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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEW HAMPSHIRE HOSPITAL

Lori A. Weaver
Commissioner

Ellen M. Lapointe
Chief Executive Officer

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January 14, 2025

Her Excellency, Governor Kelly A. Ayotte
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, New Hampshire Hospital, to enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital, for itself and on behalf of Dartmouth-Hitchcock Clinic (VC# 177160), Lebanon, NH, in the amount of \$25,000 for electroencephalogram (EEG) interpretation services, with the option to renew for up to four (4) additional years, effective upon Governor and Council approval through December 31, 2026. 30% General Funds. 70% Other Funds (Provider Fees).

Funds are available in the following account for State Fiscal Year 2025 and are anticipated to be available in State Fiscal Year 2026 and 2027, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

**05-95-94-940010-87500000 Health and Social Services, Health and Human Services
Department of, HHS: New Hampshire Hospital, New Hampshire Hospital, Acute
Psychiatric Services**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2025	102-500731	Contracts for Program Services	94057300	\$10,000
2026	102-500731	Contracts for Program Services	94057300	\$10,000
2027	102-500731	Contracts for Program Services	94057300	\$5,000
			Total	\$25,000

EXPLANATION

The Contractor currently provides testing services that ensure safety, efficiency, and timely results, significantly benefiting patient care. The vendor-owned testing equipment remains onsite in a designated space at NHH, allowing patients to undergo testing safely and securely within the hospital. Familiar staff and providers conduct the testing, enhancing comfort and continuity of care for patients. This request will allow EEG results to be promptly interpreted by the Contractor, integrated into the patient's electronic health record, and shared with the patient through their treatment team, which allows for timely decision making as it relates to any changes in care delivery. This request is therefore **Sole Source** because these streamlined processes and efficiencies cannot be replicated by an alternative vendor.

The purpose of this request is to provide neurophysiological interpretation of EEG tests for patients at New Hampshire Hospital. New Hampshire Hospital providers will perform the EEG testing and send the files to the Contractor for interpretation. EEG tests are performed to help identify psychosis, stroke, brain injury, tumor, infections, drug overuse, epilepsy, sleep disorders and dementia.

Approximately 50 individuals will be served during State Fiscal Years 2025, 2026 and 2027.

The Department will monitor services by reviewing reports provided by the Contractor for each EEG interpretation. The reports will include:

- A written summary of the EEG interpretation.
- Treatment plan recommendations.
- A medical necessity assessment for any procedures that are recommended.

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 may not be able to obtain interpretation of EEG tests by a neurophysiologist as efficiently for patients at New Hampshire Hospital.

Area served: New Hampshire Hospital.

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

Respectfully submitted,



Lori A. Weaver
Commissioner

Subject: Electroencephalogram Interpretation Services SS-2025-NHH-05-ELECT-01

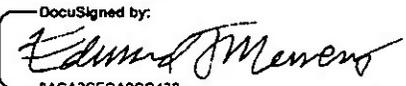
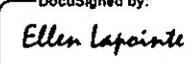
Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

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, for itself and on behalf of Dartmouth-Hitchcock Clinic		1.4 Contractor Address 1 Medical Center Drive Lebanon, NH 03756	
1.5 Contractor Phone Number 603-229-5200	1.6 Account Unit and Class 05-95-94-940010-87500000-10 2-500731	1.7 Completion Date 12/31/2026	1.8 Price Limitation \$25,000
1.9 Contracting Officer for State Agency Robert W. Moore, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by:  ate:12/5/2024 <small>BACA3CFCADCC438...</small>		1.12 Name and Title of Contractor Signatory Edward J. Merrens Chief Clinical Officer	
1.13 State Agency Signature DocuSigned by:  Date:12/13/2024 <small>48806801FCE8428...</small>		1.14 Name and Title of State Agency Signatory Ellen Lapointe Chief Executive Officer	
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:  On: 12/16/2024 <small>48734844941160...</small>			
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, 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.

3.3 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. 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 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, 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 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. 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.

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 The State's liability under this Agreement shall be limited to monetary damages not to exceed the total fees paid. The Contractor agrees that it has an adequate remedy at law for any breach of this Agreement by the State and hereby waives any right to specific performance or other equitable remedies against the State.

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 and the Governor's order on Respect and Civility in the Workplace, Executive order 2020-01. 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 age, sex, sexual orientation, race, color, marital status, physical or mental disability, religious creed, national origin, gender identity, or gender expression, and will take affirmative action to prevent such discrimination, unless exempt by state or federal law. The Contractor shall ensure any subcontractors comply with these nondiscrimination requirements.

6.3 No payments or transfers of value by Contractor or its representatives in connection with this Agreement have or shall be made which have the purpose or effect of public or commercial bribery, or acceptance of or acquiescence in extortion, kickbacks, or other unlawful or improper means of obtaining business.

6.4. 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 this Agreement and all rules, regulations and orders pertaining to 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 The Contracting Officer specified in block 1.9, or any successor, shall be the State's point of contact pertaining to this Agreement.

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) calendar days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) calendar 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.

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) calendar 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) calendar 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. In addition, at the State's discretion, the Contractor shall, within fifteen (15) calendar days of notice of early termination, develop and submit to the State a transition plan for Services under the Agreement.

10. PROPERTY OWNERSHIP/DISCLOSURE.

10.1 As used in this Agreement, the word "Property" shall mean all data, 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 Disclosure of data, information and other records shall be governed by N.H. RSA chapter 91-A and/or other applicable law. Disclosure 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 Contractor shall provide the State written notice at least fifteen (15) calendar days before any proposed assignment, delegation, or other transfer of any interest in this Agreement. No such assignment, delegation, or other transfer shall be effective without the written consent of the State.

12.2 For purposes of paragraph 12, 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.

12.3 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State.

12.4 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. The Contractor shall indemnify, defend, and hold harmless the State, its officers, and employees from and against all actions, claims, damages, demands, judgments, fines, liabilities, losses, and other expenses, including, without limitation, reasonable attorneys' fees, arising out of or relating to this Agreement directly or indirectly arising from death, personal injury, property damage, intellectual property infringement, or other claims asserted against the State, its officers, or employees caused by the acts or omissions of negligence, reckless or willful misconduct, or fraud by the Contractor, its employees, agents, or subcontractors. 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 State's sovereign immunity, 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 any successor, a certificate(s) of insurance for all insurance required under this Agreement. At the request of the Contracting Officer, or any successor, the Contractor shall provide certificate(s) of insurance for all renewal(s) of insurance required under this Agreement. 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 any successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. A State's failure to enforce its rights with respect to any single or continuing breach of this Agreement shall not act as a waiver of the right of the State to later enforce any such rights or to enforce any other or any subsequent breach.

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

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

19. CHOICE OF LAW AND FORUM.

19.1 This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire except where the Federal supremacy clause requires otherwise. 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.

19.2 Any actions arising out of this Agreement, including the breach or alleged breach thereof, may not be submitted to binding arbitration, but must, instead, be brought and maintained in the Merrimack County Superior Court of New Hampshire which shall have exclusive jurisdiction thereof.

20. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and any other portion of this Agreement including any attachments thereto, the terms of the P-37 (as modified in EXHIBIT A) shall control.

21. THIRD PARTIES. This Agreement is being entered into for the sole benefit of the parties hereto, and nothing herein, express or implied, is intended to or will confer any legal or equitable right, benefit, or remedy of any nature upon any other person.

22. 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.

23. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

24. FURTHER ASSURANCES. The Contractor, along with its agents and affiliates, shall, at its own cost and expense, execute any additional documents and take such further actions as may be reasonably required to carry out the provisions of this Agreement and give effect to the transactions contemplated hereby.

25. 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.

26. 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
Electroencephalogram Interpretation 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 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 9, Termination, is amended to read:

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by 30 calendar days' written notice to the Contractor that the State is exercising its option to terminate the Agreement. The Contractor may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by one hundred and twenty (120) calendar days' written notice to the State that the Contractor 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 thirty (30) calendar 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. In addition, at the State's discretion, the Contractor shall, within thirty (30) calendar days of notice of early termination, develop and submit to the State a transition plan for Services under the Agreement.

1.3. 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.

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT A

- 1.4. 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.
- 1.5. 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. These insurance requirements may be satisfied through a program of self-insurance.

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT B

Scope of Services

1. Statement of Work

- 1.1. The Contractor must provide remote Electroencephalogram (EEG) Interpretation Services upon request of New Hampshire Hospital and receipt of the EEG scan by encrypted email.
- 1.2. The Contractor must ensure each EEG interpretation is conducted by a licensed physician with proficiency in clinical neurophysiology and certification by the American Board of Clinical Neurophysiology.
- 1.3. The Contractor must complete each requested EEG interpretation no later than five (5) business days after receiving the request.
- 1.4. The Contractor must participate in meetings with the Department on an as-needed basis, as requested by the Department.

1.5. Reporting

- 1.5.1. The Contractor must submit a report for each completed EEG interpretation to the Department by secure fax transmission that is auto routed to a preconfigured and tested fax number/destination, to be approved by the Department. Each report must include a written summary of the EEG interpretation.
- 1.5.2. The Contractor may be required to provide other key data and metrics to the Department in a format specified by the Department.

1.6. Confidential Data

- 1.6.1. The Contractor must meet all information security and privacy requirements as set by the Department and in accordance with the Department's Information Security Requirements Exhibit as referenced below.
- 1.6.2. The Contractor must ensure any individuals involved in delivering services through this Agreement contract sign an attestation agreeing to access, view, store, and discuss Confidential Data in accordance with federal and state laws and regulations and the Department's Information Security Requirements Exhibit. The Contractor must ensure said individuals have a justifiable business need to access confidential data. The Contractor must provide attestations upon Department request.

