence in Mental Health Foundation continuing education series.

#**Barnett, E. R.,** Murphy, D. M., Kerns, S., Jankowski, M. K., Scheeringa, M. S. (March 2018). *A tale of two states: Outcomes from two state-wide demonstration projects to expand evidence-based psychotherapies for traumatized youth*. Symposium presented at the 31st Annual Research and Policy Conference on Children's Behavioral Health, Tampa FL.

#**Barnett, E. R.,** Neese-Todd, S., Masseli, B., Concepcion-Zayas, M., & Bellonci, C. (March 2018). *"But if I don't take it, I can't get up outta here": Where is youth voice in decisions related to psychotropic medications?* Symposium proposal submitted to the 31st Annual Research and Policy Conference on Children's Behavioral Health, Tampa FL.

#**Scheeringa, M.,** Barto, B., **Barnett, E. R.** (November 2015). *Using Innovative Strategies to Meet the Needs of Traumatized Children in Child Welfare*. Presented at the annual International Society for Traumatic Stress Studies. New Orleans, LA.

#**Bernardy, N.,** **Barnett, E. R.,** & Jenkyn, A. (November 2015). *Factors that Influence PTSD Treatment*

Decisions among Prescribing Providers in the Department of Veterans Affairs. Presented at the annual International Society for Traumatic Stress Studies. New Orleans, LA.

#^Ake, G., Barnett, E. R., & Barto, E. (2012). *Screening and Assessment of Children in Child Welfare.* National Child Traumatic Stress Network, Child Welfare Learning Community Webinar.

Regional/local location

*^Barnett, E. R. (September 2022). Overview of evidence-based treatments for PTSD and mechanisms of change. Presented at the New Hampshire Hospital Grand Rounds. Concord, NH.

*^Barnett, E. R., & Douglas, L. (April 2021). *"Trauma-informed care for the whole family,"* presented for DHMC CHAD Shield our Children from Harm annual conference. Lebanon, NH

*^Barnett, E. R. (September 2019). *"Adversity during childhood: impacts on the mind, body, and soul,"* Presented for the DHMC NE Alliance for Nursing conference. Lebanon, NH

*^Barnett, E. R. (July 2019). *"Adversity and resiliency during childhood,"* presented for DHMC CHAD Shield our Children from Harm annual conference. Lebanon, NH

*^Barnett, E. R. (2018). Lunch 'N Learn "Trauma-Informed Care," presented for DHMC Strong Families Strong Starts, Pediatric Clinics, DHMC, Valley Regional Hospital, Alice Peck Day. 3 1-hour trainings. Lebanon and Claremont, NH

*Barnett, E. R. (2018-current, annual). *"Adverse childhood experiences,"* presented for the DHMC partnership with community business leaders. Lebanon, NH

^#Barnett, E. R. (August 2019). Infusing attachment, play, music, and art into TF-CBT. Presented at the Child and Adolescent Complex Trauma Conference, Manchester, VT.

*Barnett, E. R. (May 2019). Trauma-Informed Care: Supporting families, communities, and workforce through the opioid epidemic. Maine CDC Maternal Child Health Substance Exposed Infant Conference, Bangor, ME.

*Barnett, E. R. (August 2019). The shifting landscape of education: Building resiliency and trauma-sensitive strategies in the classroom. Presented at the annual Southwest NH Summer Educators Institute, Keene State College, Keene, NH.

*Barnett, E. R. (October 2018). Looking through the Trauma Lens: Understanding and helping traumatized children in schools. Presented at the NH National Educator Association Annual Conference, Manchester, NH.

*Barnett, E. R. (May 2017). Neurobiology of Trauma. Presented at the annual New England Head Start Conference, North Conway, NH.

*Barnett, E. R. (May 2017). Effects of Domestic Violence on Young Children. Presented at the annual New England Head Start Conference, North Conway, NH.

^#Barnett, E. R. (May 2016). Safe and effective psychotropic medications for children: Decision-making, coordination, and oversight. Presented at the Dartmouth Psychiatric Research Center Research

Presentation Series, Lebanon, NH.

[^]Robb, M., Yackley, C., **Barnett, E. R.**, Neubacher, K. (2014-2016). Four 2-day trainings delivered to clinicians across NH in the delivery of Child Parent Psychotherapy, and evidence-based psychotherapy for traumatized children 0-6 years and caregivers. *Child Parent Psychotherapy*, Concord, NH.

[^]Robb, M., Stearns, S., **Barnett, E. R.**, Neubacher, K. (2014-2016). Four 2-day trainings delivered to clinicians across NH in the delivery of Trauma-Focused Cognitive Behavioral Therapy, an evidence based therapy for traumatized children ages 4-18. *Trauma-Focused Cognitive Behavioral Therapy*, Concord, NH.

***Barnett, E. R.** (June 2014). Webinar presented for the NH Children's Behavioral Health Collaborative Workforce Development Foundational Training Webinar Series. *Foundations of Trauma*.

[^]**Barnett, E. R.** (September 2013). Presented at the NH annual Infant Mental Health Association Conference. *Early childhood trauma: impact, your role, and screening*. Plymouth, NH.

Barnett, E. R. and Jankowski, K. (May 2013). Presented at the annual DCYF conference. *Critical issues when providing services to children involved with child welfare*. Concord, NH.

Barnett, E. R. and Jankowski, K. (October 2012). *Looking through the trauma lens*. Presented at the NH Mental Health and Schools Conference. Concord, NH.

Barnett, E. R. (November 2011). *Early childhood trauma*. Presented to New Hampshire Early Supports and Services directors. Concord, NH.

XXII. Bibliography

*trainees underlined

A. Peer-reviewed publications in print or other media

1. Most significant original articles:

a. list of most significant articles

1. **Barnett, E. R.**, Jankowski, M. K., & Trepman, A. (2019). State-wide implementation of evidence-based psychotherapies for youth exposed to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 11(7), 775-783. doi: 10.1037/tra0000444. PMID: 30816774
2. Jankowski, M. K., Schifferdecker, K. E., Butcher, R. L., Foster-Johnson, L., **Barnett, E. R.** (2019). Effectiveness of a trauma informed care initiative in a state child welfare system: A randomized study. *Child Maltreatment*. Epub ahead of print: 1077559518796336. PMID: 30200774

Papers 1 and 2 are associated with a 5-year state-wide project to infuse trauma-informed care into two child-serving state systems. The 2019 *Child Maltreatment* paper demonstrates efficacy of a system-wide trauma-informed care program implemented and tested by our team within the NH state child welfare system in a randomized controlled trial. Alongside this work, we implemented state-wide training and consultation in two evidence-based therapies for child trauma within the NH children's community mental health system. These implementation

outcomes are demonstrated in the 2019 *Psychological Trauma* paper. The outcomes from these two studies had major impacts, ultimately leading to two state policies while building a culture of trauma-informed, evidence-based care and improving the lives of vulnerable children and families.

3. **Barnett, E. R., Trepman, A. Z.,** Fuson, H. A., Aquilano, S. C., McLaren, J. L., Woloshin, S., & Leyenaar, J. K. (2020). Deprescribing psychotropic medications in children: Results of a national qualitative study. *BMJ Quality and Safety*, 29:655-663 PMID: 31836627
4. **Barnett, E. R.,** Boucher, E. A., Daviss, W. B., Drake, R. E., Elwyn, G. (2017). Supporting shared decision making for children's complex behavior problems: Development and user-testing of an Option Grid decision aid. *Community Mental Health Journal*, 54, 7-16. PMID: 28401416

Papers 3 and 4 reflect innovation in the psychiatric care of children that have helped shift the status quo from one that traditionally adds psychotropic medications to one that considers removing them. The 2020 *BMJ Quality and Safety* paper describes findings from a nationally representative sample of pediatric primary care and mental health specialty providers regarding their perspectives on the over-use of psychotropic medications with children and deprescribing. No other study has examined attitudes and practices around deprescribing in children's psychiatric care, a novel concept and practice that our team has spear-headed in the field. This paper also facilitated the development of our deprescribing protocol. The 2017 *Community Mental Health Journal* paper highlight another innovative and complementary tool to improve the quality of children's psychiatric care. This paper demonstrates the feasibility of an Option Grid decision aid to support shared decision-making in real practice with parents of children with behavior problems presenting to clinical prescribers.

2. All other publications:

b. Original peer review

5. Craig, James T., Moore, C., **Barnett, E. R.,** Knight-Zhang, E., Sanders, M. T., Breslend, N., Haskell, H., & Jankowski, M. K. (in press). The Feasibility and Acceptability of Delivering Brief Telehealth Behavioral Parent Training in Pediatric Primary Care, *Journal of Child and Family Studies*.
6. Sternberg, K.F., Bausha, C.E., Jones, C., Knight, E., Steltenpohl, C.N., Parton, R., McLaren, J.L., **Barnett, E.** (2024). Expanding Access to Trauma-informed Treatment and Assessment for Neurodivergent and/or Gender-expansive Youth (Project ATTAIN). *Developmental Disabilities Network Journal*.
7. **Barnett, E. R.,** Knight-Zhang, E., Haskell, H. G., Merriweather, K. A., Gaspar, H., Parton, R. L., & Jankowski, M. K. (2023). Family Engagement in Services during COVID-19: A mixed methods study of caregiver and staff perspectives. *Journal of Pediatric Health Care*.
8. Chien, A. T., Leyenaar, J., Tomaino, M., Woloshin, S., Leininger, L., **Barnett, E. R.,** McLaren, J. L., and Meara, E.. (2022). Difficulty Obtaining Behavioral Health Services for Children: A National Survey of Multiphysician Practices. *The Annals of Family Medicine* January 2022, 20 (1) 42-50; DOI: <https://doi.org/10.1370/afm.2759>
8. McLaren, J.L., **Barnett, E. R.,** Acquilano, S.C., Zayas, M.T., Drake, R.E., & Leyenaar, J.K. (2021). Psychotropic Polypharmacy and Antipsychotics in Children: A Survey of Caregiver's Perspectives. *Community Mental Health Journal*, doi:10.1007/s10597-021-00845-2. PMID: 34057662
9. Cleary, S. E., **Barnett, E. R.,** Butcher, R. L., Huckins, J., & Jankowski, M. K. (2018). A

comparison of foster and adoptive parent satisfaction and commitment. *Children & Youth Services Review*, **88**, 205-210. PMID: 29723028

10. Barnett, E. R., Cleary, S. E., & Donnelly, C. L. (2018). Psychotropic medications for youth in child welfare: Developing and pilot-testing a field guide for team decision-making. *Journal of Public Child Welfare*, *12*, 492-513. PMID: not available
11. Barnett, E. R., Cleary, S. E., Butcher, R. L., & Jankowski, M. K. (2019). Child behavior problems and satisfaction of foster and adoptive parents: Do trauma-informed services make a difference? *Psychological Trauma: Theory, Research, and Practice*, *11*, 73-81. PMID: 29723028
12. Barnett, E. R., Jankowski, M. K., Butcher, R. L., Meister, C., Parton, R. L., & Drake, R. E. (2017). Foster and adoptive parent perspectives of needs and services: A mixed methods study. *Journal of Behavioral Health Services & Research*, *45*, 74-89. PMID: 22852992
13. Barnett, E. R., Yackley, C. R., & Licht, E. S. (2018). Developing, implementing, and evaluating a trauma-informed care program in a youth residential treatment center and special needs school. *Journal of Residential Treatment for Youth*, *35*, 95-113. PMID: not available
14. Barnett, E. R., Boucher, E.A., Neubacher, K., & Carpenter-Song, E. A. (2016). Decision-making around psychotropic medications for children in foster care: Perspectives from foster parents. *Children & Youth Services Review*, *70*, 206-213. PMID: not available
15. Barnett, E. R., Butcher, R., Neubacher, K., Jankowski, M. K., Daviss, W. B., Carluzza, K., & Yackley, C. (2016). Psychotropic medications in child welfare: From federal mandate to direct care. *Children & Youth Services Review*, *66*, 9-17. PMID: not available
16. Barnett, E. R., Bernardy, N., Jenkyn, A., Lund, B., Alexander, B., & Friedman, M. (2014). Prescribing clinician's perspectives on evidence-based psychotherapies for post-traumatic stress disorder. *Behavioral Sciences*, *4*(4), 410-22. PMID: 25431445
17. Barnett, E. R., Rosenberg, H., Osofsky, J., Rosenberg, S., & Wolford, G. (2014). Dissemination and implementation of Child-Parent Psychotherapy in rural public health settings. *Child and Adolescent Mental Health*, *19*(3), 215-18. PMID: 328783736

c. Reviews/Systematic Reviews (each reviewed by peers and editor):

18. Barnett, E. R., Knight, E., Herman, R. J., Amarakaran, K., & Jankowski, M. K. (2021). Difficult binds: A systematic review of facilitators and barriers to treatment among mothers with substance use disorders. *Journal of Substance Abuse Treatment*, *126*. PMID: Available soon
19. McLaren, J. L., Barnett, E. R., Concepcion-Zayas, M. T., Lichtenstein, J., Acquilano, S. C., Schwartz, L. M., Woloshin, S., Drake, R. E. (2018). Psychotropic medications for highly vulnerable children. *Expert Opinion on Pharmacotherapy*, *19*, 547-560. PMID: 29596008.
20. Barnett, E. R., Concepcion-Zayas, M. T., Zisman-Ilani, Y., Bellonci, C. (2018). Psychiatric care for youth in foster care: A systematic and critical review of patient-centered care. *Journal of Public Child Welfare*, *13*, 2, 1-28. PMID: not available

21. Zisman-Ilani, Y., Harik, J. M., **Barnett, E. R.**, Pavlov, A., & O'Connell, M. (2017). Expanding the concept of shared decision-making in mental health: Systematic search and scoping review of interventions. *The Mental Health Review Journal*, 22,3, 191-213. PMID: not available

d. Book chapters:

22. **Barnett, E. R.**, Cleary, S., Neubacher, K., Daviss, W. B. (2017). Post-traumatic stress disorder and attention deficit hyperactivity disorder. In W. B. Daviss (Ed.), *Moodiness in Patients with ADHD: Optimizing Assessment and Treatment* (pp. 55-72). New York, NY: Springer Press.
23. Hamblen, J. L., **Barnett, E. R.**, Hermann, B., Schnurr, P. (2013). Overview of PTSD treatment research: The impact of trial design. In J. G. Beck & D. M. Sloan (Eds.), *The Oxford Handbook of Traumatic Stress Disorders* (pp. 415-426). New York, NY: Oxford University Press.
24. Hamblen, J. L., **Barnett, E. R.**, & Norris, F. H. (2012). Long term mental health treatment for adult disaster survivors. In J. Framingham and M. Teasley (Eds.), *Behavioral health response to disasters* (pp. 301-318). Boca Raton, FL: CRC Press.
25. Greco, L. A., **Barnett, E. R.**, Blomquist, K. K., & Gevers, A. (2008). Body image, acceptance, and health in adolescence. In L. A. Greco & S. C. Hayes (Eds.), *Acceptance and mindfulness Interventions for children, adolescents, and families* (pp. 187-214). Reno, NV: Context Press-New Harbinger.