1.7. Privacy Impact Assessment

- 1.7.1. Upon request, the Contractor must allow and assist the Department in conducting a Privacy Impact Assessment (PIA) of its system(s)/application(s)/web portal(s)/website(s) or Department system(s)/application(s)/web portal(s)/website(s) hosted by the Contractor, if Personally Identifiable Information (PII) is collected, used,

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT B

accessed, shared, or stored. To conduct the PIA the Contractor must provide the Department access to applicable systems and documentation sufficient to allow the Department to assess, at minimum, the following:

- 1.7.1.1. How PII is gathered and stored;
 - 1.7.1.2. Who will have access to PII;
 - 1.7.1.3. How PII will be used in the system;
 - 1.7.1.4. How individual consent will be achieved and revoked; and
 - 1.7.1.5. Privacy practices.
- 1.7.2. The Department may conduct follow-up PIAs in the event there are either significant process changes or new technologies impacting the collection, processing or storage of PII.

2. Exhibits Incorporated

- 2.1. The Contractor must manage all confidential data related to this Agreement in accordance with the terms of Exhibit D, DHHS Information Security Requirements.
- 2.2. The Contractor must 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 E, Business Associate Agreement, which has been executed by the parties.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

- 3.1.1. 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.

3.2. Credits and Copyright Ownership

- 3.2.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement must 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

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT B

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

- 3.2.2. All materials produced or purchased under the Agreement must have prior approval from the Department before printing, production, distribution or use.
- 3.2.3. The Department must retain copyright ownership for any and all original materials produced, including, but not limited to:
 - 3.2.3.1. Brochures.
 - 3.2.3.2. Resource directories.
 - 3.2.3.3. Protocols or guidelines.
 - 3.2.3.4. Posters.
 - 3.2.3.5. Reports.
- 3.2.4. The Contractor must not reproduce any materials produced under the Agreement without prior written approval from the Department.

4. Records

4.1. The Contractor must keep records that include, but are not limited to:

- 4.1.1. 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 Contract, and all income received or collected by the Contractor.
- 4.1.2. 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.
- 4.1.3. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department and any of their designated representatives must have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts.

4.3. If, upon review of the Final Expenditure Report the Department must disallow any expenses claimed by the Contractor as costs hereunder, the Department retains the right, at its discretion, to deduct the amount of such expenses disallowed or to recover such sums from the Contractor.

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
 - 1.1. 30% General funds.
 - 1.2. 70% Other funds (Provider Fees).
2. For the purposes of this Agreement the Department has identified the Contractor as a Contractor, based on criteria in 2 CFR 200.331.
3. Payment shall be for services provided in the fulfillment of this Agreement, as specified in Exhibit B Scope of Work, will be at the rate allowable be at the current Medicaid Rate for Services, NH Fee Schedule-Covered Procedures Report, as published by the New Hampshire Department of Health and Human Services as NH MMIS AD HOC Reports, Report ID# ADH-REF-101, as the same may be amended from time to time, for each Electroencephalogram interpretation completed by the Contractor. Report ID# ADH-REF-101 is published on the Department's website at: New Hampshire MMIS Health Enterprise Portal (nh.gov) on page ADH-REF-101 (nh.gov).
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
 - 4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
 - 4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
 - 4.3. Identifies and requests payment for allowable costs incurred in the previous month.
 - 4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
 - 4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
 - 4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to NHHFinancialServices@dhhs.nh.gov or mailed to:

Financial Manager
Department of Health and Human Services
New Hampshire Hospital
36 Clinton Street
Concord, NH 03301

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT C

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.
6. The final invoice and supporting documentation for authorized expenses 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.
7. Notwithstanding Paragraph 18 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.
8. Audits
 - 8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:
 - 8.1.1. 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.
 - 8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b.
 - 8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.
 - 8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.
 - 8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.
 - 8.3. 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.

**New Hampshire Department of Health and Human Services
Electroencephalogram Interpretation Services**

EXHIBIT C

- 8.4. Any Contractor that receives an amount equal to or greater than \$250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA upon request.
- 8.5. In addition to, and not in any way in limitation of obligations of the Agreement, 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 Agreement to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services

Exhibit D

BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement (Form P-37) ("Agreement"), and any of its agents who receive use or have access to protected health information (PHI), as defined herein, shall be referred to as the "Business Associate." The State of New Hampshire, Department of Health and Human Services, "Department" shall be referred to as the "Covered Entity," The Contractor and the Department are collectively referred to as "the parties."

The parties agree, 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 of these laws and regulations may be amended from time to time.

(1) Definitions.

- a. The following terms shall have the same meaning as defined in HIPAA, the HITECH Act, and Part 2, as they may be amended from time to time:
 - "Breach," "Designated Record Set," "Data Aggregation," "Designated Record Set," "Health Care Operations," "HITECH Act," "Individual," "Privacy Rule," "Required by law," "Security Rule," and "Secretary."
- b. Business Associate Agreement, (BAA) means the Business Associate Agreement that includes privacy and confidentiality requirements of the Business Associate working with PHI and as applicable, Part 2 record(s) on behalf of the Covered Entity under the Agreement.
- c. "Constructively Identifiable," means there is a reasonable basis to believe that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information.
- d. "Protected Health Information" ("PHI") as used in the Agreement and the BAA, 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, if applicable, as defined below.
- e. "Part 2 record" means any patient "Record," relating to a "Patient," and "Patient Identifying Information," as defined in 42 CFR Part 2.11.
- f. "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 the Agreement. Further, Business Associate, including but not limited to all its directors,

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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, according to the terms set forth in paragraph c. and d. below;
 - III. According to the HIPAA minimum necessary standard;
 - IV. For data aggregation purposes for the health care operations of the Covered Entity; and
 - V. Data that is de-identified or aggregated and remains constructively identifiable may not be used for any purpose outside the performance of the Agreement.
- 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.
- 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;

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- 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 to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein and an agreement that the Covered Entity shall be considered a direct third party beneficiary of all the Business Associate's business associate agreements.
 - 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.
 - 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)

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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, or if retention is governed by state or federal law, 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

Covered Entity shall post a current version of the Notice of the Privacy Practices on the Covered Entity's website: <https://www.dhhs.nh.gov/oos/hipaa/publications.htm> in accordance with 45 CFR Section 164.520.

- a. 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.
- b. 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 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 D, to a Section in HIPAA or 42 Part 2, means the Section as in effect or as amended.

- b. Change in law. Covered Entity and Business Associate agree to take such action as is necessary from time to time for the Covered Entity and/or Business Associate to

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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.
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 BAA 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) n.l., the defense and indemnification provisions of section (3) g. 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 Business Associate Agreement.

Department of Health and Human Services
The State

DocuSigned by: Ellen Lapointe
Signature of Authorized Representative

Ellen Lapointe
Name of Authorized Representative

Chief Executive Officer
Title of Authorized Representative

12/13/2024
Date

Mary Hitchcock Memorial Hospital, for itself and on behalf of Dartmouth-Hitchcock Clinic

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

12/5/2024
Date

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Date 12/5/2024

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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 any 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 E) means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

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

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.
5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.
6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents



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include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic documents or mail.

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

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

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

II. METHODS OF SECURE TRANSMISSION OF DATA

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

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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 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS Confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently supported and hardened operating systems, current, updated, and maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.
6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

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B. Disposition

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

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

IV. PROCEDURES FOR SECURITY

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

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).
3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.
4. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will ensure End-User will maintain an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

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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, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.
8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.
9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable health information and as applicable under State law.
10. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at <https://www.nh.gov/doit/vendor/index.htm> for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.
11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer, and additional email addresses provided in this section, of any security breach within 24-hours of the time that



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the Contractor learns of its occurrence. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

12. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.
13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit E.

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

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches within 24- hours of the time that the Contractor learns of their occurrence.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with the HIPAA, Privacy and Security Rules. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

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

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

New Hampshire Department of Health and Human Services

Exhibit E



VI. PERSONS TO CONTACT

- A. DHHS contact program and policy:
(Insert Office or Program Name)
(Insert Title)
DHHS-Contracts@dhhs.nh.gov
- B. DHHS contact for Data Management or Data Exchange issues:
DHHSInformationSecurityOffice@dhhs.nh.gov
- C. DHHS contacts for Privacy issues:
DHHSPrivacyOfficer@dhhs.nh.gov
- D. DHHS contact for Information Security issues:
DHHSInformationSecurityOffice@dhhs.nh.gov
- E. DHHS contact for Breach notifications:
DHHSInformationSecurityOffice@dhhs.nh.gov
DHHSPrivacyOfficer@dhhs.nh.gov

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: 0006776481



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 12th day of September A.D. 2024.

A handwritten signature in black ink, appearing to read "D. Scanlan", is written over a circular embossed mark.

David M. Scanlan
Secretary of State

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 DARTMOUTH-HITCHCOCK CLINIC is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on March 01, 1983. 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: 69168

Certificate Number: 0006776484



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 12th day of September 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 25th day of November, 2024.

A handwritten signature in black ink, appearing to read "Roberta L. Hines", written over a horizontal line.

Roberta L. Hines, MD, Board Chair

DATE: July 1 2024

CERTIFICATE OF INSURANCE

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

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

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

COVERAGES

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

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002024-A	7/1/2024	7/1/2025	EACH OCCURRENCE	\$1,000,000
					DAMAGE TO RENTED PREMISES	\$1,000,000
	X CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	\$1,000,000
					GENERAL AGGREGATE	\$3,000,000
OTHER					PRODUCTS-COMP/OP AGG	\$1,000,000
PROFESSIONAL LIABILITY		0002024-A	7/1/2024	7/1/2025	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



About Dartmouth Hitchcock Medical Center and 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 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 2021, 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 for high performance in 11 clinical specialties, 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 51 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 black ink, appearing to read "Priscilla A. Cooper, CPA".

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>	2023	2022
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	(13)	(23)
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	(18,653)	(17,467)
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	833,800	942,897
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	193,485	396,975
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	1,325	206
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 (APO) 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 APO 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.

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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)

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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 FASS 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		
	PPS	CAH	Total
Hospital			
Medicare	\$ 587,377	\$ 106,370	\$ 693,747
Medicaid	168,410	18,824	187,234
Commercial	862,502	88,492	950,994
Self-pay	11,307	802	12,109
Subtotal	<u>1,629,596</u>	<u>214,488</u>	<u>1,844,084</u>
Professional	504,370	35,578	539,948
Subtotal	<u>2,133,966</u>	<u>250,066</u>	<u>2,384,032</u>
Home based care			13,125
Subtotal			<u>2,397,157</u>
Other revenue			706,242
Provider Relief Funds			1,822
Total operating revenue and other support			<u>\$ 3,105,221</u>
<i>(in thousands of dollars)</i>	2022		
	PPS	CAH	Total
Hospital			
Medicare	\$ 542,292	\$ 99,976	\$ 642,268
Medicaid	158,121	15,739	173,860
Commercial	809,736	81,395	891,131
Self-pay	7,027	902	7,929
Subtotal	<u>1,517,176</u>	<u>198,012</u>	<u>1,715,188</u>
Professional	470,559	40,186	510,745
Subtotal	<u>1,987,735</u>	<u>238,198</u>	<u>2,225,933</u>
Home based care			17,304
Subtotal			<u>2,243,237</u>
Other revenue			528,762
Provider Relief Funds			98,829
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	<u>100%</u>	<u>100%</u>

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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>	2023	2022
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	\$ 624,238	\$ 629,448	\$ 1,253,686

<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	\$ 736,448	\$ 619,762	\$ 1,356,210

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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>	2023	2022
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	1,101,410	1,042,582
Subtotal property, plant, and equipment	<u>2,404,106</u>	<u>2,276,053</u>
Less accumulated depreciation	1,592,484	1,511,213
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			Total
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</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	507,821	116,417		624,238
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	132,841			132,841
Beneficial interest in trusts			14,875	14,875
Total assets	\$ 640,662	\$ 116,417	\$ 14,875	\$ 771,954

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<i>(in thousands of dollars)</i>	2022			
	<u>Level1</u>	<u>Level2</u>	<u>Level3</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>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>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>	2023	2022
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		
<i>(in thousands of dollars)</i>	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	\$ -	\$ 111,843	\$ 111,843
Board-designated endowment funds	28,688		28,688
Total endowed net assets	\$ 28,688	\$ 111,843	\$ 140,531

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

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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		13,954	
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		14,903	
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>	2023	2022
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 20188, 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 20178, 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 20148, principal maturing in varying annual amounts, through August 2033 (7)	14,530	14,530
Series 20168, 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	32	55
Total nonobligated group debt	<u>2,607</u>	<u>2,719</u>
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	6,453	6,806
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 APO. The members of the obligated group at June 30, 2022 consisted of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and APO. 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	15,820	13,139
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	<u>(177,006)</u>	<u>(191,791)</u>
Less: Current portion of liability for pension		
Long-term portion of liability for pension	<u>(177,006)</u>	<u>(191,791)</u>
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 ("LOI") 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 LOI strategy will hedge approximately 70% of the interest rate risk associated with pension liabilities. As of June 30, 2022, the expected LOI 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>Level1</u>	<u>Level2</u>	<u>Level3</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>Level1</u>	<u>Level2</u>	<u>Level3</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>		

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

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		
	<u>Hedge Funds</u>	<u>Equity Funds</u>	<u>Total</u>
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>
	2022		
	Private		
	<u>Hedge Funds</u>	<u>Equity Funds</u>	<u>Total</u>
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.

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

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

	2023	2022
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	62	752
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		(33)
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>	2023	2022
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, APO, 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:

	2023		
		RRG	Total
<i>(in thousands of dollars)</i>			
Assets	\$ 93,777	\$ 2,372	\$ 96,149
Shareholders' equity	13,620	50	13,670
	2022		
		RRG	Total
<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:

<i>(in thousands of dollars)</i>	2023			
	<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>
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>	Program Services	Management and General	Fundraising	Total
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>
	Program Services	Management and General	Fundraising	Total
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>	2023	2022
Operating lease cost	\$ 9,590	\$ 9,573
Variable and short term lease cost (a)	10,608	10,894
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	546	448
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>	2023	2022
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	3,599	3,255
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>	2023	2022
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	<u>25,386</u>	<u>32,207</u>
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	<u>20,285</u>	<u>16,617</u>
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	11,340	15,043
Total lease payments	<u>36,225</u>	<u>29,114</u>
Less: Imputed interest	3,040	5,294
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. 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	\$ 2,375	\$ 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	136,937	832,895	13,089	17,990	25,786	(16,760)	1,009,937	61,525		1,071,462
Notes receivable, related party	843,946	14,308	588			(844,777)	14,065	(588)	(13,477)	
Other investments for restricted activities	5	126,671	2,632	3,206	7,208		139,722	42,502		182,224
Property, plant, and equipment, net		624,394	27,724	44,547	16,260		712,925	98,697		811,622
Right-of-use assets, net	344	32,819	14,967	286	4,897		53,313	2,215		55,528
Other assets	1,943	168,736	13,798	6,622	4,688		195,787	(2,454)		193,333
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	\$	\$ 15,236
Current portion of right-of-use obligations	204	9,136	759	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	151,473	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		28,560	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	14,786	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	55,098	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	83,708	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	56,396	(40)	210,333
Total net assets	(60,863)	614,616	86,339	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	136,937	860,436	13,376	17,990	27,090	13,089	19,304	(16,760)	1,071,462
Notes receivable, related party	843,946	14,308						(858,254)	
Other investments for restricted activities	5	134,091	34,711	3,206	7,209	2,911	91		182,224
Property, plant, and equipment, net		627,070	72,289	44,547	17,593	44,435	5,688		811,622
Right-of-use assets, net	344	32,819	2,145	286	4,898	14,967	69		55,528
Other assets	1,943	168,902	7,130	6,622	2,231	6,505			193,333
Total assets	\$ 1,005,102	\$ 2,291,551	\$ 164,319	\$ 118,204	\$ 80,503	\$ 145,198	\$ 29,367	\$ (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		137,467
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	\$ 29,367	\$ (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	MI 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	\$	\$ 191,925
Patient accounts receivable, net		206,400	18,106	9,817	9,175	5,360		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	1,362	35,321	1,830	14,892	166	5,249		734,387	30,453		764,840
Other assets	681	146,516	1,187	14,391	6,573	4,983		58,820	105		58,925
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	60		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	16,607	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		189,383	1,177		190,560
Estimated third-party settlements	3,002	68,876	22,999	17,488	21,886	647		134,898			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	21,867	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		129,092	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	53,646	54,590	48,974	31,078		580,905	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	18,106	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	58,902	42,094	18,561	60,389	4,110	(33,344)	612,312
Assets limited as to use	301,000	884,007	13,183	16,005	26,979	14,680	24,088	(98,848)	1,181,094
Notes receivable, related party	842,052	11,557						(853,609)	
Other investments for restricted activities	490	125,614	37,124	3,925	6,846	1,031	86		175,116
Property, plant, and equipment, net		587,739	66,385	45,973	16,947	42,436	5,360		764,840
Right-of-use assets, net	1,362	35,321	1,830	166	5,248	14,892	106		58,925
Other assets	681	146,699	8,316	6,573	2,526	7,292	76		172,163
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	22,999	21,886	647	17,488			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	MLAscutney 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	578,965	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	Cheshire 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	262,266	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	53,203	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	\$ 9,096	\$ (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	(60,573)	77,293	458	(85)	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	39,026	2,390,775	261,325	104,005	87,493	65,519	(111,284)	2,836,859	35,229	(1,260)	2,870,828
Operating expenses											
Salaries		1,091,601	135,083	43,266	40,219	28,960	(45,229)	1,293,900	20,422	1,085	1,315,407
Employee benefits		266,795	31,761	10,302	7,537	8,240	(5,842)	318,793	3,514	263	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)	394,274	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	25,365	914	876	1,073	493	(29,530)	31,727	386		32,113
Total operating expenses	58,174	2,403,394	271,923	90,160	79,496	63,969	(113,463)	2,853,653	39,716	(462)	2,892,907
Operating (loss) margin	(19,148)	(12,619)	(10,598)	13,845	7,997	1,550	2,179	(16,794)	(4,487)	(798)	(22,079)
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 other 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	(6,658)
Total non-operating (losses) gains, net	(11,566)	(48,712)	(602)	(795)	(1,113)	(1,386)	(2,179)	(66,353)	(5,937)	798	(71,492)
(Deficiency) excess of revenue over expenses	(30,714)	(61,331)	(11,200)	13,050	6,884	164		(83,147)	(10,424)		(93,571)
Net assets without donor restrictions											
Net assets released from restrictions for capital		678	52		460	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	\$ (23,114)	\$ (107,898)	\$ (11,578)	\$ 15,621	\$ 9,417	\$ 1,240	\$	\$ (116,312)	\$ (8,018)	\$	\$ (124,330)