B. Other scholarly publications in print or other media, including editorials

1. Editorials

26. McLaren, J. L., **Barnett, E. R.**, Zito, J., & Fegert, J. (2024). Editorial: Psychotropic Overprescribing to Youth: Scope of the Problem, Causes, and Possible Solutions, *Frontiers in Psychiatry*.
27. **Barnett, E. R.** & Concepcion-Zayas, M. T. (2019). High-risk psychotropic medications for U.S. Children with Trauma Sequelae. *Epidemiology and Psychiatric Sciences*, 28(4), 360-364. PMID: 30392479. PMC: 6998973
28. Daviss, W. B., **Barnett, E.R.**, Neubacher, K., Drake, R.E. (2016). Use of antipsychotics for non-psychotic children. *Psychiatric Services*, 67(3): 339-41. PMID: 26725298
29. **Barnett, E. R.**, & Neubacher, K. A. (2014). Traumatic stress in very young children. The Carlat Report: Child Psychiatry. Special Issue: From Birth to Preschool: Psychiatry in Young Children. Carlat Publishing, LLC.

2. Print Resources

30. Agrawal, N., Anderson, C., **Barnett, E. R.**, Bethell, C., Brewer, K., Gordon, J. et al. (2023). Mobilizing America to End Child Abuse and Neglect. Endcan.org

3. Electronic resources

31. **Barnett, E. R.**, & Hamblen, J. (2012). Trauma, attachment, and PTSD in young children. Fact Sheet for the VA's

National Center for PTSD. Available at:

https://www.ptsd.va.gov/professional/treat/specific/attachment_child.asp

32. Hamblen, J. & Barnett, E.R. (2012). PTSD in children and adolescents. Fact Sheet for the VA's

National Center for PTSD. Available at:

https://www.ptsd.va.gov/professional/treat/specific/ptsd_child_teens.asp

4. Large team publications NA

5. White papers NA

6. Other NA

C. Abstracts NA

Updated May 21, 2024

NH Department of Health and Human Services

KEY PERSONNEL

List those primarily responsible for meeting the terms and conditions of the agreement.

Job descriptions not required for vacant positions.

Contractor Name: Mary Hitchcock Memorial Hospital

NAME	JOB TITLE	ANNUAL AMOUNT PAID FROM THIS CONTRACT	ANNUAL SALARY
Arun Krishnan	Staff Physician	\$145,875.00	\$145,875.00
Samantha Morin	Forensic Child Psychologist	\$148,395.00	\$148,395.00
Erin Barnett	Psychologist, Program Director	\$13,569.00	\$135,687.00

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

129 PLEASANT STREET, CONCORD, NH 03301-3857
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Lori A. Sbiblnette
Commissioner

Lori A. Weaver
Deputy Commissioner

February 18, 2022

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, Office of the Commissioner, to enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, New Hampshire, in the amount of \$9,109,658 to provide clinical and administrative services to meet the specialized health and related clinical and administrative needs of New Hampshire residents, with the option to renew for up to four (4) additional years, effective upon Governor and Council approval, through June 30, 2025. 28% Federal Funds. 72% General Funds.

This request represents one (1) of three (3) corresponding requests with Mary Hitchcock Memorial Hospital for the following services: 1) Clinical and Administrative Services; 2) Psychiatric and Medical Services; and 3) Neuropsychology Services. This request is contingent upon Governor and Council approval of all three (3) requests.

Funds are available in the following accounts for State Fiscal Years 2022 and 2023, and are anticipated to be available in State Fiscal Years 2024 and 2025, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

See Fiscal Detail Sheet Attached

EXPLANATION

The Department currently has an agreement with the Mary Hitchcock Memorial Hospital, which was competitively bid in 2016, to provide physician, clinical, and administrative services in seven (7) service areas: New Hampshire Hospital; Glenclyff Home; Medicaid; Children, Youth, and Families; Behavioral Health; Elderly and Adult Services; and Developmental Services. The existing agreement includes an option to renew services through June 30, 2025. However, House Bill 2, of the 2021 Regular Legislative Session, appropriated \$30 million to the Department for the purpose of constructing a 24-bed forensic psychiatric hospital. Consequently, the Department needed to reassess the existing contracted services to incorporate the new clinical needs arising from the planned New Hampshire Forensic Hospital and released competitive bids for 1) Psychiatric and Medical Services and 2) Neuropsychology Services.

His Excellency, Governor Christopher T. Sununu
 and the Honorable Council
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The following table outlines the Department's reprocurement strategy, which includes three (3) distinct actions. The Department will terminate the current agreement upon approval of the contracts specified in the table. As noted below, the neuropsychology, psychiatric, and medical services components of the existing contract have been bid out to incorporate the new forensic psychiatric hospital needs rather than incorporating them into an existing agreement. The purpose of this Sole Source request is to enter into a new contract to continue the other five (5) service areas that are not being reprocured and would have been continued under the existing agreement. The Contractor is uniquely experienced and qualified to provide the complex array of clinical and administrative services to the Department in these five (5) service areas. These services enable the Department to meet a wide range of specialized health and clinical needs of New Hampshire residents.

Reprocurement Strategy		
Description of Service Area	Procurement	DHHS Areas Served
Clinical and Administrative Services	New Sole Source	Medicaid Children, Youth, and Families Behavioral Health Elderly and Adult Services Developmental Services
Psychiatric and Medical Services	RFP issued July 2021	NHH Glenclyff Forensic Hospital*
Neuropsychology	RFP issued November 2021	NHH Forensic Hospital*
* The Department anticipates the Forensic Hospital will open in State Fiscal Year 2024.		

Approval of this request will allow the Contractor to continue to work with the Department to apply principles of managed care for clinical treatment, educational and training programs. The Contractor will continue to provide the Department with a Chief Medical Officer, who plays an integral role in providing medical oversight of the State's publicly funded health insurance programs, informing key policy decisions, and shaping administrative planning strategies to enhance the operating efficiency of Medicaid and Children's Health Insurance Program (CHIP) and related healthcare initiatives across the state. In addition, the Contractor will identify and address medical research issues relative to the Department mission under RSA 135-C.

The Contractor will develop strategic clinical relationships with physicians as well as partnerships with academic institutions and deferral agencies, with a focus on quality improvement and the implementation of federal health care reforms to support the Departments responsibility to administer the Medicaid medical assistance program.

The Contractor will provide psychiatric services to youth served by the Department that include treatment planning; clinical consultations; assessments to treatment coordinators; program development at the Sununu Youth Services Center and fosters improved interagency

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 3 of 3

collaboration between Juvenile Justice Services, area mental health agencies and New Hampshire Hospital to enhance mental health services of adjudicated youth. The Contractor will also provide the personnel needed to help the Department achieve positive outcomes for individuals serviced by the behavioral health program; coordinate long-term care support services and to direct resources where they are needed most; and provide psychiatric and services and expert guidance and training to the Department's developmental services staff.

The Department will monitor contracted services by requiring the Contractor to:

- Identify performance metrics and monitoring processes, in collaboration with the Department;
- Develop a Quality Assurance and Monitoring Plan and report on progress toward goals;
- Review staff performance annually; and
- Adhere to certification guidelines.

As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up four (4) additional years, 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 Department will be severely limited in its ability to provide essential services in the service areas identified above, thereby putting many of the State's most vulnerable residents at risk.

Area served: Statewide

Source of Federal Funds: Catalog of Federal Assistance (CFDA) #93.778, CFDA #93.994, CFDA #93.004, CFDA #93.958 and CFDA #93.959.

Respectfully submitted,



Lori A. Shibinette
Commissioner

**Fiscal Detail Sheet
 SS-2022-OCOM-02-CLINI-01
 Clinical and Administrative Services**

05-95-95-950010-50000000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, COMMISSIONER'S OFFICE, OFFICE OF THE COMMISSIONER, COMMISSIONER'S OFFICE

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	95063303	\$148,811
2023	102-500731	Contracts for Prog Svc	95063303	\$459,358
2024				\$ 0
2025				\$ 0
			<i>Subtotal</i>	\$608,169

05-95-47-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES, MEDICAID ADMINISTRATION

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022				\$ 0
2023				\$ 0
2024	102-500731	Contracts for Prog Svc	47000021	\$ 472,670
2025	102-500731	Contracts for Prog Svc	47000021	\$ 486,381
			<i>Subtotal</i>	\$959,051

05-95-42-421510-66430000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, HHS: HUMAN SERVICES, SUNUNU YOUTH SERVICE CENTER, SYSC HB2 91:327

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	101-506224	Medical Payments to Providers	42151501	\$279,985
2023	101-506224	Medical Payments to Providers	42151501	\$864,807
2024	101-506224	Medical Payments to Providers	42151501	\$890,406
2025	101-506224	Medical Payments to Providers	42151501	\$916,773
			<i>Subtotal</i>	\$2,951,971

**Fiscal Detail Sheet
 SS-2022-OCOM-02-CLINI-01
 Clinical and Administrative Services**

**05-95-92-922010-41170000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS,
 HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVIC, CMH PROGRAM
 SUPPORT**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	92204117	\$199,947
2023	102-500731	Contracts for Prog Svc	92204117	\$616,422
2024	102-500731	Contracts for Prog Svc	92204117	\$634,191
2025	102-500731	Contracts for Prog Svc	92204117	\$652,492
			<i>Subtotal</i>	\$2,103,052

**05-95-92-922010-41200000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS,
 HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVIC, MENTAL
 HEALTH BLOCK GRANT.**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	92254120	\$97,114
2023	102-500731	Contracts for Prog Svc	92254120	\$286,437
2024	102-500731	Contracts for Prog Svc	92254120	\$207,564
2025	102-500731	Contracts for Prog Svc	92254120	\$84,041
			<i>Subtotal</i>	\$675,156

**05-95-48-481010-78720000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS,
 HHS: DLTSS-ELDERLY&ADULT SVCS, GRANTS FOR SOCIAL SVC PROG, ADM ON AGING**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	540-500382	Social Svc Contracts	48130305	\$13,420
2023	540-500382	Social Svc Contracts	48130305	\$41,461
2024	540-500382	Social Svc Contracts	48130305	\$42,696
2025	540-500382	Social Svc Contracts	48130305	\$43,968
			<i>Subtotal</i>	\$141,545

Fiscal Detail Sheet
SS-2022-OCOM-02-CLINI-01
Clinical and Administrative Services

05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS, HHS: DLTSS-DEVELOPMENTAL SVCS, DIV OF DEVELOPMENTAL SVCS, SPECIAL MEDICAL SERVICES

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	561-500911	Specialty Clinics	93001000	\$30,000
2023	561-500911	Specialty Clinics	93001000	\$30,000
2024	561-500911	Specialty Clinics	93001000	\$30,000
2025	561-500911	Specialty Clinics	93001000	\$30,000
			<i>Subtotal</i>	<i>\$120,000</i>

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS, HHS: DLTSS-DEVELOPMENTAL SVCS, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	93005947	\$74,788
2023	102-500731	Contracts for Prog Svc	93005947	\$293,514
2024	102-500731	Contracts for Prog Svc	93005947	\$302,938
2025	102-500731	Contracts for Prog Svc	93005947	\$312,645
			<i>Subtotal</i>	<i>\$983,885</i>

05-95-92-920510-19810000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SVCS, SABG ADDITIONAL

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	92059502	\$77,876
2023	102-500731	Contracts for Prog Svc	92059502	\$231,038
2024	102-500731	Contracts for Prog Svc	92059502	\$173,875
2025	102-500731	Contracts for Prog Svc	92059502	\$84,040
			<i>Subtotal</i>	<i>\$566,829</i>
			TOTAL	\$9,109,658

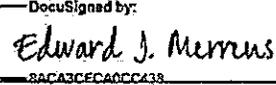
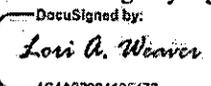
Subject: Clinical and Administrative Services (SS-2022-OCOM-02-CLINI-01)

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 One Medical Center Drive Lebanon, New Hampshire 03756	
1.5 Contractor Phone Number (603) 650-5000	1.6 Account Number 05-95-92-922010-4117 05-95-92-922010-4120 05-95-92-920510-1981 05-95-42-421510-6643 05-95-95-950010-5000 05-95-93-930010-5191 05-95-93-930010-5947 05-95-48-481010-7872 05-95-47-470010-7937	1.7 Completion Date June 30, 2025	1.8 Price Limitation \$9,109,658
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by:  Edward J. Merrens 8AFA3CECA0CC438 Date: 3/2/2022		1.12 Name and Title of Contractor Signatory Edward J. Merrens Chief Clinical Officer	
1.13 State Agency Signature DocuSigned by:  Lori A. Weaver 4C1A92904125473 Date: 3/2/2022		1.14 Name and Title of State Agency Signatory Lori A. Weaver Deputy Commissioner	
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)			

By: *Tahmina Rahmatova*

On: 3/2/2022

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
Clinical and Administrative Services

EXHIBIT A

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 four (4) additional years 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 subparagraphs 7.1 and 7.2 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.

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 personnel 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.

1.3. 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.