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	APDand Subsidiary	VNH and Subsidiaries	Eliminations	Health 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		(60,659)	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	25,365	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)	(4,496)		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>

Celestina "Tina" M. Dooley-Jones, PhD
Retired Senior Foreign Service Officer

Nancy M. Dunbar, MD
Medical Director, Blood Bank
Department of Pathology and Laboratory Medicine

Roberta L. Hines, MD
MHMH/DHC Boards' Chair
Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine

Keith J. Loud, MD - beginning in March 2024
Chair, Department of Pediatrics and Adolescent Medicine

Jennifer L. Moyer, MBA
Managing Director & CAO, White Mountains Insurance Group, Ltd

Sherri C. Oberg, MBA
CEO and Co-Founder of Particles for Humanity, PBC

David P. Paul, MBA
MHMH/DHC Boards' Secretary & Treasurer
Retired President & COO, JBG SMITH

Mark S. Speers, MBA
Co-founder & Senior Advisor, Health Advances, LLC

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
Director, Executive Administration and Exec/Governance
One Medical Center Drive, Lebanon, NH 03756
kimberley.a.gibbs@hitchcock.org

Administrative Support:

Claire M. Lillie
Exec. Coordinator for Exec/Governance & Leadership
claire.m.lillie@hitchcock.org

Laura K. Rondeau
Exec. Coordinator for Exec/Governance & Leadership
laura.k.rondeau@hitchcock.org

Brian Fidali, MD

Dartmouth Hitchcock Medical Center
Neurology Division: Epilepsy (Floor 4)
1 Medical Center Drive
Lebanon, NH 03756

Prepared: June 14, 2024

1 EDUCATION

MD with Honors in Research <i>Weill Cornell Medical College, New York, NY</i>	08/2012 – 06/2017
Certificate in Clinical & Translational Investigation <i>Weill Cornell Medical College, New York, NY</i>	09/2015 – 08/2016
Bachelor of Arts Intensive music major, with distinction, <i>cum laude</i> <i>Yale University, New Haven, CT</i>	09/2007 – 05/2011

2 POSTGRADUATE TRAINING

ACGME Epilepsy Fellowship <i>NewYork-Presbyterian Hospital/Columbia, New York, NY</i>	07/2022 – 06/2023
ACGME Clinical Neurophysiology Fellowship (EEG track) <i>NewYork-Presbyterian Hospital/Columbia, New York, NY</i>	07/2021 – 06/2022
Neurology Residency <i>NewYork-Presbyterian Hospital/Columbia, New York, NY</i>	07/2018 – 06/2021
Medical Internship <i>NewYork-Presbyterian Hospital/Columbia, New York, NY</i>	06/2017 – 06/2018

3 ACADEMIC APPOINTMENTS

Assistant Professor of Neurology <i>Dartmouth Geisel School of Medicine, Hanover, NH</i>	08/2023 – present
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Brian Fidali, MD

4 LICENSURE & BOARD CERTIFICATION

4.1 LICENSURE

New Hampshire
Vermont

08/2023 – present
(application pending)

4.2 BOARD CERTIFICATIONS

American Board of Psychiatry and Neurology: **Neurology**
American Board of Psychiatry and Neurology: **Clinical Neurophysiology**
American Board of Psychiatry and Neurology: **Epilepsy**

09/2021
10/2023
Expected Fall 2024

5 PROFESSIONAL ORGANIZATIONS & SOCIETIES

Member, *American Epilepsy Society*
Member, *American Clinical Neurophysiology Society*
Member, *Eastern Association of Encephalographers*
Member, *American Society of Neurophysiological Monitoring*

6 GRANT SUPPORT

NIH TL1 Training Award

06/2014 – 05/2015

Source: National Institutes of Health: Clinical & Translational Science Awards
Title: "EEG correlates of music processing in disorders of consciousness"
Role: Trainee / Co-Investigator
Award: \$23,476
Institution: *Weill Cornell Medical College, New York, NY*

NIH T32 Institutional National Research Service Award

06/2013 – 09/2013

Funding: National Institutes of Health: Clinical & Translational Science Awards
Title: "Using EEG power spectra to identify differential cerebral responses to music and language stimuli in the minimally conscious state"
Role: Trainee
Award: \$1,500
Institution: *Weill Cornell Medical College, New York, NY*

CREATE Award in Auditory Cognitive Neuroscience

05/2011 – 09/2011

Funding: National Science and Engineering Research Council of Canada
Project: "Neuromagnetic representations of timing processes associated with reversals of duple and triple meter in hemiola patterns"
Role: Trainee
Award: \$4,500 CDN
Institution: *Rotman Research Institute of Baycrest, Toronto, ON, Canada*

Brian Fidali, MD

7 AWARDS & HONORS

- AES Fellows Program** 2022
American Epilepsy Association
- The Dean's Research Award** 06/2017
Weill Cornell Medical College
Cash prize presented annually to a medical student who, in the judgment of the Research Committee, has performed an outstanding piece of original biomedical or original clinical research. One student selected annually.
- Albert L. Rubin, M.D. Class of '50 Scholarship** 02/2017
The Rogosin Institute, Weill Cornell Medical College
Merit-based financial aid award by the Rogosin Institute to a Weill Cornell student demonstrating excellence in research and clinical medicine. One student selected annually.

8 PUBLICATIONS

8.1 PEER-REVIEWED RESEARCH PUBLICATIONS

- *Iotzov I, *Fidali BC, Petroni A, Conte MM, Schiff ND, Parra LC. Divergent neural responses to narrative speech in disorders of consciousness. *Annals of clinical and translational neurology*. 2017 Nov;4(11):784-92. doi:10.1002/acn3.470 *Equal contribution
- Tegeler CH, Cook JF, Tegeler CL, Hirsch JR, Shaltout HA, Simpson SL, Fidali BC, Gerdes L, Lee SW. Clinical, hemispheric, and autonomic changes associated with use of closed-loop, allostatic neurotechnology by a case series of individuals with self-reported symptoms of post-traumatic stress. *BMC psychiatry*. 2017 Dec;17(1):1-1. doi.org/10.1186/s12888-017-1299-x
- Shah SA, Goldin Y, Conte MM, Goldfine AM, Mohamadpour M, Fidali BC, Cicerone K, Schiff ND. Executive attention deficits after traumatic brain injury reflect impaired recruitment of resources. *Neuroimage: clinical*. 2017 Jan 1;14:233-41. doi:10.1016/j.nicl.2017.01.010
- Fujioka T, Fidali BC, Ross B. Neural correlates of intentional switching from ternary to binary meter in a musical hemiola pattern. *Frontiers in psychology*. 2014 Nov 12;5:1257. doi:10.3389/fpsyg.2014.01257
- Fidali BC, Poudrier È, Repp BH. Detecting perturbations in polyrhythms: effects of complexity and attentional strategies. *Psychological research*. 2013 Mar;77(2):183-95. doi:10.1007/s00426-011-0406-8
- Tegeler CH, Kumar SR, Conklin D, Lee SW, Gerdes L, Turner DP, Tegeler CL, C. Fidali B, Houle TT. Open label, randomized, crossover pilot trial of high-resolution, relational, resonance-based, electroencephalic mirroring to relieve insomnia. *Brain and Behavior*. 2012 Nov;2(6):814-24. doi:10.1002/brb3.101

8.2 REVIEWS, CHAPTERS, MONOGRAPHS, & EDITORIALS

- Fidali BC, Stevens RD, Claassen J. Novel approaches to prediction in severe brain injury. *Current opinion in neurology*. 2020 Dec 1;33(6):669-75. doi:10.1097/WCO.0000000000000875

Brian Fidali, MD

8.3 MEETINGS/INVITED ORAL AND POSTER PRESENTATIONS

Goron, A, **BC Fidali**, CE Snow, WJ Apfeldorf (05/20/2017). High-lethality suicide attempt as a precipitant of acute stress disorder. American Psychiatric Association 2017 Annual Meeting, San Diego, CA.

Fidali, BC, MM Conte, DJ Thengone, TJ Nauvel, & ND Schiff (03/03/2015). qEEG of passive musical paradigms assays integrative cerebral function in the minimally conscious state. 'Data Blitz Session 2,' Cognitive Neuroscience Society 2015 Annual Meeting, San Francisco, CA.

Conte, MM, **BC Fidali**, HM Markell, & ND Schiff (10/19/2015). EEG evidence of auditory working memory and selective attention in disorders of consciousness, Program No. 405.18, 2015 Neuroscience Meeting Planner. Chicago: Society for Neuroscience, 2015.

Fidali, BC, DJ Thengone, T Nauvel, & ND Schiff (07/27/2014). EEG correlates of music processing in disorders of consciousness James S. McDonnell Foundation Phase II Coma Consortium Annual Conference, Montaiione, Italy.

Fidali, BC, DJ Thengone, T Nauvel, ZM Adams, & ND Schiff (11/19/2014). Differential electroencephalographic responses to familiar and unfamiliar music processing in disorders of consciousness, Program No. 703.05, 2014 Neuroscience Meeting Planner. Washington, DC: Society for Neuroscience, 2014.