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**New Hampshire Department of Health and Human Services
Clinical and Administrative Services
EXHIBIT A**

- 1.4. 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.
- 1.5. Paragraph 14, Insurance, is amended by modifying subsection 14.1.2 to delete the text in its entirety and replace it to read:
- 14.1.2. Professional liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 per annual aggregate.
- 1.6. Paragraph 14, Insurance, is amended by modifying subparagraph 14.2 to read:
- 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 or registered to conduct business in the State of New Hampshire.
- 1.7. Paragraph 17, Amendment, is amended by adding subparagraph 17.1, to read:
- 17.1 In the event the State wishes to change the location(s) in which the services are performed by the Contractor hereunder, in whole or in part, the State shall provide Contractor with reasonable advance written notice of the same. Thereafter, the parties shall meet in good faith in order to mutually agree upon possible adjustments to the terms and conditions, if required, which shall be documented in the form of an amendment to this Agreement in accordance with paragraph 17.

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

EXHIBIT B

Scope of Services

1. Statement of Work

- 1.1. The Contractor shall provide clinical and administrative services to the Department of Health and Human Services (the "Department") and various populations served by the Department in all five (5) Service Areas identified below and as described herein:
 - 1.1.1. Service Area #1 – Medicaid
 - 1.1.2. Service Area #2 – Children, Youth and Families
 - 1.1.3. Service Area #3 – Behavioral Health
 - 1.1.4. Service Area #4 – Elderly and Adult Services
 - 1.1.5. Service Area #5 – Developmental Services
- 1.2. For the purposes of this agreement, all references to days shall mean business days, unless otherwise specified.
- 1.3. For the purposes of this Solicitation, one (1) full-time equivalent (FTE) is equal to one (1) full-time employee who works forty (40) hours per week.
- 1.4. The Contractor shall provide all services described herein for the full term of the contract.
- 1.5. **General Requirements Applicable to All Service Areas**
 - 1.5.1. The Contractor shall deliver the services to the Service Areas in Subsection 1.1 as described in this Exhibit B, Scope of Services, by providing qualified personnel, and as otherwise necessary, to fulfill the requirements described herein.
 - 1.5.2. The Contractor shall work with the Department to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.
 - 1.5.3. The Contractor shall work with the Department to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the Department mission under RSA 135-C. The activities shall be directed at enhancing applied research resources, capacities and activities within the State mental health services system and implementing a program of applied research relative to that system.
 - 1.5.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by the Contractor under this contract shall be considered an employee of the State of New Hampshire.

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- 1.5.5. In the event of a healthcare system emergency, including but not limited to a local epidemic, pandemic, facility closures, or mass-quarantine in which additional staffing or resources are required due to a surge of individuals requiring services under this Agreement, the total number of psychiatrists or other medical providers provided by the Contractor may be adjusted to include up to three (3) full-time staff positions and one part-time staff position to serve any or all of the five (5) Service Areas.
- 1.5.6. The Department shall identify one (1) primary designee for each Service Area. The designee will serve as the primary point of contact, oversee the services provided, and provide required approvals as described herein for each Service Area.

1.6. Specific Service Requirements – Service Area #1 – Medicaid

1.6.1. Chief Medical Officer

- 1.6.1.1. The Contractor shall provide one (1) Full-Time Equivalent (FTE) physician to serve as the Department's Chief Medical Officer.
- 1.6.1.2. The Chief Medical Officer shall plan and direct all aspects of the Department's medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the Department designee.
- 1.6.1.3. The Chief Medical Officer shall:
- 1.6.1.3.1. Possess a medical degree (MD or DO);
 - 1.6.1.3.2. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
 - 1.6.1.3.3. Possess a graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
 - 1.6.1.3.4. Have a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;
 - 1.6.1.3.5. Have work experience in managed care settings focused on improved health outcomes;
 - 1.6.1.3.6. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider community;

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1.7. Specific Service Requirements – Service Area #2 – Children, Youth and Families

1.7.1. Staff Psychologist

1.7.1.1. The Contractor shall provide one (1) FTE Staff Psychologist who is a faculty member and/or employee of the Contractor, to provide the services described herein to the programs within the Children, Youth and Families service area.

1.7.1.2. The Contractor shall work directly with the Department designee for the Sununu Youth Services Center (SYSC) and ensure the Staff Psychologist:

1.7.1.2.1. Provides treatment planning oversight, clinical consultations, case reviews, and assessments to treatment coordinators and Juvenile Probation and Parole Officers;

1.7.1.2.2. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;

1.7.1.2.3. Provides program development at SYSC, using a resiliency-building framework, and implements Evidence-Based Practices (EBP) to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy;

1.7.1.2.4. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;

1.7.1.2.5. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for Juvenile Justice Services (JJS);

1.7.1.2.6. Fosters improved interagency collaboration between JJS services, Community Mental Health Centers (CMHCs), and New Hampshire Hospital (NHH) and/or Hampstead Hospital to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court-involved youths; and

1.7.1.2.7. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

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- 1.7.1.3. The Contractor shall ensure the Staff Psychologist meets the following qualifications:
- 1.7.1.3.1. Possesses a Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.) degree from a college or university accredited by the American Psychological Association.
 - 1.7.1.3.2. Experience and interest in both child psychology and criminal justice;
 - 1.7.1.3.3. Certification by NH Board of Psychologists.
 - 1.7.1.3.4. Maintains an unrestricted license to practice Psychology
 - 1.7.1.3.5. Possesses at least five (5) years of experience in community mental health, criminal justice, or similar training.
- 1.7.1.4. The Staff Psychologist will maintain a professional calendar electronically, in a format subject to Department approval, and make the calendar available to the Department designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes appropriate information, including, but not limited to, approved leave time, conferences, and trainings.
- 1.7.1.5. The Contractor shall ensure the Staff Psychologist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. The Staff Psychologist shall provide prior, timely notification to the designated Department representative of any leave time taken. Absences due to vacation and/or continuing education shall be planned in advanced in consideration of the business needs of the Department. The Contractor shall ensure appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Staff Psychologist is on leave.
- 1.7.1.6. The Contractor shall ensure that any out-of-state travel for conferences and/or trainings for the Staff Psychologist is subject to the prior approval of the Department designee.
- 1.7.1.7. The Staff Psychologist's primary workspace shall be located in Manchester, New Hampshire, in a Department-designated facility. The Department shall provide office space, furniture, a computer with access to Department shared network drives, as necessary, the usual and customary office supplies, a mobile phone for business use and administrative and clerical support.

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The Contractor shall ensure the Staff Psychologist utilizes Department-provided information and technology resources consistent with applicable State policies.

1.7.2. Staff Psychiatrist

- 1.7.2.1. The Contractor shall provide one (1) part-time (.25 FTE) Staff Psychiatrist who is a faculty member and/or employee of the Contractor to provide psychiatric services to programs within the Children, Youth and Families service area for a minimum of ten (10) hours per week.
- 1.7.2.2. The Staff Psychiatrist's responsibilities shall include, but are not limited to:
 - 1.7.2.2.1. Providing medical and psychiatric services at SYSC.
 - 1.7.2.2.2. Documenting the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System.
 - 1.7.2.2.3. Providing clinical supervision and teaching child psychiatry residents and fellows at SYSC.
 - 1.7.2.2.4. Providing supervision and teaching interns, residents, and fellows at SYSC.
- 1.7.2.3. The Contractor shall ensure the Staff Psychiatrist meets the following qualifications:
 - 1.7.2.3.1. Possesses a medical degree (MD or DO);
 - 1.7.2.3.2. Specializes in child psychiatry with an interest in criminal justice;
 - 1.7.2.3.3. Completed both an ACGME approved residency program in psychiatry and a two (2) year ACGME approved fellowship in child/adolescent psychiatry;
 - 1.7.2.3.4. Board certified by the American Board of Psychiatry and Neurology in Psychiatry;
 - 1.7.2.3.5. Maintains an unrestricted license as a physician by the New Hampshire Board of Medicine; and
 - 1.7.2.3.6. Possesses post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

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1.7.3. Psychiatric Consultant

- 1.7.3.1. The Contractor shall provide one (1) part-time (.25 FTE) Psychiatric Consultant to provide psychiatric consultation services to programs within the Children, Youth and Families service area for a minimum of ten (10) hours per week.
- 1.7.3.2. The Psychiatric Consultant shall provide consultation to the Department on psychotropic medication prescriptions for youth who are in out-of-home care at a location other than SYSC. Consultation typically includes a review of the psychotropic medication prescriptions for identified youth and peer-to-peer consultation with prescribers to help ensure the appropriate utilization of psychotropic medications.
- 1.7.3.3. The Contractor shall ensure the Psychiatric Consultant meets the following qualifications:
 - 1.7.3.3.1. Has clinical experience in addiction treatment and criminal justice.
 - 1.7.3.3.2. Has completed a fellowship training and/or board certification in Child Psychiatry.

1.7.4. Sununu Youth Services Center (SYSC) – Medical Doctor

- 1.7.4.1. The Contractor shall provide one (1) Medical Doctor to perform medical rounds to address and follow up on resident medical concerns or ailment for one (1) hour per day on Monday, Wednesday, and Friday each week, not to exceed three (3) hours per week. The Contractor shall maintain an on-call rotation to address and manage emergent situations and provide aid to Registered Nursing (RN) staff, as requested by the Department.
- 1.7.4.2. The Contractor shall ensure that admissions and readmission physical assessments are completed within three (3) business days of resident arrival.
- 1.7.4.3. The Medical Doctor shall prescribe medication and/or perform other medical procedures for residents as needed, including but not limited to:
 - 1.7.4.3.1. X-rays.
 - 1.7.4.3.2. Laboratory work.

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1.7.4.4. The Medical Doctor shall make service referrals for residents as needed to other providers, including but not limited to:

1.7.4.4.1. SYSC Staff Dentist.

1.7.4.4.2. SYSC Psychiatrist.

1.7.4.4.3. External medical providers.

1.7.4.5. The Medical Doctor shall ensure all medications for residents are ordered and received prior to any upcoming furlough or discharge of residents from SYSC.

1.7.5. Sununu Youth Services Center – Clinicians

1.7.5.1. The Contractor shall provide two (2) licensed Clinicians to provide clinical support and services to SYSC residents in accordance with SYSC policies and protocols. Services shall include, but are not limited to:

1.7.5.1.1. Individual, group and family therapy;

1.7.5.1.2. Watch assessments;

1.7.5.1.3. Crisis intervention and/or support and processing; and

1.7.5.1.4. Development of youth treatment plans.

1.7.5.2. The Contractor shall ensure Clinicians are available to provide on-call services Monday through Friday from 5:00 p.m. to 7:00 a.m. and weekends.

1.7.5.3. The Clinicians shall complete the On-Call Coverage Report and submit a copy to the SYSC supervisor by the following business day.

1.7.5.4. The Clinicians shall conduct clinical assessments and screenings, including but not limited to:

1.7.5.4.1. Initial watch assessment, including PREA interviews and suicide screenings.

1.7.5.4.2. Full psychosocial assessment, including a clinical interview and information gathering about the youth, their history, and family history.

1.7.5.4.3. Mental health screening.

1.7.5.4.4. Substance use screening.

1.7.5.4.5. Trauma screening.

1.7.5.5. The Clinicians shall conduct Child and Adolescent Needs and Strengths Assessment and prepare parole and court reports and participate in hearings as necessary.

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- 1.7.5.6. The Contractor shall ensure Clinicians complete all necessary documentation.
- 1.7.5.7. The Clinicians shall attend all required meetings to support the clinical work of the facility, including but not limited to:
 - 1.7.5.7.1. Monthly Treatment Plan Meetings.
 - 1.7.5.7.2. Twice weekly case reviews.
 - 1.7.5.7.3. Bi-weekly clinical team meetings.
 - 1.7.5.7.4. Monthly youth clinical ranking meetings.
 - 1.7.5.7.5. Monthly staff meetings.
 - 1.7.5.7.6. Weekly individual supervision.
 - 1.7.5.7.7. Various consultation meetings.
- 1.7.5.8. The Clinicians shall schedule and facilitate youth trust meetings, as requested by the Department.

1.8. Specific Service Requirements – Service Area #3 – Behavioral Health

1.8.1. Medical Director

- 1.8.1.1. The Contractor shall provide one part-time (.50 FTE) Medical Director to provide the services described herein to the Behavioral Health service area.
- 1.8.1.2. The Contractor shall ensure the Medical Director is present on-site at a Department-designated location for twenty (20) hours per week. The Medical Director shall be available via telephone, email, and in person by appointment.
- 1.8.1.3. The Medical Director shall, in collaboration with the Department, be responsible for the following:
 - 1.8.1.3.1. Meeting weekly with the Department designee;
 - 1.8.1.3.2. Addressing Behavioral Health clinical issues;
 - 1.8.1.3.3. Reviewing and informing Behavioral Health policy issues;
 - 1.8.1.3.4. Enhancing housing support capacity planning;
 - 1.8.1.3.5. Reviewing and informing Medicaid and state rule issues;
 - 1.8.1.3.6. Assisting in developing telemedicine capacity;
 - 1.8.1.3.7. Utilizing electronic medical records, as needed;
 - 1.8.1.3.8. Coordinating care between NHH and GMHCs;

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- 1.8.1.3.9. Overseeing and consulting on implementation of Evidence Based Practices;
- 1.8.1.3.10. Developing funding and reimbursement strategies;
- 1.8.1.3.11. Reviewing and informing the sustainability of behavior change programs; and
- 1.8.1.3.12. Assessing the needs of patients in NHH and Transitional Housing Services who might be served in the community.
- 1.8.1.4. The Medical Director shall attend meetings with the Department's Behavioral staff and various community stakeholder groups, including, but not limited to the Community Behavioral Health Association and the Disabilities Rights Center, to communicate, develop support for, and gather input on Behavioral Health initiatives; and
- 1.8.1.5. The Medical Director shall serve as the Lead Manager for the ProHealth integration grant, working in collaboration with the Department and identified programs, to implement grant deliverables.
- 1.8.1.6. The Medical Director shall oversee quality assurance and quality improvement functions including, but not limited to:
 - 1.8.1.6.1. Monitoring the effectiveness of the Department's Behavioral Health contracted services to enhance cost effectiveness and promote positive health outcomes for service recipients; and
 - 1.8.1.6.2. Developing research-based outcome measures and quality oversight models for community mental health services in collaboration with the Department.
- 1.8.1.7. The Medical Director shall be responsible for the following:
 - 1.8.1.7.1. Participating on departmental and legislative committees, as required by the Department, which may include, but are not limited to, the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the Department Institutional Review Board;
 - 1.8.1.7.2. Providing expert review and consultation to inform and support legislation that will affect individuals and families affected by severe and persistent mental illness to ensure the implications and outcomes are in the best interest of this population;

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- 1.8.1.7.3. Serving as secretary for the Mental Health Council and ensuring that the work of the council supports the goals of the Department;
- 1.8.1.7.4. Attending regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;
- 1.8.1.7.5. Attending monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of Department research participants;
- 1.8.1.7.6. Participating on several Behavioral Health System Transformation Workgroups, including the Evidence Based Practices Steering Committee, Programmatic Workgroup, and Quality Assurance Group;
- 1.8.1.7.7. Coordinating and meeting with Department leadership as required by the Department;
- 1.8.1.7.8. Conducting meetings monthly, or at a frequency as otherwise requested by the Department, to coordinate efforts between the Department and CMHCs to address Behavioral Health issues and initiatives that include, but are not limited to:
 - 1.8.1.7.8.1. Medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including, but not limited to, preferred drug list issues.
 - 1.8.1.7.8.2. Providing Consultation and Technical Assistance.
 - 1.8.1.7.8.3. Coordination with NHH admissions and treatment.
 - 1.8.1.7.8.4. Medicaid interruption during institutionalization.
 - 1.8.1.7.8.5. Enhancement of community housing supports.
 - 1.8.1.7.8.6. Use of information technology.
 - 1.8.1.7.8.7. Administrative issues.