Tegeler, CH, **BC Fidali**, SW Lee, CL Tegeler, & L Gerdes (11/02/2012). Case Series of PTSD Symptom Reduction Through a New, Non-Invasive, EEG-Based Technology for Facilitating Self-Regulation of Neural Oscillations (HIRREM). 28th Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles, CA.

8.4 NON-AUTHORED PUBLICATIONS/ACKNOWLEDGEMENTS

Fujioka T, Ross B, Trainor LJ. Beta-band oscillations represent auditory beat and its metrical hierarchy in perception and imagery. *Journal of Neuroscience*. 2015 Nov 11;35(45):15187-98

Fujioka T, Ween JE, Jamali S, Stuss DT, Ross B. Changes in neuromagnetic beta-band oscillation after music-supported stroke rehabilitation. *Annals of the New York Academy of Sciences*. 2012 Apr;1252(1):294-304.

9 JOURNAL REFEREE ACTIVITY

The Neurohospitalist

2023

Epilepsy & Behavior

2024

Curriculum Vitae

George W. Culler IV M.D.

George Wesley Culler IV
Dartmouth-Hitchcock Medical Center Lebanon
One Medical Center Drive, Lebanon, NH, 03756-0001
Date Prepared 02.14.2022

I. Education

<u>DATES</u>	<u>INSTITUTION</u>	<u>DEGREE</u>
08/06-06/10	University of Texas at Austin Austin, Texas	B.S. (Biology: Neurobiology)
07/10-06/14	Baylor College of Medicine Houston, Texas	M.D.

II. Postdoctoral Training

<u>DATES</u>	<u>INSTITUTION</u>	<u>SPECIALTY</u>
06/14-06/15	Baylor College of Medicine Houston, Texas	Internal Medicine Internship
07/15-06/18	McGaw Medical Center of Northwestern University Chicago, Illinois	Neurology Residency
07/17-06/18	McGaw Medical Center of Northwestern University Chicago, Illinois	Chief Resident
07/18-06/19	McGaw Medical Center of Northwestern University Chicago, Illinois	Clinical Neurophysiology Fellowship
07/19-06/20	McGaw Medical Center of Northwestern University Chicago, Illinois	Epilepsy Fellowship

III. Professional Development Activities

<u>DATES</u>	<u>INSTITUTION</u>	<u>ACTIVITY/PROGRAM</u>
07/18-06/20	McGaw/Northwestern University	Medical Education Clinical Scholars (MECS) Program Certificate

IV. Academic Appointments:
Assistant Professor of Neurology

Curriculum Vitae

George W. Culler IV M.D.

Dartmouth-Hitchcock Medical Center/Geisel School of Medicine-Dartmouth
July 2020-Present

V. Institutional Leadership Roles

VI. Licensure and Certification (if applicable)

06/2020 – Present (Expires 06/30/2022)
State of New Hampshire (License #20467)

09/01/2021 – Present (Expires 11/30/2022)
State of Vermont (License #042.0015495)

VII. Hospital or Health System Appointments

<u>DATES</u>	<u>HOSPITAL</u>	<u>APPOINTMENT</u>
07/21 – Present	Dartmouth-Hitchcock Medical Center	Attending Neurologist, Epileptologist and Clinical Neurophysiologist
11/20 – Present	New London Hospital New London, NH	Attending Clinical Neurophysiologist (Teleneurology)
11/20 – Present	Alice Peck Day Hospital Lebanon, NH	Attending Clinical Neurophysiologist (Teleneurology)

VIII. Other Professional Positions (non-Dartmouth)

IX. Teaching Activities

A. Undergraduate (College) teaching

B. Undergraduate Medical Education (UME, Medical student) Classroom Teaching

<u>DATES</u>	<u>INSTITUTION</u>	<u>COURSE TITLE</u>	<u>ROLE</u>	<u>HOURS/YEAR</u>
2020-present	Dartmouth-Hitchcock Geisel School of Medicine	Neurology Clerkship Infectious and Inflammatory diseases	Facilitator	12
2020-present	Geisel School of Medicine	Med Student Capstone Course "Neurologic Emergencies"	Lecturer	2

C. Undergraduate Medical Education (UME, Medical student) Clerkship or Clinical Teaching

<u>DATES</u>	<u>INSTITUTION</u>	<u>COURSE TITLE</u>	<u>ROLE</u>	<u>HOURS/YEAR</u>
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Curriculum Vitae

George W. Culler IV M.D.

2021-present Dartmouth-Hitchcock On-Doctoring Preceptor 32
Geisel School of
Medicine

D. Graduate Medical Education (GME) Teaching – inclusive of instruction of residents and fellows during clinical practice

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2020-present	Dartmouth-Hitchcock	Epilepsy Service	Attending physician	100
2020-present	Dartmouth-Hitchcock	Inpatient general and consulting neurology service	Attending physician	40
2020-present	Dartmouth-Hitchcock	CNP Lecture Series	Lecturer	3
2020-present	Dartmouth-Hitchcock	IOM Lecture Series	Lecturer	2
2020-present	Dartmouth-Hitchcock	Resident Epilepsy Lectures	Lecturer	5
2021-present	Dartmouth-Hitchcock	Status Epilepticus Simulation for Neurology Residents	Program Director Lecturer	4

E. Other clinical education programs (e.g., PA programs)

F. Graduate teaching (post-college students enrolled in advance degree-granting programs, e.g., MS, MPH, PhD)

G. Other professional/academic programs

X. Primary Research Advising

A. Undergraduate Students

B. Graduate Students

C. Medical Students

DATES	STUDENT'S NAME	PROGRAM NAME
AY 2021-2022	Adam Glaser	Geisel School of Medicine (Research Mentor)

D. Residents/Fellows

Curriculum Vitae

George W. Culler IV M.D.

<u>DATES</u>	<u>FELLOW/RESIDENT'S NAME</u>	<u>SPECIALTY</u>
7/20-6/21	Payam Moein, MD	EEG/IONM (CNP)
7/20-Present	Melissa Crowder, MD	Epilepsy and IONM
7/20-Present	David Benezra, MD	Epilepsy and IONM (CNP)
7/21-Present	Michael Fitzpatrick, MD	Epilepsy
7/21-Present	Kevin Williams, MD	Epilepsy and IONM

E. Others

XI. Advising/Mentoring (other/not research)

XII. Engagement, Community Service/Education

<u>DATES</u>	<u>INSTITUTION</u>	<u>COURSE TITLE</u>	<u>ROLE</u>	<u>HOURS/YEAR</u>
2021-present	Dartmouth-Hitchcock Medical Center/EFNE	Epilepsy Education Day: "Advances in Epilepsy Therapies"	Lecturer/Panelist	2

XIII. Research Activities (reverse chronological order)

A. Sponsored Activity (grants and contracts)

<u>DATES</u>	<u>PROJECT TITLE</u>	<u>SPONSORING AGENCY</u>	<u>AWARD</u>
09/20-09/21	Multimodal Respiratory Monitoring in the EMU	Diamond Mini-Grant Award	\$5000

B. Pending Submissions

C. Clinical Faculty

<u>DATE</u>	<u>PROJECT NAME</u>	<u>ROLE</u>	<u>PROTECTED TIME</u>	<u>IRB</u>
05/2020 – Present	Stimulation of the Thalamus for Arousal Restoral in TLE (START)	Sub-I	1%	Yes
07/2018 – 01/2020	SUTRA multi-center retrospective enrollment for biomarkers related to SUDEP.	Sub-I	5%	Yes

XIV. Program Development

<u>TITLE</u>	<u>TYPE</u>	<u>MISSION/AIM</u>	<u>ROLE</u>	<u>ASSESSMENT</u>
Simulation-based learning for the management of status epilepticus (07/21 - Present)	Educational	Teach residents appropriate identification and management of status epilepticus	Preceptor Lecturer	Mastery Checklist

Curriculum Vitae

George W. Culler IV M.D.

XV. Entrepreneurial Activities

XVI. Major Committee Assignments, inclusive of Professional Societies

XVII. Memberships, Office and Committee Assignments in Professional Societies

<u>DATES</u>	<u>SOCIETY</u>	<u>ROLE</u>
2015-Present	American Academy of Neurology (AAN)	Member
2017-Present	American Clinical Neurophysiology Society (ACNS)	Member
2018-Present	American Epilepsy Society (AES)	Member

XVIII. Institutional Center or Program Affiliations

XIX. Editorial Boards

<u>DATE</u>	<u>SOCIETY</u>	<u>ROLE</u>
2021-Present	Micromachines: Biology and Biomedicine Special Issue "Intracranial Electrodes for Epilepsy: Fabrication, Applications and Indications"	Guest Editor

XX. Journal Referee Activity

<u>DATE</u>	<u>Journal</u>
2018-Present	Neurology
2018-Present	Frontiers in Neurology
2018-Present	Annals of Neurology

XXI. Awards and Honors

09/2018

Arnold P. Gold Humanism Honor Society, Feinberg/Northwestern University Chapter

06/2018

Resident Teaching Award

Department of Neurology, selected by the neurology residents for academic year 2017-18

06/2018

Resident Teacher of the Year

Department of Neurology, selected by the rotating neurology clerkship medical students for academic year 2017-18

04/2018

Resident Scholarship to the American Academy of Neurology annual meeting

XXII. Invited Presentations

International Meetings:

Curriculum Vitae

George W. Culler IV M.D.