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- 1.8.1.7.8.8. Use and implementation of evidence, implementation of Evidence Based Practices.
- 1.8.1.7.8.9. Integration of mental and physical health care.
- 1.8.1.7.8.10. Smoking cessation.
- 1.8.1.7.9. Coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects.
- 1.8.1.7.10. Monitoring the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in New Hampshire, including, but not limited to, engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
- 1.8.1.7.11. Communicating regularly with and providing clinical consultation, including but, not limited to, potential site visits, conference calls, and written reports, to Behavioral Health management staff regarding current and challenging clinical issues, including, but not limited to, conditional discharges, Medicaid consumer cases, and suicide monitoring;
- 1.8.1.7.12. Collaborating with other Department staff, including, but not limited to, Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including, but not limited to, drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity;
- 1.8.1.7.13. Providing oversight of and implementing evidence-based practices, including, but not limited to, the Medicaid Program for Community Mental Health

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Services practices and practices specifically required in accordance with the Community Mental Health Agreement.

- 1.8.1.7.14. Supporting the expansion and development of new programs informed by evidenced-based and emerging best practices to fill gaps in the mental health continuum of care.
- 1.8.1.8. The Contractor shall ensure the Medical Director meets the following qualifications:
 - 1.8.1.8.1. Possesses a medical degree (MD or DO);
 - 1.8.1.8.2. Board Certified by the American Board of Psychiatry and Neurology in Psychiatry;
 - 1.8.1.8.3. Maintains an unrestricted license as a physician by the New Hampshire Board of Medicine; and
 - 1.8.1.8.4. Has at least five (5) years of experience in public mental health and services for people with mental illness.

1.8.2. Evidence-Based Practices (EBP) Training and Consultation

- 1.8.2.1. The Contractor shall provide part-time Trainers and/or Consultants, equal to (2) FTEs in total, to provide EBP Training and Consultation Services as described herein to sustain and continuously improve the quality of EBP in the Community Mental Health system as follows:

- 1.8.2.1.1. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the Department, and conduct training for CMH staff on IMR and/or **Enhanced IMR (E-IMR)** in specific topic areas, subject to Department approval. The Contractor shall conduct IMR/E-IMR training sessions as follows:

- 1.8.2.1.1.1. Two (2) trainings of no less than fifteen (15) hours each training, presented in two (2) full-day or four (4) half-day training sessions, for new IMR/E-IMR practitioners, to fulfill the specifications described in He-M 426 to provide IMR/E-IMR services. The capacity for each training event shall be no fewer than ten (10) participants and no more than forty (40) participants, depending on the availability of the training space;

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1.8.2.1.1.2. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions, for supervisors of and/or experienced IMR/E-IMR staff that shall fulfill the specifications in He-M 426 for ongoing providers of IMR/E-IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR/E-IMR services through practice-specific supervision. The capacity for this training event shall be no fewer than ten (10) participants and no more than twenty (20) participants.

1.8.2.1.2. **Individual Placement and Support Supported Employment (IPS-SE):** The Contractor shall develop, in collaboration with the Department, and conduct training for CMH staff on IPS-SE services in specific topic areas, subject to Department approval. The Contractor shall conduct IPS-SE training sessions as follows:

1.8.2.1.2.1. Two (2) trainings of no less than fifteen (15) hours each training, presented in two (2) full-day or four (4) half-day training sessions, for new IPS-SE practitioners to fulfill the specifications described in He-M 426 to provide evidence based SE services. The capacity for each training shall be no fewer than ten (10) participants and no more than forty (40) participants.

1.8.2.1.2.2. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced IPS-SE practitioners. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of IPS-SE services. This training will focus on job development strategies used with community partners and employers. The capacity for each of these training events shall be no fewer than ten (10) participants and no more than thirty (30) participants.

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1.8.2.1.2.3. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced IPS-SE practitioners and IPS-SE supervisors and/or experienced IPS-SE staff. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of evidence based SE services. The content shall include information on developing and improving collaboration with the New Hampshire Department of Vocational Rehabilitation and other important community partners in providing effective IPS-SE services. The capacity for each of these training events shall be no fewer than ten (10) participants and no more than twenty (20) participants.

1.8.2.1.3. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the Department, ACT services training for CMH staff on specific topic areas, subject to Department approval. The Contractor shall conduct ACT trainings as follows:

1.8.2.1.3.1. Two (2) trainings of no less than fifteen (15) hours each training, presented in two (2) full-day or four (4) half-day training sessions, for new ACT practitioners to fulfill the specifications described in He-M 426 to provide IPS-SE services. The capacity for each training shall be no fewer than ten (10) participants and no more than forty (40) participants.

1.8.2.1.3.2. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced ACT practitioners. The combination of attending the two (2) events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. This training will focus on working with individuals with co-occurring substance use disorders. The capacity for each training shall be no fewer than ten (10) participants and no more than forty (40) participants.

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1.8.2.1.3.3. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced ACT practitioners and ACT supervisors. The combination of attending the two (2) events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each training shall be no fewer than ten (10) participants and no more than twenty (20) participants.

1.8.2.1.4. **Consultation to CMH Program Leadership and Workforce Development:** The Contractor shall provide agency-based consultations to all CMH programs as designated by the Department designee to assist agencies in sustaining and providing continuous quality improvement for IMR/E-IMR, ACT and IPS-SE services. The Contractor shall ensure that CMH program leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described in Subparagraph 1.9.2.7, and at the Department's request. Consultations shall include the development of ideas, strategies and interventions that each individual CMH program may utilize to most effectively sustain and improve IMR, ACT and IPS-SE services.

1.8.2.1.4.1. In cases where CMH programs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall provide such further interventions upon mutual agreement of the Department designee, the Contractor, and CMH program leadership.

1.8.2.1.4.2. Such interventions shall be targeted and focused and customized to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

1.8.2.1.5. **NH Behavioral Health Service Area Consultations and Collaboration:** The Contractor shall assist with sustaining and improving the quality of IMR/E-IMR,

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ACT and IPS-SE services in the NH Community Mental Health system by providing consultation services to the Department and CMHCs, as identified by the Department, including but not limited to, consulting on, in collaboration with the Department designee, emerging best practices, evidence-based practices, and practice innovations to support overall system implementation and to inform the design and/or transformation of services.

1.8.2.2. The Contractor shall provide staff or other qualified professionals, subject to the approval by the Department, necessary to provide additional education, training, technical assistance, and consultation to Department and CMH providers, including but not limited to, training the CMH workforce to improve the quality of IMR/E-IMR, IPS-SE, and ACT services. The Contractor shall:

1.8.2.2.1. Provide education and training to CMH staff identified by the Department. The Contractor shall provide a total of eighteen (18) days of training, but schedules and requirements for each EBP as outlined below may be adjusted upon mutual agreement between the Department and Contractor in order to meet the needs of the CHM staff.

1.8.2.2.2. Ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR/E-IMR, IPS-SE, and ACT in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M 426 for CMHC programs of EBPs in NH.

1.8.2.2.3. Ensure each training event includes, at a minimum:

1.8.2.2.3.1. Invitations provided to CMHC staff before the training event;

1.8.2.2.3.2. A description of who should attend the training;

1.8.2.2.3.3. Outcomes for participants attending the training;

1.8.2.2.3.4. Sufficient time to provide instruction and practice for skills;

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- 1.8.2.2.3.5. Content designed to improve the fidelity of the practice at CMHCs;
 - 1.8.2.2.3.6. Documentation of all participants attending the training; and
 - 1.8.2.2.3.7. Certificates of attendance for all participants completing the training.
- 1.8.2.3. The Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the Department designee and the Contractor.
- 1.8.2.4. The Contractor's attendance at other events as collaboratively agreed upon by the Department designee and the Contractor for the purposes of sustaining and improving the quality of IMR/E-IMR, ACT, and IPS-SE.
- 1.8.2.5. **Evidence Based Practices Fidelity Assessments:** The Contractor shall conduct fidelity assessments to determine organizational faithfulness to the principles of ACT and evidence based SE practices for all CMH programs, as requested by the Department. The Contractor shall:
- 1.8.2.5.1. Conduct fidelity assessments for the purpose of monitoring the implementation of ACT and IPS-SE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMH programs.
 - 1.8.2.5.2. Develop, in collaboration with the Department designee, a specific schedule designating specific time periods for each CMH program, ACT and IPS-SE fidelity assessment and/or related consultations(s). The schedule shall be subject to the advanced approval of the Department designee.
 - 1.8.2.5.3. Ensure that each fidelity assessment includes, at a minimum:
 - 1.8.2.5.3.1. Written instructions to the CMH program regarding preparation for fidelity assessments that includes necessary observations, interviews, data access/documents and other activities for the assessment.
 - 1.8.2.5.3.2. A specific written assessment schedule developed jointly by the Contractor and the CMH program.

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- 1.8.2.5.3.3. Sufficient time to assess and evaluate the CMH program's delivery of ACT or IPS-SE.
 - 1.8.2.5.3.4. A debriefing at the end of the assessment to review themes from the review with CMH program leadership.
 - 1.8.2.5.3.5. A written fidelity assessment report to include findings, rationale/observations, scoring, identified strengths, identified areas of improvement with recommendations provided to CMH leadership and the Department no later than four weeks following the assessment visit.
- 1.8.2.6. The Contractor shall provide one (1) full-time position (1.0 FTE) to provide training, consultation and technical assistance to community mental health and substance use disorder treatment contracting organizations on:
- 1.8.2.6.1. Organizational change and workflows to support treatment of co-occurring disorders for organization leaders and team leaders, including hiring, treatment program structures, supervision practices, EMR changes, and other organizational structures and practices;
 - 1.8.2.6.2. Identification and diagnosis of substance use disorders in people with mental health disorders from both clinical and systems perspectives;
 - 1.8.2.6.3. Identification and diagnosis of mental health disorders in people with substance use disorders (SUD) from both clinical and systems perspectives;
 - 1.8.2.6.4. Evidence-based practice treatment for co-occurring disorders including:
 - 1.8.2.6.4.1. Motivational interviewing for behavior change;
 - 1.8.2.6.4.2. Cognitive and behavioral treatment for SUD;
 - 1.8.2.6.4.3. Incorporating SUD treatment into Assertive Community Treatment;
 - 1.8.2.6.4.4. Cognitive and behavioral treatment for PTSD and depressive disorders in people with SUD;

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- 1.8.2.6.4.5. Medication assisted treatment for SUD including alcohol, opioid, and tobacco use disorders;
- 1.8.2.6.4.6. Medication treatment for PTSD and depressive disorder in people with SUD;
- 1.8.2.6.4.7. Six (6) months of weekly group consultation/case supervision to support treatment skills following evidence-based practice treatment for co-occurring disorders training; and
- 1.8.2.6.4.8. Use of digital interventions in conjunction with EBPs to extend and enhance treatment
- 1.8.2.6.5. The position will work with the Department to engage contracting organizations in order to tailor training content, schedule training, engage trainees and assess outcomes of training, consultation and technical assistance;
- 1.8.2.6.6. The position will develop training materials and provide the to the Department to post and distribute;
- 1.8.2.6.7. The position will conduct satisfaction surveys with trainees and continuously improve training, consultation, and technical assistance;
- 1.8.2.6.8. The position will work with current EBP Trainers and Consultants and Department staff to collaborate and coordinate activities.

1.8.3. Behavioral Health Policy Institute (BHPI)

- 1.8.3.1. The Contractor shall provide a part-time (.10 FTE) Behavioral Health Policy Institute Consultant. Under the direction of the Department designee and the Behavioral Health Medical Director, the Behavioral Health Policy Institute Consultant shall:
 - 1.8.3.1.1. Conduct analyses of Medicaid claims, as requested by the Department, to address policy issues and questions under consideration from the Behavioral Health program.
 - 1.8.3.1.2. Participate in regular meetings with the Department designee and/or the Behavioral Health Medical Director to review analyses and associated policy implications.

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1.8.4. Committee for the Protection of Human Services (CPHS)

- 1.8.4.1. The Contractor shall provide one (1) part-time (.15 FTE) Support Staff/Co-Chair and one (1) part-time (.50 FTE) Research Assistant to support the Committee for the Protection of Human Services.
- 1.8.4.2. Responsibilities of the Contractor staff shall include, but are not limited to:
 - 1.8.4.2.1. Attending and fully participating in CPHS full committee meetings (once per month);
 - 1.8.4.2.2. Conducting expedited reviews as requested by the CPHS Administrator;
 - 1.8.4.2.3. Providing consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject protections, including, but not limited to, pre-reviewing materials; reviewing requirements for exempt and expedited determinations, and reviewing significant adverse event reports;
 - 1.8.4.2.4. Serving on the Consent Form Template and Forms sub-committees, or other sub-committees, as requested by the CPHS Chairperson; and
 - 1.8.4.2.5. Serving as the Co-Vice Chair to the CPHS.
 - 1.8.4.2.6. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the Department designee. The availability of additional federal funds to support the implementation of additional EBP may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.
- 1.8.4.3. The Contractor shall provide research, scientific and human subject expertise to the CPHS for the purpose of sustaining and supporting oversight of research funded by federal agencies and other non-state sources and conducted in New Hampshire Department-funded programs that serve people with mental

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illness, developmental disabilities and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a.

1.8.5. Crisis System Transformation Evaluation

1.8.5.1. The Contractor shall provide consultation and technical assistance to review, advise on, and support successful implementation of NH's behavioral health crisis system (Rapid Response).

1.8.5.2. The Contractor shall provide consultation and technical assistance to evaluate NH's behavioral health crisis system (Rapid Response) transformation and impact.

1.8.5.3. The Contractor shall work with the Department in months 0-3 to evaluate and inform the initial transformation of NH's crisis system by:

1.8.5.3.1. Developing a process to review the initial crisis transformation data, which is intended to determine if, and to what extent, the target CMHCs have converted services from hospital-based emergency services to community-based mobile crisis services.

1.8.5.3.2. Identifying available data sources for evaluation of the system transformation, including emergency department waitlists, Designated Receiving Facility (DRF) census data, and Rapid Response system data.

1.8.5.3.3. Identifying key leaders and stakeholders involved in crisis system transformation and conducting semi-structured interviews to identify important contextual variables across the different CMHCs, as well as potential barriers and facilitators to crisis system transformation.

1.8.5.3.4. Developing a comprehensive evaluation plan that outlines measures and methods for collecting process and outcome data, with particular focus on collecting process / implementation data in the first six months to guide roll-out of the Rapid Response system at the second cohort of clinics.

1.8.5.4. The Contractor shall work with the Department in months 0-6 to evaluate and inform the initial transformation of NH's crisis system by:

1.8.5.4.1. Analyzing quantitative and qualitative data to make quality improvement recommendations for the Rapid Response system. Activities shall include:

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- 1.8.5.4.1.1. Reviewing comprehensive data regarding initial Rapid Response implementation;
- 1.8.5.4.1.2. Gathering community provider, stakeholder, and user input about their experience and opportunities for process and/or system improvements; and
- 1.8.5.4.1.3. Issuing an initial report of findings and recommendations to the Department.
- 1.8.5.4.2. Developing a process or system, such as a data dashboard, to compile and review crisis system data over time, including but not limited to the emergency department waitlist, Designated Receiving Facility (DRF) census data, and initial Rapid Response system data to determine if, and to what extent, the Rapid Response system has changed utilization trends for inpatient hospitalization and/or crisis apartment utilization.
- 1.8.5.4.3. Providing consultation and technical assistance regarding findings and recommendations that may include:
 - 1.8.5.4.3.1. Consultation to improve implementation per fidelity to the current Rapid Response model;
 - 1.8.5.4.3.2. Adaptation of the Rapid Response crisis system for NH's environments, specifically rural regions; and
 - 1.8.5.4.3.3. Consultation to expand the stabilization component of the Rapid Response model that will be sustainable and accessible statewide. Models such as crisis apartments, in-home stabilization services, and additional stationary crisis centers all need to be explored as potential solutions.
- 1.8.5.4.4. Developing a plan for any needed adaptations of the NH Rapid response crisis model based on national research, data review, stakeholder, and provider input.
- 1.8.5.5. The Contractor shall work with the Department in months 6-12 to evaluate and guide the transformation of NH's crisis system by:

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- 1.8.5.5.1. Providing technical assistance to the CMHCs to adapt services based on recommendations outlined in the above plan;
 - 1.8.5.5.2. Refining the longitudinal evaluation plan to track and analyze data to assess crisis system changes, reach, and effectiveness over time, including the baseline year before and after the changes;
 - 1.8.5.5.3. Developing a crisis system quality review tool for ongoing quality monitoring of the community-based Rapid Response crisis teams;
 - 1.8.5.5.4. Consulting on a set of standardized data dashboards the Department can use on a quarterly and annual basis to monitor the quality, reach, and effectiveness of NH's Rapid Response crisis system; and
 - 1.8.5.5.5. Consulting on a set of data reports, including extracts from the internal dashboards, that the Department should develop for public reporting in order to communicate effectiveness of the system, overall system trends, and specific data points for tracking the implementation of the crisis system transformation.
- 1.8.5.6. The Contractor shall work with the Department in months 12-24 to support, refine, and guide sustainability of the transformation of NH's crisis system by:
- 1.8.5.6.1. Collecting and comparing clinic-level qualitative and quantitative data to explore what is working well, where (i.e., CMHCs) and for whom (e.g., types of crises, patient backgrounds), to inform implementation adjustments to scale successes and strengthen sustainability across all centers;
 - 1.8.5.6.2. Providing data-informed technical assistance to centers to support successful implementation and ensure fidelity to the model;
 - 1.8.5.6.3. Providing technical assistance to the Department to refine dashboards and reporting tools based on feedback from key stakeholders and the public;
 - 1.8.5.6.4. Providing technical assistance to the Department regarding utilization of the crisis system quality review tool; and

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- 1.8.5.6.5. Consulting with the Department on ongoing quality improvement, needed adaptations to the selected crisis model, and data reporting.
- 1.8.5.7. In collaboration with the Department, the Contractor shall prepare a public report regarding efficacy and outcomes of the crisis system transformation. The final report shall include, but is not limited to:
 - 1.8.5.7.1. Findings from both quantitative and qualitative data collected at various time points;
 - 1.8.5.7.2. Summary of needed adaptations, if applicable, with rationale and recommendations;
 - 1.8.5.7.3. Summary of any identified crisis system gaps that became evident throughout the analysis; and
- 1.8.5.8. Evaluation findings regarding the "fit" of the crisis system model to rural settings, staffing capacity, and funding and other resources necessary to meet current and anticipated future needs.
- 1.8.6. **Time Studies** – The Contractor shall perform regular time studies in accordance with the Centers for Medicare and Medicaid Services (CMS) and Department Medicaid Cost Allocation procedures to document activities relating directly to the administration of the Medicaid program and to draw down federal matching revenues. The Contractor shall provide any such time studies in a format approved by the Department.
- 1.9. **Specific Service Requirements – Service Area #4 – Elderly and Adult Services**
 - 1.9.1. **Medical Director**
 - 1.9.1.1. The Contractor shall provide one (1) part-time (.125 FTE) Medical Director to provide consultation services to the Elderly and Adult Services service area. The Medical Director shall:
 - 1.9.1.1.1. Provide consultation and direction for the Elderly and Adult Services clinical components to policies and procedures, forms and administrative rules;
 - 1.9.1.1.2. Serve as a technical advisor for wellness and prevention initiatives to improve the lives of individuals served by Elderly and Adult Services service area;
 - 1.9.1.1.3. Perform medical consultation, clinical oversight and authority, and provide and guide education instruction within the Elderly and Adult Services service area;

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- 1.9.1.1.4. Provide guidance and consultation regarding new developments and emerging trends in clinical practice, research and best practices that would have an impact on service development, service delivery and clinical policy and practice;
- 1.9.1.1.5. As requested by the Department, participate in the quality initiative, Sentinel Event Reviews and other case consultation and case reviews, as requested by the Department; and
- 1.9.1.1.6. Meet bi-monthly with Department designee to review initiatives and check in on consultation services.
- 1.9.1.2. The Contractor shall ensure the Medical Director meets the following qualifications:
 - 1.9.1.2.1. Possesses a medical degree (MD or DO);
 - 1.9.1.2.2. Maintains board certification in Gerontology or Preventive Medicine/Community Health;
 - 1.9.1.2.3. Possesses expertise in clinical, policy or outcomes research; and
 - 1.9.1.2.4. Possesses expertise in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

1.10. Specific Service Requirements – Service Area #5 – Developmental Services

1.10.1. Medical Director

- 1.10.1.1. The Contractor shall provide one (1) part-time (.40 FTE) Medical Director to provide psychiatric consultation services to the Developmental Services service area sixteen (16) hours per week. The Medical Director shall:
 - 1.10.1.1.1. Provide services in response to referrals from the ten (10) Area Agencies and the Department's Bureau for Family Centered Services (BFCS). Referrals shall be prioritized over all other duties and may include performing evaluations, consultations and medication reviews. Reports and recommendations must be shared with the referring entity.

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- 1.10.1.1.2. Based on He-M 1201, serve as chairperson for and facilitate meetings for the Developmental Services Medication Committee, and provide expert opinion and leadership to ensure the Committee functions effectively.
- 1.10.1.1.3. Assist the Department's Developmental Services staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews.
- 1.10.1.1.4. Provide educational training to the Department's Developmental Services staff, Area Agencies, subcontracted agencies and other stakeholders as identified and directed by the Department.
- 1.10.1.1.5. Provide additional expertise and support to improve New Hampshire's developmental services system, as directed by the Department.
- 1.10.1.1.6. Submit encounter documentation and data as requested by the Department.
- 1.10.1.2. The Contractor shall ensure the Medical Director meets the following qualifications:
 - 1.10.1.2.1. Possesses a medical degree (MD or DO);
 - 1.10.1.2.2. Maintains board certification in Child and Adult Psychiatry; and
 - 1.10.1.2.3. Possesses expertise and experience in developmental disability, including Autism Spectrum Disorders.

1.10.2. Developmental Services Interdisciplinary Clinic Team

- 1.10.2.1. The Contractor shall provide the following part-time positions for the children and adults Developmental Services Interdisciplinary Clinic Team:
 - 1.10.2.1.1. Child Psychiatrist- 0.1 FTE
 - 1.10.2.1.2. Psychiatrist - 0.1 FTE
 - 1.10.2.1.3. Neuropsychologist - 0.1 FTE
 - 1.10.2.1.4. Neuropsychology Fellow - 0.15 FTE
 - 1.10.2.1.5. Neurologist - 0.05 FTE
 - 1.10.2.1.6. Primary Care Physician - 0.05 FTE
 - 1.10.2.1.7. Occupational Therapist - 0.05 FTE
 - 1.10.2.1.8. Administrative Support - 0.05 FTE

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1.10.2.2. The Interdisciplinary Clinic Team members' responsibilities are as follows:

1.10.2.2.1. **Psychiatrist (Child Psychiatrist):** The Psychiatrist shall serve as the Clinic Director, coordinating the team and/or providers involved in the Clinic. The Psychiatrist shall conduct a comprehensive psychiatric examination, including reviewing clients' psychiatric treatment and medical history. The Psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client.

1.10.2.2.2. **Neuropsychologist:** The Neuropsychologist will review all clients' psychiatric medical records, neuropsychological testing and behavioral incidents. The Neuropsychologist shall document recommendations as part of the comprehensive report. The Neuropsychologist shall supervise the Neuropsychology Fellow and oversee the documentation of historical information regarding the client.

1.10.2.2.3. **Neuropsychology Fellow:** The Neuropsychology Fellow shall review clients' medical and psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report.

1.10.2.2.4. **Neurologist:** The Neurologist shall review clients' medical records, conduct a physical examinations, and document findings and recommendations as part of the comprehensive report.

1.10.2.2.5. **Primary Care Physician:** The Primary Care Physician shall review past medical records, conduct a physical examination, and document findings and recommendations as part of the comprehensive report.

1.10.2.2.6. **Occupational Therapist:** The Occupational Therapist shall review past medical records, conduct an occupational therapy evaluation, document findings and recommendations as part of the comprehensive report; and

1.10.2.2.7. **Administrative Support Staff:** The Administrative Support Staff shall schedule appointments,

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received documents and checklists of requested documents, copy records for providers and fax completed reports. In addition, Administrative Support Staff will support the Developmental Services Medical Director.

1.10.2.3. The Contractor shall:

- 1.10.2.3.1. Ensure the Interdisciplinary Clinic Team accepts children and adults referred from the Area Agencies;
- 1.10.2.3.2. Prioritize clients based on the most immediate need and critical situation;
- 1.10.2.3.3. Provide high quality interdisciplinary evaluations to children and adults with developmental disabilities and acquired brain injuries:
- 1.10.2.3.4. Develop one (1) comprehensive report for each client that includes, but is not limited to:
 - 1.10.2.3.4.1. A comprehensive understanding of each client with a focus on a biological, psychological, social and/or environmental approach and the interaction of these factors as they relate to the clients' strengths, skills, and interests.
 - 1.10.2.3.4.2. Recommendations that can be utilized by the Systemic, Therapeutic, Assessment, Resources, and Treatment (START) Coordinators, Area Agencies, service providers and medical providers to provide the best quality of care for each person.
- 1.10.2.3.5. Serve as the point of access to a team of expert providers which will reduce each client's number of medical appointments and reduce each client's need to travel to multiple appointments.
- 1.10.2.3.6. Convene the Interdisciplinary Clinic Team one (1) time per month and conduct a face-to-face or remote appointment with two (2) clients per month, for a total of twenty-four (24) clients per year.
 - 1.10.2.3.6.1. Interdisciplinary clinic team meetings and client appointments shall take place by telehealth or in person at DHMC in Lebanon, as determined clinically appropriate and

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necessary by the Interdisciplinary Clinic Team.

1.10.2.3.6.2. The Contractor's Interdisciplinary Clinic Team shall review all previous records of each client prior to each client appointment. The Interdisciplinary Clinic Team shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history and/or concerns and to examine the client.

1.10.2.3.6.3. After meeting and examining the client, the Interdisciplinary Clinic Team will meet to discuss recommendations.

1.10.2.3.6.4. The Interdisciplinary Clinic Team shall draft a comprehensive report regarding the visit and recommendations. The report shall be made available within fifteen (15) business days from the date of the last meeting of the Interdisciplinary Clinic Team.

1.10.2.3.7. Have the client, or the client's authorized representative, sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

1.10.2.3.8. Submit encounter documentation as directed by the Department.

1.11. General Staffing Requirements applicable to all Service Areas and personnel provided under the Agreement

1.11.1. The Contractor shall recruit and retain qualified individuals for the staffing needs as specified, and as otherwise necessary, to fulfill the requirements as described in this Exhibit B, Scope of Services, Section 1. Statement of Work.