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
1/27/22	Knowledge Gap Between Current and Ideal Practice in NIOM Session: Early Career Training In NIOM: Challenges, Controversies, and Insights	American Clinical Neurophysiology Society (ACNS)	Orlando, FL (Virtual)

National Meetings:

Regional/local Meetings:

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
5/15/21	Apnea and its Relation to Sudden Unexpected Death In Epilepsy Patients	Northwestern's 5th Annual Advances in Epilepsy and EEG	Chicago, IL
9/2/21	Neuroanatomy and Epilepsy	15 th Annual Northwestern Neurophysiology Course	Chicago, IL

XXIII. Bibliography

A. Peer-reviewed publications

1. Most significant publications:

Culler G, Bachman E, VanHaerents S. Paraclinical serum markers as aids in the diagnosis of autoimmune encephalitis. *J Neuroimmunol.* 2020;347:577324. doi:10.1016/j.jneuroim.2020.577324

Tio E*, Culler GW*, Bachman EM, Schuele S. Ictal central apneas in temporal lobe epilepsies. *Epilepsy Behav.* 2020;112:107434. doi:10.1016/j.yebeh.2020.107434

2. All other publications (excluding any listed in part 1):

Original peer-reviewed articles

Glaser A, Song Y, Lee J, Kanter J, Leeds ZT, Culler GW. Retrospective case review of lumbar spinal surgery patients with erector spinae plane block and concurrent intraoperative neurophysiological monitoring. Submitted, under review.

Quon RJ, Meisenhelter S, Camp EJ, Testorf ME, Song Y, Song Q, Culler GW, Moein P, Jobst BC. AiED: Artificial intelligence for the detection of intracranial interictal epileptiform discharges. *Clin Neurophysiol.* 2022 Jan;133:1-8. doi: 10.1016/j.clinph.2021.09.018. Epub 2021 Oct 27. PMID: 34773796.

Curriculum Vitae

George W. Culler IV M.D.

Mikhaeil-Demo Y, Holmboe E, Gerard EE, Wayne DB, Cohen ER, Yamazaki K, Templer JW, Bega D, **Culler GW**, Bhatt AB, Shafi N, Barsuk JH. Simulation-Based Assessments and Graduating Neurology Residents' Milestones: Status Epilepticus Milestones. *J Grad Med Educ.* 2021 Apr;13(2):223-230. doi: 10.4300/JGME-D-20-00832.1. Epub 2021 Apr 16. PMID: 33897956; PMCID: PMC8054597.

Meisenhelter S, Quon RJ, Steimel SA, Testorf ME, Camp EJ, Moein P, **Culler GW**, Gross RE, Lega BC, Sperling MR, Kahana MJ, Jobst BC. Interictal Epileptiform Discharges are Task Dependent and are Associated with Lasting Electrographic Changes. *Cereb Cortex Commun.* 2021 Mar 20;2(2):tgab019. doi: 10.1093/texcom/tgab019. PMID: 34296164; PMCID: PMC8152941.

Mikhaeil-Demo Y, Barsuk JH, **Culler GW**, Bega D, Salzman DH, Cohen ER, Templer JW, Gerard EE. Use of a simulation-based mastery learning curriculum for neurology residents to improve the identification and management of status epilepticus. *Epilepsy Behav.* 2020 Oct;111:107247. doi: 10.1016/j.yebeh.2020.107247. Epub 2020 Jun 27. PMID: 32603805.

Sampat A, Larson D, **Culler G**, Bega D. Formalizing a Residency Mentorship Program with a "Business of Medicine" Curriculum. *J Med Educ Curric Dev.* 2020 Sep 24;7:2382120520959685. doi: 10.1177/2382120520959685. PMID: 33029558; PMCID: PMC7520920.

Reviews

Culler GW, Jobst BC. Surgical Treatments in Epilepsy. *Continuum (Minneapolis, Minn).* Invited Review (under review), In Press, April 2022.

Culler GW, VanHaerents S. Immunologic Treatments of Seizures and Status Epilepticus. *Semin Neurol.* 2020 Dec;40(6):708-718. doi: 10.1055/s-0040-1719111. Epub 2020 Nov 11. PMID: 33176369.

Books/book chapters/monographs

Nascimento, FA, **Culler G**, Schuele SU, Gavvala JR. Posterior Cortex Epilepsy. Chapter 15. A Practical Approach to Stereo EEG. Springer Publishing Company; 2020 Dec 16 (177-192).

B. Other scholarly work in print or other media:

C. Abstracts (include both oral, exhibit and poster presentations):

Tio E, **Culler G**, Bachman E, Schuele S. Ictal Central Apnea in Temporal Lobe Epilepsies. 2019 AES Annual Conference, Baltimore, Maryland

Larson D, **Culler G**, VanHaerents S, Macken M, Maas M, Adler M. A Novel Neurology Curriculum for Internal Medicine Residents: From needs-assessment to curriculum development and implementation. 2019 Medical Education Clinical Scholars Graduation and Research Day, Chicago, Illinois

Culler G, Bachman E, Gerard E, Templer J, Schuele S, VanHaerents S. Electroclinical Features of Autoimmune Encephalitis and Encephalopathy. 2019 ACNS Annual Conference, Las Vegas, Nevada

Culler G, Bachman E, VanHaerents S. Paraclinical Aids in the Diagnosis of Autoimmune Encephalitis and Encephalopathy. 2018 AES Annual Conference, New Orleans, Louisiana

Curriculum Vitae

George W. Culler IV M.D.

Mikhaeil-Demo Y, Barsuk J, Templer J, VanHaerents S, Bellinski I, **Culler G**, Bega D, Salzman D, Gerard E. The Development of a Simulation-Based Mastery Learning Curriculum to Improve the Identification and Management of Status Epilepticus. 2018 AES Annual Conference, New Orleans, Louisiana

Culler G, VanHaerents S. An Institutional Analysis of Serum and CSF Autoantibodies to Aid in the Diagnosis of Limbic Encephalitis. *Neurology*. Apr 2018, 90 (15 Supplement) P5.405

Culler G, Afshari M, Maas M. Dural Arteriovenous Fistula, Medullary Edema, and Ondine's Curse: A Case Report (P3.195). *Neurology*. Apr 2016, 86 (16 Supplement):

Nicole Odom, M.D.

Professional Interests

Clinical epilepsy, ICU continuous EEG monitoring, Intraoperative monitoring, Epilepsy Monitoring Unit /LongTerm vEEG Monitoring, Epilepsy surgery for medically refractory epilepsy, mortality in epilepsy, neurophysiology and general neurology

Current Work Experience

12/2019-Current	Assistant Professor of Neurology, Dartmouth Hitchcock Medical Center Director of continuous EEG monitoring, concentration in epilepsy, intraoperative monitoring and general neurology	Lebanon, NH
08/2015-10/2019	General Neurologist with a concentration in Epilepsy, Pinehurst Neurology Outpatient general neurology, roughly 40% epilepsy patients. Read all EEGs including continuous and EEG monitoring during carotid endarterectomies for First Health of the Carolinas	Pinehurst, NC
01/2016-10/2019	Neurohospitalist, Moore Regional Hospital, First Health of the Carolinas Occasional weekend call with active inpatient consult service including stroke and teleneurology stroke call	Pinehurst, NC
12/2017-10/2019	Adjunctive faculty, UNC Neurology/ Epilepsy Division	Chapel Hill, NC

Board Certification and License

Full medical license in NH	Current
American Board of Psychiatry and Neurology, Epilepsy	10/20/2017, Certified
American Board of Psychiatry and Neurology, Clinical Neurophysiology	10/23/2015, Certified
American Board of Psychiatry and Neurology	09/19/2013, Certified
USMLE I, II CK, II CS, III	Passed 06/21/2007, 09/18/2008, 02/28/2009, 06/01/2010

Post Doctoral Training

07/2013- 06/2015	Department of Neurology, Columbia University Medical Center Division of Clinical Neurophysiology, EEG/Epilepsy Fellow, PGY 5-6	New York, NY
07/2010-06/2013	Department of Neurology, University of North Carolina Hospitals Adult Neurology Resident, PGY 2-4	Chapel Hill, NC
07/2009-06/2010	Department of Internal Medicine Pitt County Memorial Hospital at Brody School of Medicine Preliminary Year Internship, PGY1	Greenville, NC

Education

08/2005-05/2009	University of Maryland School of Medicine M.D., May 2009	Baltimore, MD
09/2003-05/2004	Boston University Courses in biochemistry and physics	Boston, MA
06/2002-08/2003	Johns Hopkins University Certificate in premedical studies, August 2003	Baltimore, MD

08/1998-05/2002

Colby College
B.A. May 2002, Psychology Major

Waterville, ME

Research Experience

08/2013- 06/2015

Awarded the Clinical and Translational Neuroscience Research Fellowship Grant to investigate the relationship of SUDEP, sleep and neuroendocrine dysfunction.

Lisa Bateman, M.D., Assistant Professor of Clinical Neurology, Columbia University Medical Center

05/2013- 12/2014

Safety in the epilepsy monitoring unit and autonomic changes during seizures
Hae Won Shin, M.D. Assistant Professor in Neurology, UNC School of Medicine

02/2004-08/2005

The role of B cells in demyelinating disease

And 01-02/2008

David Hafler, M.D. and Kevin O'Connor, Ph.D., Center for Neurologic Diseases, Brigham and Women's Hospital/Harvard Institutes of Medicine

Publications

1. Odom N, Thadani VM. Respect the Resection. *Neurology*. 2022 Jul 5;99(1):11-12. doi: 10.1212/WNL.000000000000200841. Epub 2022 May 4. PMID: 35508391.
2. Odom N, Bateman LM. Sudden unexpected death in epilepsy, peri-ictal physiology, and the SUDEP-7 Inventory. *Epilepsia* 2018;00:1-4. <https://doi.org/10.1111/epi.14552>
3. Billakota S, Odom N, Westwood A, Hanna E, Pack A and Bateman, LM. Sleep disordered breathing, neuroendocrine function and clinical SUDEP risk in patients with epilepsy. *Epilepsy & Behavior*. 2018 Aug 31;87:78-82. doi: 10.1016/j.yebeh.2018.07.011
4. Gold C and Odom N, Haggiagi A, Mitchell L, Srinivasan S and Odia Y. Electrographic correlates of plateau waves in patients with leptomeningeal metastases. *The Neurohospitalist*, 2016 Oct; 6 (4):161-166
5. Odom, Nicole. "New Insights into the basic mechanisms, diagnosis and staging of epilepsy." *The Neurology Report: Selected Reports from the 67th Annual Meeting of the American Epilepsy Society*; Winter 2014; Vol. 6, 2
6. O'Connor KC, Lopez-Amaya C, Gagne D, Lovato L, Moore-Odom NH, Kennedy J, Krupp L, Tenembaum S, Ness J, Belman A, Bovkova A, Bykova O, Mah JK, Stoian CA, Waubant E, Kremenutzky M, Ruggieri M, Bardini MR, Rensel M, Hahn J, Weinstock-Guttman B, Yeh EA, Farrell K, Freedman MS, Iivanainen M, Bhan V, Dilenge M, Hancock MA, Gano D, Fattahie R, Kopel L, Fournier AE, Moscarello M, Banwell B, Bar-Or A. "Anti-myelin antibodies modulate clinical expression of childhood multiple sclerosis." *The Journal of Neuroimmunology*, 2010 Jun; 223(1-2):92-9
7. O'Connor K, Appel H, Bregoli L, Call M, Catz I, Chan J, Moore N, Warren K, Wong S, Hafler D and Wucherpfennig K. "Antibodies from inflamed CNS tissue recognize myelin oligodendrocyte glycoprotein." *The Journal of Immunology*. 2005; 175: 1974-1982

Relevant Presentations

1. Poster Presentation: American Academy of Neurology 67th Annual Meeting, April 2015, Washington, DC.
C. Gold and N. Odom, A. Haggiagi, L. Mitchell, Y. Odia. "Electroencephalography Correlates of Intracranial Hypertension in 3 Patients with Leptomeningeal Metastases."
2. SUDEP Special Interest Group Invited Speaker and Poster Presentation: American Epilepsy Society 68th Annual Meeting, December 2014, Seattle, WA
N. Odom and L. M. Bateman "Sudden Unexpected Death in Epilepsy, Peri-ictal Physiology and the SUDEP-7 Inventory."
3. Poster Presentation: American Epilepsy Society 68th Annual Meeting, December 2014, Seattle, WA
R. Davis, N. Odom, S. Sutton, B. Vaughn, A. Hinn, E. Ryan, H. Ritchie, H. Shin. "Changing Practice Pattern Before and After the Modification of EMU at UNC."
4. Poster Presentation: Partners Against Mortality in Epilepsy Conference, June 2014, Minneapolis, MN
N. Odom and L. M. Bateman, M.D. "A case control study of sudden unexpected death in epilepsy and the SUDEP-7 inventory."
5. Poster Presentation: Federation of Clinical Immunology Societies 2005, Boston, MA

K'O'Connor, N. Moore, L. Bregoli, E. Bradshaw, K. Wucherpfennig, D. Hafler, "Characterization of B cell immunoglobulin variable region genes derived from lesions of patients with multiple sclerosis."

References Available Upon Request

Jared Quast

Previous/Current Positions:

2024-Current Clinical Instructor of Neurology/Non-ACGME Epilepsy Fellow
Dartmouth-Hitchcock Medical Center
Lebanon, NH

Postgraduate Training

2023-2024 Epilepsy Fellow
Dartmouth-Hitchcock Medical Center
Lebanon, NH

2022-2023 Chief Resident, Neurology
University of Massachusetts Chan Medical School
Worcester MA

2020-2023 University of Massachusetts Chan Medical School
Worcester, MA
Completion of Neurology Residency Anticipated June 2023

2019-2020 University of Massachusetts Chan Medical School
Worcester, MA
Internship in Internal Medicine

Education

2015-2019 St. George's University School of Medicine
Grenada, West Indies
Doctor of Medicine, magna cum laude

2010-2014 University of California, Riverside
Riverside, California
Bachelor of Science in Biochemistry
Minor: Religious Studies

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Medical Licensure:

October 2024 Vermont

October 2024 Maine

July 2023 New Hampshire

Certifications:

2024 J. Kiffin Penry Neurosimulation for Epilepsy

2023 American Board of Psychiatry and Neurology Certification

2023 ACLS Certification

2023 BLS Certification

2020 USMLE Step 3: Pass

2018 USMLE Step 2 CK: Pass

2018 USMLE Step 2 CS: Pass

2017 USMLE Step 1: Pass

Professional Memberships:

2024-Current Society for Adolescent Health and Medicine

2023-Current American Epilepsy Society

2022-Current Alpha Omega Alpha Honor Medical Society

2020-Current American Academy of Neurology

Honors and Awards

2022 UMass Chan Medical School Neurology Resident as Teacher Award

2021 UMass Medical School Neurology Purple Brain Service Award

2020 UMass Medical School Internal Medicine Preliminary Intern of the Year

2017-2019 Iota Epsilon Alpha International Medical Honors Society

2015-2019 Legacy of Excellence Scholarship

2017 St. George's University Dean's Honor List

2012, 2013 UC Riverside Dean's Honor List

2010-2014 UC Riverside University Honors Program

Conference Presentations and Speaking Roles

October 2024 Northern New England Neurological Society Annual Meeting:

"Experiences in Adolescent Transitional Epilepsy" scheduled presentation

October 2024 Northern New England Neurological Society Neurology for the Non-Neurologist Annual Meeting:

"Ask the Experts Panel" Panel Member

"Transitions from Pediatric to Adult Neurology" scheduled presentation

October 2023 Northern New England Neurological Society Neurology for the Non-Neurologist Annual Meeting:

"Ask the Experts Panel" Panel Member

"Anti-seizure Medications" scheduled presentation

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Invited Lectures

- 10/10/24 Grand Rounds Conference: "Young Adult Epilepsy Transitions," St. Vincent Hospital
- 07/18/24 Neurology Resident EEG Conference: "What's wrong with it? Abnormal EEG," Dartmouth Hitchcock Geisel School of Medicine
- 06/28/24 Neurology Resident Conference: "Quantitative EEG," University of Massachusetts Chan Medical School
- 06/20/25 Neurology Resident EEG Conference: "So my patient has epilepsy...Epilepsy Patient Counseling - Driving," Dartmouth Hitchcock Geisel School of Medicine
- 05/16/24 Neurology Resident EEG Conference: "Posterior Quadrant Semiologies and End of Chain Discharges," Dartmouth Hitchcock Geisel School of Medicine
- 04/18/24 Neurology Resident EEG Conference: "When Medications Fail: Introduction to Epilepsy Surgery," Dartmouth Hitchcock Geisel School of Medicine
- 03/28/24 Neurology Resident EEG Conference: "Quantitative EEG," Dartmouth Hitchcock Geisel School of Medicine
- 01/18/24 Neurology Resident EEG Conference: "RITE Jeopardy Review," Dartmouth Hitchcock Geisel School of Medicine
- 02/16/24 Grand Rounds Conference: "From Space Invaders to Cyberpunk: Video Game Epilepsy", Dartmouth Hitchcock Geisel School of Medicine
- 10/19/23 Neurology Resident EEG Conference: "What's wrong with it? Abnormal EEG," Dartmouth Hitchcock Geisel School of Medicine
- 9/21/23 Neurology Resident EEG Conference: "What is normal anyway? Normal awake, drowsy, and asleep EEG," Dartmouth Hitchcock Geisel School of Medicine
- 8/17/23 Neurology Resident EEG Conference: "How do I use this thing? EEG Setup and Montages," Dartmouth Hitchcock Geisel School of Medicine
- 03/21/23 Grand Rounds Conference: "From Space Invaders to Cyberpunk: Video Game Epilepsy", University of Massachusetts Chan Medical School
- 2/24/23 Chief Report: "Refractory Status Epilepticus," University of Massachusetts Chan Medical School
- 12/23/22 Chief Report: "Postpartum Headache," University of Massachusetts Chan Medical School
- 11/29/22 Morbidity and Mortality Grand Rounds Conference: "Challenges surrounding brain death and prognostication", University of Massachusetts Chan Medical School
- 10/28/22 Chief Report: "Aphasia," University of Massachusetts Chan Medical School
- 8/5/22 Chief Report: "Seizure," University of Massachusetts Chan Medical School

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10/26/21 Morbidity and Mortality Grand Rounds Conference: "Are we ready for Baclofen pump as an institution?", University of Massachusetts Chan Medical School

Curriculum Development

2022-2023 University of Massachusetts Chan Medical School Neurology Residency
Journal Club

Quality Improvement and Clinical Development:

2024-Current Dartmouth Hitchcock Young Adult Epilepsy Transition Clinic

Publications:

Garcia-Dominguez, Maria A.; Srichawla, Bahadar S.; Pacut, Peter; **Quast, Jared**; Sivakumar, Shravan; Belgrad, Jillian; Panda, Ashwin; Carbone, Sara; Sanders, Delia T.; Min, Eli; Hayes, Nicole T.; Bose, Abigail; Lee, Vanessa; Kipkorir, Vincent; Ghasemi, Mehdi. A single-center retrospective study of hospitalized COVID-19 patients: demographics, laboratory markers, neurological complications, ICU admission, and mortality. *Annals of Medicine and Surgery*. 2023.