1.11.2. All personnel provided under this Contract shall be subject to Department approval prior to the Contractor notifying candidates of assignment and/or hire to fulfill a specified staffing role. The Department shall inform the Contractor of its applicable designee for this purpose per position or service area. The Department designee, at their discretion, shall be entitled to interview any such candidate. The Contractor shall facilitate coordinating such interviews upon the Department designee's request.

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- 1.11.3. The Department at its sole discretion may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the following reasons:
- 1.11.3.1. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;
 - 1.11.3.2. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;
 - 1.11.3.3. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;
 - 1.11.3.4. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or
 - 1.11.3.5. Any other reason that includes, but is not limited to, misconduct, violation of Department policy, or violation of state or federal laws and regulations pertaining to the applicable Department service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.
- 1.11.4. In the event of such rescission:
- 1.11.4.1. The Department shall provide the Contractor with reasonable advance notice to the extent possible and the applicable reason. No additional payments will be paid by the State for any staff removed from duty by the Department for any reason;
 - 1.11.4.2. The Contractor's applicable staff member shall be prohibited from providing services under the Agreement for the period of time that the Department exercises this right;
 - 1.11.4.3. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under this contract including, but not limited to, being subject to the Department approval specified in 1.11.2;
 - 1.11.4.4. The Contractor shall be responsible for providing transition services to the applicable Department service area to avoid interruption of services and administrative responsibilities at no additional cost to the Department; and
 - 1.11.4.5. The Department will inform the Contractor of the anticipated duration for which approval will remain rescinded. If the duration of a temporarily rescinded approval is greater than five (5) calendar days, the Contractor shall furnish within ten (10)

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business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption.

- 1.11.4.6. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its employee(s). However, nothing herein shall prohibit the Contractor from seeking information from the Department regarding the Department's decision, unless such information is otherwise restricted from disclosure by the Department based on internal Department policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.
- 1.11.5. The Contractor shall ensure, prior to providing the applicable services to the applicable Department service area or facility, all required licenses, certifications, privileges or other specified minimum qualifications are met for all Contractor staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable Department designee with a copy of all such documents. The Contractor acknowledges and agrees that the Department shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.
- 1.11.6. Work schedules for Contractor staff provided under this Agreement may be modified as needed to meet the requirements described herein, subject to the approval of the appropriate Department designee.
- 1.11.7. The Contractor shall ensure all staff provided under this Agreement are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. In addition to any required approvals by the Contractor for its employees, Contractor staff providing services under this Agreement shall provide timely, prior notification to the applicable Department designee for any anticipated leave time, including, but not limited to, vacation and continuing education leave time.
- 1.11.8. The Contractor shall ensure all staffing positions provided under this Agreement are continuously filled or in active recruitment.
- 1.11.9. The Contractor will automatically reduce invoices for payment by the appropriate amount immediately upon a position becoming vacant.
- 1.11.10. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the

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individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required. The Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described in the table below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
2	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
3	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Elderly and Adult Services	Criminal Background, BEAS State Registry
5	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

1.11.11. The Contractor shall ensure the criminal background, registry, screening and medical examinations above are kept current as required and in accordance with the Department's confidentiality policy; the Department receives copies of all required documentation prior to the commencement of services; and the Department will not be responsible for any costs incurred in obtaining the documentation.

1.11.12. The Contractor shall not utilize any personnel including Subcontractors, to fulfill any obligations of this contract, who have been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or misdemeanor offense for which incarceration for up to one (1) year is an authorized penalty. The Contractor will initiate a criminal background check re-investigation of all personnel provided under this contract every five (5) years. The five (5) year period will be based on the date of the last criminal background check conducted by the Contractor or its agents.

1.11.13. State Owned Devices, Systems and Network Usage

1.11.13.1. Personnel provided by the Contractor under this Agreement shall use a state-issued device, including, not limited to computers,

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tablets or mobile telephones, in fulfilling the requirements of this contract. The Contractor shall ensure all personnel provided under this Agreement:

- 1.11.13.1.1. Use the information that they have permission to access solely for conducting official state business. All other use or access is strictly forbidden including, but not limited, to personal or other private and non-State use, and that at no time shall Contractor workforce or agents access or attempt to access information without having the express authority of the Department to do so;
- 1.11.13.1.2. Not access or attempt to access information in a manner inconsistent with the approved policies, procedures, and/or agreement relating to system entry/access;
- 1.11.13.1.3. Not copy, share, distribute, sub-license, modify, reverse engineer, rent, or sell software licensed, developed, or being evaluated by the state. At all times the Contractor must use utmost care to protect and keep such software strictly confidential in accordance with the license or any other agreement executed by the State. Only equipment or software owned, licensed, or being evaluated by the State can be used by the Contractor. Non-standard software shall not be installed on any equipment unless authorized by the Department's Information Security Office;
- 1.11.13.1.4. Agree that email and other electronic communication messages created, sent, and received on a state-issued email system are the property of the State of New Hampshire and to be used for business purposes only. Email is defined as "internal email systems" or "state-funded email systems." The Contractor understands and agrees that use of email shall follow Department and State standard policies; and
- 1.11.13.1.5. The Internet and/or Intranet is to be used for access to and distribution of information in direct support of the business of the State of New Hampshire according to policy. At no time should the Internet be used for personal use.

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2. Exhibits Incorporated

- 2.1. 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 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.
- 2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.
- 2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Reporting Requirements for All Service Areas

- 3.1. The Contractor shall provide the Department with detailed personnel listings for all staff performing services in each Service Area under the Agreement on an annual basis for each State Fiscal Year, or more frequently as required by the Department, to ensure the accuracy of information contained therein and proper cost allocation. The listings will include information for each Service Area that includes, but is not limited to staff names, titles and personnel costs (including salary costs, fringe benefit costs, and indirect rates). The listings will be in a format as determined and approved by the Department.

4. Performance Measures and Monitoring

4.1. Service Area #1 – Chief Medical Officer – Medicaid

- 4.1.1. Within forty-five (45) days of the contract effective date of the Chief Medical Officer, and annually thereafter, the Contractor and the Department designee, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the Department designee prior to being effective. Performance measures and monitoring tools may include, but are not limited to:
 - 4.1.1.1. Attendance records of Medicaid Management Team meetings; and
 - 4.1.1.2. A checklist of core duties and expectations, as described in Subsection 1.6, with feedback solicited the Department.
- 4.1.2. The Department designee and Chief Medical Officer shall meet quarterly, or on a frequency as otherwise determined by the Department, to review these performance metrics and associated data. These meetings shall be documented with written progress notes by the Department designee.

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- 4.1.3. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. The Contractor shall, no less than annually and more frequently as requested by the Department, provide an evaluation tool that is based on the mutually agreed upon performance metrics for the previous year to solicit input from the Department regarding the Chief Medical Officer's performance in providing of services under the Agreement.
- 4.1.4. In the event that the Chief Medical Officer's performance requires improvement, as determined by the Contractor and/or the Department, the Contractor shall develop and submit a proposed corrective action plan to the Department for review and approval.
- 4.1.5. The Department designee, the Contractor, and the Chief Medical Officer shall establish goals annually for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer. In the event that the Chief Medical Officer position is vacated and refilled, the evaluation tool shall be completed at six (6) months and at one (1) year of employment, and annually thereafter on the contract anniversary date.

4.2. Service Area #2 – Staff Psychologist – Children, Youth and Families

- 4.2.1. Within forty-five (45) days of the assignment of the Staff Psychologist, and annually thereafter, the Contractor and the Department designee, in consultation with the Staff Psychologist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychologist, including, but not limited to, clinical documentation monitoring. The performance metrics shall be approved by the Department designee prior to being effective. The Department designee and Staff Psychologist shall meet quarterly, or on a frequency as otherwise determined by the Department, to review these performance metrics. These meetings shall be documented with written progress notes by the Department designee.
- 4.2.2. The Contractor shall ensure the services provided by the Staff Psychologist are satisfactory to the Department. The Contractor shall, no less than annually and more frequently as requested by the Department, provide an evaluation tool that is based on the mutually agreed upon performance metrics for the previous year to solicit input from the Department regarding the Staff Psychologist's performance in providing of services under the Agreement.
- 4.2.3. In the event that the Staff Psychologist's performance requires improvement, as determined by the Contractor and/or the Department, the Contractor shall develop and submit a proposed corrective action plan to the Department for review and approval.

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4.2.4. The Department designee, the Contractor, and the Staff Psychologist shall establish goals annually for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychologist. In the event that the Staff Psychologist position is vacated and refilled, the evaluation tool shall be completed at six (6) months and at one (1) year of employment, and annually thereafter on the contract anniversary date.

4.3. Service Area #2 – Staff Psychiatrist – Children, Youth and Families

4.3.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and annually thereafter, the Contractor and the Department designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. Performance metrics and monitoring may include, but are not limited to:

4.3.1.1. Regular checks of the Staff Psychiatrist's electronic calendar to ensure proposed leave time, conferences, and trainings are recorded appropriately;

4.3.1.2. Clinical documentation monitoring to ensure timeliness and completeness standards are being met as established by Children, Youth, and Families;

4.3.1.3. Counts of activities, including, but not limited to, the number of treatment team meetings and clinical consultations provided, types and numbers of EBP provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and

4.3.1.4. Feedback collected in a checklist to assess effectiveness in establishing interagency collaboration between JJS, CMHCs, and NHH.

4.3.2. Performance metrics shall be approved by the Department designee prior to being effective. The Department designee and Staff Psychiatrist shall meet quarterly, or on a frequency as otherwise determined by the Department, to review these performance metrics. These meetings shall be documented with written progress notes by the Department designee.

4.3.3. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. The Contractor shall, no less than annually and more frequently as requested by the Department, provide an evaluation tool that is based on the mutually agreed upon performance metrics for the previous year to solicit input from the Department regarding the Staff Psychiatrist's performance in providing of services under the Agreement.

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4.3.4. In the event that the Staff Psychiatrist's performance requires improvement, as determined by the Contractor and/or the Department, the Contractor shall develop and submit a proposed corrective action plan to the Department for review and approval.

4.3.5. The Department designee, the Contractor, and the Staff Psychiatrist shall establish goals annually for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist. In the event that the Staff Psychiatrist position is vacated and refilled, the evaluation tool shall be completed at six (6) months and at one (1) year of employment, and annually thereafter on the contract anniversary date.

4.4. Service Areas #3 Behavioral Health, #4 Elderly and Adult Services and #5 Developmental Services

4.4.1. Upon Department request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes for Service Areas 3, 4 and 5.

4.5. Performance Evaluations

4.5.1. The Contractor shall conduct performance reviews annually for all staff provided under the Agreement, unless otherwise specified in the Agreement, in a format as approved by the Department.

4.5.2. The Contractor shall conduct such reviews by first obtaining feedback from the applicable Department designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of the Department over the course of the contract period.

4.6. Quality Assurance Plan and Monitoring

4.6.1. The Contractor shall develop and submit a Quality Assurance Plan, subject to approval and/or modification as requested by the Department. The Quality Assurance Plan shall include, at a minimum:

4.6.1.1. Services and activities that will be monitored;

4.6.1.2. How monitoring will be conducted;

4.6.1.3. Individuals who will conduct the monitoring, specifying the roles and responsibilities of staff and any other third party, if applicable;

4.6.1.4. Department resources, if any, that will be requested for the monitoring process, and how the Department resources will be involved; and

4.6.1.5. Process for documenting monitoring efforts and results.

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- 4.6.2. The Contractor shall monitor progress toward the stated goals in the Quality Assurance and Monitoring Plan and provide progress reports to the Department, as requested by the Department.
- 4.6.3. In consultation with the Department, the Contractor shall review and revise the Quality Assurance and Monitoring Plan at minimum on an annual basis, or as otherwise requested by the Department.
- 4.7. The Contractor shall actively and regularly collaborate with the Department to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.
- 4.8. The Contractor may be required to provide other key data and metrics to the Department, including client-level demographic, performance, and service data.
- 4.9. Where applicable, the Contractor shall collect and share data with the Department in a format specified by the Department.

5. Additional Terms

5.1. Impacts Resulting from Court Orders or Legislative Changes

- 5.1.1. 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. In the event that any future state or federal legislation or court order impacts the Services described herein, the Department shall provide the Contractor with reasonable advanced notice of any necessary modification to Service priorities and expenditure requirements. The parties agree to cooperate in the implementation and planning of any such modification and the Department shall consider Contractor's reasonable requests with respect to such modifications. Notwithstanding the foregoing, the Department shall retain the final right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance with any future state or federal legislation or court orders that have an impact on the Services described herein.

5.2. Credits and Copyright Ownership

- 5.2.1. 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

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required, e.g., the United States Department of Health and Human Services.”

5.2.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

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

5.2.3.1. Brochures.

5.2.3.2. Resource directories.

5.2.3.3. Protocols or guidelines.

5.2.3.4. Posters.

5.2.3.5. Reports.

5.2.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

5.3. Eligibility Determinations

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

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

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

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

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6. Records

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

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

6.1.2. 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.

6.2. 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 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.

7. Continuity of Services and Liquidated Damages

7.1. Liquidated damages are specified in, and may be assessed in accordance with, Exhibit C, Payment Terms, Section 17.

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Payment Terms

1. This Agreement is funded by:
 - 1.1. 28% Federal Funds from:
 - 1.1.1. The Centers for Medicare & Medicaid Services (CMS), Catalog of Federal Assistance (CFDA) #93.778;
 - 1.1.2. Health Resources and Services Administration (HRSA), Maternal and Child Health Block Grant, CFDA #93.994;
 - 1.1.3. Administration on Aging, Title III-B Social Services, CFDA #93.004;
 - 1.1.4. Substance Abuse & Mental Health Services Administration (SAMHSA), Community Mental Health Block Grant, CFDA #93.958; and
 - 1.1.5. SAMHSA, Substance Abuse Block Grant ARPA, CFDA #93.959.
 - 1.2. 72% General funds.
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.
 - 2.2. The Department has identified this Agreement as NON-R&D, in accordance with 2 CFR §200.332.
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 items, as specified in Exhibit C-1, Budget through Exhibit C-7, Budget.
 - 3.1. Services provided in the event of a healthcare system emergency as specified in Paragraph 1.5.5 of Exhibit B, Scope of Services, are budgeted to serve any or all of the five (5) service areas. The Contractor shall invoice the Department at the hourly rate per position, which is inclusive of direct salary and benefits, for the number of hours worked. The budget for these services shall be unencumbered per State Fiscal Year as specified below:

Service	Effective Date to 6/30/2022	7/1/2022 to 6/30/2023	7/1/2023 to 6/30/2024	7/1/2024 to 6/30/2025
Healthcare Emergency	\$921,941	\$2,823,038	\$2,754,340	\$2,610,338

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4. The Contractor shall submit five (5) monthly invoices to the Department in a form satisfactory to the State by the twentieth (20th) working day of the following month, with the exception of June invoices, which shall be submitted by the tenth (10th) working day of the following month, including one distinct and separate invoice for each of the five (5) Service Areas requesting reimbursement for authorized expenses incurred for services provided in the prior month. The five (5) Service Areas include:
 - 4.1. Service Area #1 – Medicaid
 - 4.2. Service Area #2 – Children, Youth and Families
 - 4.3. Service Area #3 – Behavioral Health
 - 4.4. Service Area #4 – Elderly and Adult Services
 - 4.5. Service Area #5 – Developmental Services
5. The Contractor shall reduce invoices by the appropriate amount immediately upon a position becoming vacant and not being backfilled with a locum.
6. In the event that the Contractor provides healthcare system emergency services specified in Subsection 3.1 above, the Contractor shall submit a separate invoice that distinctly identifies and differentiates the expenses as charged according to each of the five (5) Service Areas for which services are provided. The invoice shall include the dates worked, the name of the employee and their title, the hourly rate, and the number of hours worked per day.
7. The Contractor shall ensure the invoices are completed, dated and returned to the Department in order to initiate payment.
8. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to Mary.E.Calise@dhhs.nh.gov, or invoices may be mailed to:

Financial Manager
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
9. The Contractor shall designate a contact person to resolve any questions or discrepancies regarding invoices. The Contractor shall provide DHHS with the name, title, telephone number, fax number and email address of the contact person. The Contractor shall also notify DHHS in the event of a change of the designated contact person. DHHS shall provide the Contractor with the name, title, mailing address, and telephone number of the corresponding DHHS contact person. DHHS shall notify the Contractor in the event of a change in the designated contact person.
 - 9.1. Contingent upon additional state or federal funding and pursuant to a mutually agreed upon contract amendment, the Contractor may be asked to provide additional services appropriate for inclusion in the

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contract's scope, if such services are not otherwise detailed in this Agreement.

10. 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.
11. The final invoices shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.
12. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.
13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B, Scope of Services.
14. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.
15. 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.
16. **Audits**
 - 16.1. The Contractor must email an annual audit to melissa.s.morin@dhhs.nh.gov if any of the following conditions exist:
 - 16.1.1. 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.
 - 16.1.2. 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.
 - 16.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

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- 16.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 30 days after the completion of the single audit or upon submission of the Contractor's single audit to the Federal Audit Clearinghouse 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.
- 16.3. 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.
- 16.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

17. Liquidated Damages

17.1. Continuity of Services:

- 17.1.1. The Contractor and Department agree that the Contractor's failure to provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit B, Scope of Services, shall result in liquidated damages.
- 17.1.2. The Contractor and the Department agree that:
- 17.1.2.1. It will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit B, Scope of Services;
- 17.1.2.2. Any such breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; and
- 17.1.2.3. The liquidated damages as specified in this Exhibit C, Payment Terms, are reasonable and fair and not intended as a penalty.

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17.2. Notification:

- 17.2.1. The Department shall make all assessments of liquidated damages. Prior to the imposition of liquidated damages, as described herein, the Department shall issue a written notice of remedies that will include, as applicable, the following:
- 17.2.1.1. A citation of the contract provision violated;
 - 17.2.1.2. The remedies to be applied, and the date the remedies shall be imposed (cure period) for the Contractor to remedy such failure. A reasonable cure period will be determined by the Department based on service type, and to the extent possible, the notice will not be less than 30 days;
 - 17.2.1.3. The basis for the Department's determination that the remedies shall be imposed;
 - 17.2.1.4. A request for a written Corrective Action Plan from the Contractor below; and
 - 17.2.1.5. The timeframe and procedure for the Contractor to dispute the Department's determination.
- 17.2.2. The Contractor shall submit the written Corrective Action Plan referenced in Subparagraph 17.2.1.4 above to the Department for review within five (5) business days of receiving notification as specified in Subsection 17.2. Notification.
- 17.2.3. The Contractor agrees that the Corrective Action Plan is subject to the Department's approval prior to its implementation.
- 17.2.4. No liquidated damages will be assessed against Contractor if the parties have agreed to a Corrective Action Plan and the Contractor is in compliance with the terms of the Corrective Action Plan.
- 17.2.5. If the failure to perform by the Contractor is not resolved within the cure period as specified in the Corrective Action Plan, as approved by the Department, liquidated damages may be imposed retroactively to the date of failure to perform and will continue until the failure is cured or any resulting dispute is resolved in the Contractor's favor.
- 17.2.6. The Contractor's dispute of liquidated damages or remedies shall not stay the effective date of the proposed liquidated damages or remedies.

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17.3. Liquidated Damages:

- 17.3.1. Liquidated damages, if assessed, shall be in the amount of \$1,000 per day for each day the Contractor fails to meet the general and specific service requirements for each Service Area as identified in Exhibit B, Scope of Services.
- 17.3.2. Liquidated damages, if assessed, shall be in the amount of \$1,000 per day for each day the Contractor fails to meet and maintain the staffing levels identified in Exhibit B, Scope of Services.
- 17.3.3. Liquidated damages, if assessed, shall be in the amount of \$1,000 per day for each day the Contractor fails to meet the performance standards identified in Exhibit B, Scope of Services.
- 17.3.4. Liquidated damages, if assessed, shall be in the amount of \$1,000 per day for each day the Contractor fails to meet the reporting requirements identified in Exhibit B, Scope of Services.
- 17.3.5. Liquidated damages, if assessed, shall apply until the Contractor cures the failure cited in the notification described in Subsection 17.2, or until the resulting dispute is resolved in the Contractor's favor.
- 17.3.6. The amount of liquidated damages assessed by the Department shall not exceed the price limitation in Form P-37, General Provisions, Block 1.8 – Price Limitation.
- 17.3.7. 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 shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the

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amount of such expenses as are disallowed or to recover such sums from the Contractor.

17.4. Assessment:

17.4.1. The Department shall be entitled to assess and recover liquidated damages cumulatively under each section applicable to any given incident.

17.4.2. Assessment and recovery of liquidated damages by the Department shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to the Department for breach of contract, both at law and in equity, and shall not preclude the Department from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of the Department to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

17.5. Damages Related to Failure to Document Medical Necessity:

17.5.1. The Contractor shall be liable to the Department for any losses incurred by the Department which arise out of the failure of Contractor staff to provide the required documentation to support medical necessity as identified in Exhibit B, Scope of Services.

Exhibit C-1 Budget - Medicaid

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #1 Medicaid*
Budget Period: *SFY22 through SFY25*

Line Item	Total Program Cost <i>Enter all costs that will be incurred through this contract/agreement</i>	SFY22	SFY23	SFY24	SFY25
		<i>7/1/21 to 6/30/22</i>	<i>7/1/22 to 6/30/23</i>	<i>7/1/23 to 6/30/24</i>	<i>7/1/24 to 6/30/25</i>
1. Salary/Wages	\$ 1,119,343	106,090	327,818	337,653	347,782
2. Employee Benefits	\$ 198,124	18,778	58,024	59,765	61,557
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ -				
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ 12,000	1,200	3,600	3,600	3,600
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ 33,333	3,333	10,000	10,000	10,000
12. Subcontracts/Agreements	\$ -				
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 1,362,800	\$ 129,401	\$ 399,442	\$ 411,017	\$ 422,940
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 204,420	19,410	59,916	61,653	63,441
TOTAL	1,567,220	148,811	459,358	472,670	486,381

Exhibit C-2 Budget - Children, Youth and Families

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #2 Children, Youth and Families*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost				
	Enter all costs that will be incurred through this contract/agreement	FY22 <small>7/1/21 to 6/30/22</small>	FY23 <small>7/1/22 to 6/30/23</small>	FY24 <small>7/1/23 to 6/30/24</small>	FY25 <small>7/1/24 to 6/30/25</small>
1. Salary/Wages	\$ 1,989,165	188,531	582,560	600,037	618,038
2. Employee Benefits	\$ 544,433	51,601	159,446	164,230	169,157
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ -				
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ 3,333	333	1,000	1,000	1,000
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ 30,000	3,000	9,000	9,000	9,000
12. Subcontracts/Agreements	\$ -				
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 2,566,932	\$ 243,465	\$ 752,006	\$ 774,266	\$ 797,194
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 385,040	36,520	112,801	116,140	119,579
TOTAL	2,951,971	279,985	864,807	890,406	916,773

Exhibit C-3 Budget - Behavioral Health

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #3 Behavioral Health*
Budget Period: *SFY22 through SFY25*

Line Item	Total Program Cost <i>Enter all costs that will be incurred through this contract/agreement</i>	SFY22	SFY23	SFY24	SFY25
		<i>7/1/21 to 6/30/22</i>	<i>7/1/22 to 6/30/23</i>	<i>7/1/23 to 6/30/24</i>	<i>7/1/24 to 6/30/25</i>
1. Salary/Wages	\$ 1,315,316	124,664	385,212	396,768	408,671
2. Employee Benefits	\$ 374,941	35,536	109,808	113,102	116,495
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ 68,485	6,667	20,000	20,600	21,218
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ 50,000	5,000	15,000	15,000	15,000
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ 20,000	2,000	6,000	6,000	6,000
12. Subcontracts/Agreements	\$ -				
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 1,828,741	\$ 173,867	\$ 536,020	\$ 551,470	\$ 567,384
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 274,311	26,080	80,403	82,721	85,108
TOTAL	2,103,052	199,947	616,422	634,191	652,492

Exhibit C-4 Budget - Behavioral Health (Co-Occurring Trainer)

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
 Budget Request for: *Clinical and Administrative Services - Service Area #3 Behavioral Health (Co-occurring Trainer)*
 Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost <i>Enter all costs that will be incurred through this contract/agreement</i>	SFY22	SFY23	SFY24	SFY25
		<i>7/1/21 to 6/30/22</i>	<i>7/1/22 to 6/30/23</i>	<i>7/1/23 to 6/30/24</i>	<i>7/1/24 to 6/30/25</i>
1. Salary/Wages	\$ 304,974	28,905	89,317	91,996	94,756
2. Employee Benefits	\$ 104,911	9,843	30,725	31,647	32,596
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ 17,121	1,667	5,000	5,150	5,305
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ 25,000	2,500	7,500	7,500	7,500
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ 19,000	1,000	6,000	6,000	6,000
12. Subcontracts/Agreements	\$ -				
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 471,006	\$ 44,015	\$ 138,542	\$ 142,293	\$ 146,157
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 70,651	6,602	20,781	21,344	21,923
TOTAL	541,657	50,617	159,323	163,637	168,080

Contractor Initials DS
EJM
 Date 3/2/2022

Exhibit C-5 Budget - Behavioral Health (Crisis System Evaluator)

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #3 Behavioral Health (Crisis System Evaluator)*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost Enter all costs that will be incurred through this contract/agreement	SFY22	SFY23	SFY24	SFY25
		7/1/21 to 6/30/22	7/1/22 to 6/30/23	7/1/23 to 6/30/24	7/1/24 to 6/30/25
1. Salary/Wages	\$ 70,159	11,294	34,900	23,965	
2. Employee Benefits	\$ 24,135	3,885	12,006	8,244	
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ -				
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ -				
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ -				
12. Subcontracts/Agreements	\$ 514,687	92,970	264,532	157,185	
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 608,980	\$ 108,149	\$ 311,437	\$ 189,394	\$ -
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 91,347	16,222	46,716	28,409	0
TOTAL	700,327	124,372	358,153	217,803	0

Exhibit C-6 Budget - Elderly and Adult Services

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #4 Elderly and Adult Services*
Budget Period: *SFY22 through SFY25*

Line Item	Total Program Cost <i>Enter all costs that will be incurred through this contract/agreement</i>	SFY22	SFY23	SFY24	SFY25
		<i>7/1/21 to 6/30/22</i>	<i>7/1/22 to 6/30/23</i>	<i>7/1/23 to 6/30/24</i>	<i>7/1/24 to 6/30/25</i>
1. Salary/Wages	\$ 103,865	9,844	30,419	31,331	32,271
2. Employee Benefits	\$ 18,384	1,742	5,384	5,546	5,712
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ -				
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ 833	83	250	250	250
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ -				
12. Subcontracts/Agreements	\$ -				
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 123,083	\$ 11,670	\$ 36,053	\$ 37,127	\$ 38,233
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 18,462	1,750	5,408	5,569	5,735
TOTAL	141,545	13,420	41,461	42,696	43,968

Contractor Initials DS
EJM
 Date 3/2/2022

Exhibit C-7 Budget - Developmental Services

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #5 Developmental Services*
Budget Period: *SFY22 through SFY25*

Line Item	Total Program Cost Enter all costs that will be incurred through this contract/agreement	SFY22	SFY23	SFY24	SFY25
		7/1/21 to 6/30/22	7/1/22 to 6/30/23	7/1/23 to 6/30/24	7/1/24 to 6/30/25
1. Salary/Wages	\$ 777,658	73,705	227,750	234,582	241,620
2. Employee Benefits	\$ 155,076	14,698	45,416	46,779	48,182
3. Consultants	\$ -				
4.(a) Equipment - Rental	\$ -				
4.(b) Equipment - Repairs & Maintenance	\$ -				
4.(c) Equipment - Purchase	\$ -				
5.(a) Supplies - Educational	\$ -				
5.(b) Supplies - Lab	\$ -				
5.(c) Supplies - Pharmacy	\$ -				
5.(d) Supplies - Medical	\$ -				
5.(e) Supplies Office	\$ -				
6. Travel	\$ 16,667	1,667	5,000	5,000	5,000
7. Occupancy	\$ -				
9. Software	\$ -				
10. Marketing/Communications	\$ -				
11. Staff Education and Training	\$ 10,500	1,050	3,150	3,150	3,150
12. Subcontracts/Agreements	\$ -				
13. Other (Provide specific details)	\$ -				
Total Direct Costs	\$ 959,900	\$ 91,120	\$ 281,316	\$ 289,511	\$ 297,952
Indirect Cost Rate %	15%				
Total Indirect Costs	\$ 143,985	13,668	42,197	43,427	44,693
TOTAL	1,103,885	104,788	323,514	332,938	342,645

Contractor Initials ^{DS} EJM
 Date 3/2/2022



DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Portfolio
Cost Allocation Services

26 Federal Plaza, Room 3412
New York, NY 10278
PHONE: (212) 264-2069
EMAIL: CAS-NY@psc.hhs.gov

April 26, 2019

Ms. Tina Naimie
Vice President, Corporate Finance
Dartmouth-Hitchcock
One Medical Center Drive
Lebanon, NH 03756

Dear Ms. Naimie:

A copy of an indirect cost rate agreement is being sent to you for signature. This agreement reflects an understanding reached between your organization and a member of my staff concerning the rate(s) that may be used to support your claim for indirect costs on grants and contracts with the Federal Government.

Please have the agreement signed by an authorized representative of your organization and returned to me by email, retaining the copy for your files. Our email address is CAS-NY@psc.hhs.gov. We will reproduce and distribute the agreement to the appropriate awarding organizations of the Federal Government for their use.

An indirect cost rate proposal, together with the supporting information, is required to substantiate your claim for indirect costs under grants and contracts awarded by the Federal Government. Thus, your next proposal based on actual costs for the fiscal year ending 06/30/2020 is due in our office by 12/31/2020.

Sincerely,

Darryl W. Mayes
Deputy Director
Cost Allocation Services

DS
EJM

3/2/2022

HOSPITALS RATE AGREEMENT

EIN: 1020222140A1
 ORGANIZATION:
 Dartmouth-Hitchcock
 Mary Hitchcock Memorial Hospital
 One Medical Center Drive
 Lebanon, NH 03756-

DATE: 04/26/2019
 FILING REF.: The preceding
 agreement was dated
 11/28/2017

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES:		FIXED	FINAL	PROV. (PROVISIONAL)	PRED. (PREDETERMINED)
<u>EFFECTIVE PERIOD</u>					
<u>TYPE</u>	<u>FROM</u>	<u>TO</u>	<u>RATE (%)</u>	<u>LOCATION</u>	<u>APPLICABLE TO</u>
PRED.	07/01/2018	06/30/2021	31.00	On-Site	Other Sponsored Programs
PROV.	07/01/2021	06/30/2024	31.00	On-Site	Other Sponsored Programs

***BASE**

Total direct costs excluding capital expenditures (buildings, individual items of equipment; alterations and renovations), that portion of each subaward in excess of \$25,000; hospitalization and other fees associated with patient care whether the services are obtained from an owned, related or third party hospital or other medical facility; rental/maintenance of off-site activities; student tuition remission and student support costs (e.g., student aid, stipends, dependency allowances, scholarships, fellowships).

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 4/26/2019

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

Fringe Benefits applicable to direct salaries and wages are treated as direct costs.

TREATMENT OF PAID ABSENCES

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims are not made for the cost of these paid absences.

Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or \$5,000.

Your next proposal based upon fiscal year ending 06/30/20 is due by 12/31/20.

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 4/26/2019

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted; such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the cost principles promulgated by the Department of Health and Human Services, and should be applied to the grants, contracts and other agreements covered by these regulations subject to any limitations in A above. The hospital may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:

Dartmouth-Hitchcock

(INSTITUTION)

Tina E. Nacimic

(SIGNATURE)

Tina E. Nacimic

(NAME)

VP Corporate Finance

(TITLE)

May 14, 2019

(DATE)

ON BEHALF OF THE FEDERAL GOVERNMENT:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(AGENCY)

Darryl W. Mayes - S

Digitally signed by Darryl W. Mayes, S
DN: cn=U.S. Gov't, o=U.S. Government, ou=HHS, email=Darryl.W.Mayes@hhs.gov, c=US, postalCode=02033, serialNumber=2000131540,
cn=Darryl W. Mayes, S
Date: 2019.05.28 08:28:38 -0400

(SIGNATURE)

Darryl W. Mayes

(NAME)

Deputy Director, Cost Allocation Services

(TITLE)

4/26/2019

(DATE) 2642

HHS REPRESENTATIVE:

Ryan McCarthy

Telephone:

(212) 264-2069

DS
EJM



New Hampshire Department of Health and Human Services
Exhibit D

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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



New Hampshire Department of Health and Human Services
Exhibit D

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

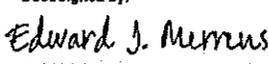
Place of Performance (street address, city, county, state, zip code) (list each location)

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

Vendor Name:

3/2/2022

Date

DocuSigned by:

 Name: Edward J. Merrens
 Title: Chief Clinical Officer

DS

 Vendor Initials
 Date 3/2/2022



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:

3/2/2022

Date

DocuSigned by:

Edward J. Merrens

Name: Edward J. Merrens

Title: chief clinical officer

DS
EJM

Vendor Initials

3/2/2022

Date

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 the attached definitions.
6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.
7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).
9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

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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:

3/2/2022

Date

DocuSigned by:
Edward J. Merrens
Name: Edward J. Merrens
Title: Chief Clinical Officer

Contractor Initials: EJM
Date: 3/2/2022



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

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

New Hampshire Department of Health and Human Services
Exhibit G



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

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

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

Contractor Name:

3/2/2022

Date

DocuSigned by:

Edward J. Merrens

Name: Edward J. Merrens

Title: chief clinical officer

Exhibit G

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

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Contractor Initials

Date 3/2/2022

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:

3/2/2022

Date

DocuSigned by:
Edward J. Merrens
Name: Edward J. Merrens
Title: chief clinical officer

New Hampshire Department of Health and Human Services



Exhibit I

BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement (Form P-37) ("Agreement") agrees, as a Business Associate, to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191, the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162, and 164 (HIPAA), provisions of the HITECH Act, Title XIII, Subtitle D, Parts 1&2 of the American Recovery and Reinvestment Act of 2009, 42 USC 17934, et sec., applicable to business associates, and as applicable, to be bound by the provisions of the Confidentiality of Substance Use Disorder Patient Records, 42 USC s. 290 dd-2, 42 CFR Part 2, (Part 2), as any may be amended from time to time.

(1) Definitions.

- a. "Business Associate" shall mean the Contractor and its agents who receive, use, or have access to protected health information (PHI) as defined in this Business Associate Agreement ("BAA") and the Agreement, and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.
- b. The following terms have the same meaning as defined in HIPAA, the HITECH Act, and Part 2, as they may be amended from time to time:

"Breach," "Covered Entity," "Designated Record Set," "Data Aggregation," "Designated Record Set," "Health Care Operations," "HITECH Act," "Individual," "Privacy Rule," "Required by law," "Security Rule," and "Secretary."

- c. "Protected Health Information" ("PHI") as used in this Agreement means protected health information defined in HIPAA 45 CFR 160.103, limited to the information created, received, or used by Business Associate from or on behalf of Covered Entity, and includes any Part 2 records relating to substance use disorder, if applicable, as defined below.
- d. "Part 2 record" means any patient "Record," relating to a "Patient," and "Patient Identifying Information," as defined in 42 CFR Part 2.11.
- e. "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.

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

- a. Business Associate shall not use, disclose, maintain, store, or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit B, Scope of Services, of the Agreement. Further, Business Associate, including

Exhibit I

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New Hampshire Department of Health and Human Services



Exhibit I

but not limited to all its directors, officers, employees, and agents, shall protect any PHI as required by HIPAA and 42 CFR Part 2, and not use, disclose, maintain, store, or transmit PHI in any manner that would constitute a violation of HIPAA or 42 CFR Part 2.

- b. Business Associate may use or disclose PHI, as applicable:
 - I. For the proper management and administration of the Business Associate;
 - II. As required by law, pursuant to the terms set forth in paragraph c. and d. below;
 - III. According to the HIPAA minimum necessary standard; and
 - IV. For data aggregation purposes for the health care operations of the Covered Entity.

- c. To the extent Business Associate is permitted under the BAA or the Agreement to disclose PHI to any third party or subcontractor, prior to making any disclosure, the Business Associate must obtain, a business associate agreement with the third party or subcontractor, that complies with HIPAA and ensures that all requirements and restrictions placed on the Business Associate as part of this BAA with the Covered Entity, are included in those business associate agreements with the third party or subcontractor.

- d. The Business Associate shall not, disclose any PHI in response to a request or demand for disclosure, such as by a subpoena or court order, on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity can determine how to best protect the PHI. If Covered Entity objects to the disclosure, the Business Associate agrees to refrain from disclosing the PHI and shall cooperate with the Covered Entity in any effort the Covered Entity undertakes to contest the request for disclosure, subpoena, or other legal process. If applicable relating to Part 2 records, the Business Associate shall resist any efforts to access part 2 records in any judicial proceeding.

(3) Obligations and Activities of Business Associate.

- a. Business Associate shall implement appropriate safeguards to prevent unauthorized use or disclosure of all PHI in accordance with HIPAA Privacy Rule and Security Rule with regard to electronic PHI, and Part 2, as applicable.

- b. The Business Associate shall immediately notify the Covered Entity's Privacy Officer at the following email address, DHHSPrivacyOfficer@dhhs.nh.gov after the Business Associate has determined that any use or disclosure not provided for by its contract, including any known or suspected privacy or security incident or breach has occurred potentially exposing or compromising the PHI. This includes inadvertent or accidental uses or disclosures or breaches of unsecured protected health information.

- c. In the event of a breach, the Business Associate shall comply with the terms of this Business Associate Agreement, all applicable state and federal laws and regulations and any additional requirements of the Agreement.

Exhibit I

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New Hampshire Department of Health and Human Services

Exhibit I

- d. The Business Associate shall perform a risk assessment, based on the information available at the time it becomes aware of any known or suspected privacy or security breach as described above and communicate the risk assessment to the Covered Entity. The risk assessment shall include, but not be limited to:
 - I. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
 - II. The unauthorized person who accessed, used, disclosed, or received the protected health information;
 - III. Whether the protected health information was actually acquired or viewed; and
 - IV. How the risk of loss of confidentiality to the protected health information has been mitigated.
- e. The Business Associate shall complete a risk assessment report at the conclusion of its incident or breach investigation and provide the findings in a written report to the Covered Entity as soon as practicable after the conclusion of the Business Associate's investigation.
- f. 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 US Secretary of Health and Human Services for purposes of determining the Business Associate's and the Covered Entity's compliance with HIPAA and the Privacy and Security Rule, and Part 2, if applicable.
- g. Business Associate shall require all of its business associates that receive, use or have access to PHI under the BAA or 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)n, and an agreement that the Covered Entity shall be considered a direct third party beneficiary of the Business Associate's business associate agreements with Business Associate's intended business associates, who will be receiving PHI pursuant to this BAA, with rights of enforcement and indemnification from such business associates who shall be governed by standard provision #13 of this Agreement for the purpose of use and disclosure of protected health information.
- h. Within ten (10) 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 BAA and the Agreement.
- i. 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.

Exhibit I

Contractor Initials

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New Hampshire Department of Health and Human Services

Exhibit I

- j. 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.
- k. Business Associate shall document any disclosures of PHI and information related to any 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.
- l. 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.
- m. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within five (5) 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.
- n. Within thirty (30) 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-ups of such PHI in any form or platform.
 - i. 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 as long as the Business 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. A current version of Covered Entity's Notice of Privacy

Exhibit I

Contractor Initials

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New Hampshire Department of Health and Human Services

Exhibit I

Practices and any changes thereto will be posted on the Covered Entity's website:
<https://www.dhhs.nh.gov/oos/hipaa/publications.htm>

- 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 BAA, 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 of Agreement for Cause

In addition to Paragraph 9 of the General Provisions (P-37) of the Agreement, the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a material breach by Business Associate of the Business Associate Agreement. 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.

(6) Miscellaneous

- a. Definitions, Laws, and Regulatory References. All laws and regulations used, herein, shall refer to those laws and regulations as amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in HIPAA or 42 Part 2, 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 BAA, from time to time as is necessary for Covered Entity and/or Business Associate to comply with the changes in the requirements of HIPAA, 42.CFR Part 2 other 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 BAA and the Agreement shall be resolved to permit Covered Entity and the Business Associate to comply with HIPAA and 42 CFR Part 2.

Exhibit I

Health Insurance Portability Act
Business Associate Agreement

Contractor Initials DS
EJM

Date 3/2/2022



New Hampshire Department of Health and Human Services

Exhibit I

- e. Segregation. If any term or condition of this BAA 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 BAA regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the BAA in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the General Provisions (P-37) of the Agreement, shall survive the termination of the BAA

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

Department of Health and Human Services

 The State
 DocuSigned by:
Lori A. Weaver

 Signature of Authorized Representative
 Lori A. Weaver

 Name of Authorized Representative
 Deputy Commissioner

 Title of Authorized Representative
 3/2/2022

 Date

Dartmouth-Hitchcock Health

 Name of the Contractor
 DocuSigned by:
Edward J. Merrens

 Signature of Authorized Representative
 Edward J. Merrens

 Name of Authorized Representative
 Chief Clinical officer

 Title of Authorized Representative
 3/2/2022

 Date

Exhibit I

Contractor Initials DS
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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:

3/2/2022

Date

DocuSigned by:

Edward J. Merrens

Name: Edward J. Merrens

Title: chief clinical officer



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: QYLXERHDAQL4

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

NO YES

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

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

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

NO YES

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

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

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

Name: _____	Amount: _____

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

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



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

April, 2020

Contractor Initials ^{DS}
EJM

Date 3/2/2022

**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.

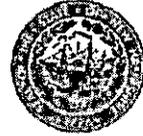
II. METHODS OF SECURE TRANSMISSION OF DATA

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

April, 2020

Contractor Initials DS
EJM
Date 3/2/2022

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

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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

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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

April, 2020

Contractor Initials

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EJM

Date 3/2/2022

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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/doiit/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

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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