Srichawla BS, **Quast J**, Pacut P, Sivakumar S, Garcia-Dominguez MA, Belgrad J, Panda A, Carbone S, Sanders DT, Min E, Hayes NT, Bose A, Lee V, Ghasemi M. COVID-19 in the intensive care unit: Unmasking the critical factors impacting patient survival. *J Investig Med*. 2023

Srichawla BS, **Quast J**. Magnesium deficiency: An overlooked key to the puzzle of posterior reversible encephalopathy syndrome (PRES) and reversible cerebral vasoconstriction syndrome (RCVS)? *Journal of Neurological Science*. 2023.

CURRICULUM VITAE

Date prepared: 01.19.24

Krzysztof A. Bujarski, MD
Professor of Neurology
Section Chief, Epilepsy
Department of Neurology
Dartmouth-Hitchcock Medical Center
Geisel School of Medicine at Dartmouth

I. Education

Date	Institution	Degree
9/1996 – 5/2000	Karol Marcinkowski University of Medical Sciences Poznan, Poland	MD
9/1991 – 5/1995	University of Chicago Chicago, IL.	BS Biology

II. Postdoctoral Training

Date	Institution	Program
7/2007 – 6/2008	Thomas Jefferson Epilepsy Center Philadelphia, PA	Epilepsy
7/2006 – 6/2007	Thomas Jefferson Epilepsy Center Philadelphia, PA	Neurophysiology
9/2004 – 6/2006	Northwestern University Chicago, IL	Behavioral Neurology
8/2001 – 8/2004	Loyola University Medical Center Maywood, IL	Neurology
8/2000 – 8/2001	Loyola University Medical Center Maywood, IL	Internal Medicine

Name: Krzysztof Bujarski

III. Academic Appointments

a. Current Dartmouth/Geisel affiliations

<i>Professor</i>	Geisel School of Medicine at Dartmouth Hanover, NH	2023 – current
<i>Associate Professor</i>	Geisel School of Medicine at Dartmouth Hanover, NH	2014 – current
<i>Assistant Professor</i>	Geisel School of Medicine at Dartmouth Hanover, NH	2008 – 2014

b. Other current affiliations

<i>Professor</i>	Integrative Neuroscience at Dartmouth Hanover, NH	2021 – present
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c. Past academic affiliations

<i>Instructor</i>	Feinberg School of Medicine Chicago, IL	2004 – 2006
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IV. Institutional Leadership Roles

Director of the Dartmouth Epilepsy Center	Dartmouth-Hitchcock Medical Center Lebanon, NH	2021 to present
Section Head of Epilepsy Department of Neurology	Dartmouth-Hitchcock Medical Center Lebanon, NH	2021 to present
Co-director of the Dartmouth Epilepsy Center	Dartmouth-Hitchcock Medical Center Lebanon, NH	2018 to 2021
Program Director of Dartmouth Epilepsy Fellowship	Dartmouth-Hitchcock Medical Center Lebanon, NH	2014 to present

Name: Krzysztof Bujarski

Director of the Epilepsy Monitoring Unit at DHMC	Dartmouth-Hitchcock Medical Center Lebanon, NH	2014 to present
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V. Licensure and Certification

2008 – current	New Hampshire State Medical License
2006 – current	American Board of Psychiatry and Neurology Certified
2010 – current	UCNS Board Certified in Behavioral Neurology and Neuropsychiatry
2013 – current	ABPN Board Certified in Epilepsy

VI. Hospital Appointments

Attending Neurologist	Dartmouth-Hitchcock Medical Center	2008 to present
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VII. Other Professional Positions

President of the Northern New England Neurological Society	NENNS	2012-2014
Phillips Neuro	Advisory Committee	2019

VIII. Professional Development Activities

12-week Leadership Development Course	DHMC	2/21/22
Diversity & Inclusion Workshop Brien Gittens, E.D	DHMC	1/13/21

Name: Krzysztof Bujarski

Behavioral Based Interviewing Workshop Danielle Potter	DHMC	9/2/20
NIH Grant Writer Workshop John D. Robertson	DHMC	12/15/17
Stereotactic EEG Course	Cleveland Clinic, Cleveland OH	10/26/16
8 th International Workshop on Advances in Electrocorticography	Chicago, IL	10/15/15
7 th International Workshop on Advances in Electrocorticography	Washington, D.C.	11/13/14
5 th International Workshop on Advances in Electrocorticography	San Diego, CA	11/07/13
Dartmouth SYNERGY Certificate Program in Translational Research Methods	DHMC	06/11/12
1 st International Workshop on Advances in Electrocorticography	Lake George, NY	10/5/2009

IX. Teaching Activities

A. UNDERGRADUATE TEACHING

B. UNDERGRADUATE MEDICAL EDUCATION: Classroom teaching

Name	Date	Program	Role	Time
Scientific Basis of Medicine	2009-15	Geisel School of Medicine at Dartmouth	Group Preceptor	Total teaching time per year 20 hours, total preparation 20 hours per year

Name: Krzysztof Bujarski

Basic Neurology Lecture Series	2016	Centre Hospitalier Universitaire de Kigali, Rwanda	Group Preceptor	10 1-hr lectures with questions. Total time for preparation approx. 50 hours
Second year Neuroscience Course	2015-19	Geisel School of Medicine at Dartmouth	Lecturer	Yearly 2-hour lecture on behavioral neurology given to second year medical students at Geisel

C. UNDERGRADUATE MEDICAL EDUCATION: Clerkship

Name	Date	Program	Role	Time
Bedside teaching	2018-20	Dartmouth-Hitchcock Medical Center	Group Preceptor	Three 90 minutes sessions per year
Bedside teaching	2016	Centre Hospitalier Universitaire de Kigali	Group preceptor	2 hours/week x 10 weeks.

D. GRADUATE MEDICAL EDUCATION: Residents and Fellows

Name	Date	Program	Role	Name
CNP/Epilepsy Fellowship Lecture Series	2015-now	Dartmouth-Hitchcock Medical Center	Director	8 lectures/year
Dartmouth-Hitchcock Epilepsy Fellowship Curriculum	2020-now	Dartmouth-Hitchcock Medical Center	Director	10 lectures/year.
Behavioral Neurology	2010-15	Dartmouth-Hitchcock Medical Center	Director	6 lecture/year

Name: Krzysztof Bujarski

CNP Fellowship Lecture series	2009-15	Dartmouth- Hitchcock Medical Center	Faulty	2 lectures/year
Internal Medicine Residency Annual Fundamentals Course	2010-14	Dartmouth- Hitchcock Medical Center	Faculty	1 lecture/year
Psychiatry Resident Lecture Series	2011-14	Dartmouth- Hitchcock Medical Center	Faculty	1 lecture/year
Neuropsychology Interns Lecture Series	2012-now	Dartmouth- Hitchcock Medical Center	Faculty	1 lecture/year
Thomas Jefferson Neurology Residency	2006-08	Thomas Jefferson, Philadelphia, PA	Faculty	1 lecture/year

E. OTHER CLINICAL EDUCATION PROGRAMS

F. GRADUATE TEACHING

G. OTHER PROFESSIONAL/ACADEMIC PROGRAMS

X. PRIMARY RESEARCH ADVISING

A. Undergraduate Students (e.g., Honors theses)

Name	Date	Program	Role	Institution
Nandita M. Kasireddy	2021	Honors Undergraduate Thesis Project	Primary advisor	Dartmouth College

Name: Krzysztof Bujarski

Zach Leeds 2019 Honors Undergraduate Thesis Project Advisor Colgate, Hamilton NY

B. Graduate Students (e.g., MS, PhD)

Name	Date	Program	Role	Institution
Tiankang Xie	2019	PhD	PhD Committee	Psychology and Brain Science, Dartmouth College, Hanover, NH

B. Medical Students (directed research)

Name	Date	Program	Role	Institution
Sophia Kolankiewicz	2016	MD	Medical Student, Research	Poznan University of Medical Sciences, Poznan, Poland

C. Residents/Fellows (directed research)

Name	Date	Program	Role
Melissa Crowder	2021	Dartmouth Epilepsy Fellowship	Research mentor
Kevin Williams	2021	Dartmouth Epilepsy Fellowship	Research mentor
Michael Fitzpatrick	2021	Dartmouth Epilepsy Fellowship	Research mentor
David Benezra	2020	Dartmouth Epilepsy Fellowship	QI project mentor
Payam Moein	2018	Dartmouth Epilepsy Fellowship	Research mentor
Alendia Hartshorn	2017	Dartmouth Epilepsy Fellowship	Research mentor
George Thomas	2015	Dartmouth Epilepsy Fellowship	Research mentor
Jado Nadaisaba	2017	International Epilepsy Mini-Fellow	Research mentor
Alissa Thomas	2013	Dartmouth Residency	Research mentor

D. Others (define)

Name	Date	Program	Role
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Name: Krzysztof Bujarski

Lindsay Schommer 2021 Department of Neurology Research mentor

XI. ADVISING/MENTORING (OTHER)

A. Undergraduate Students (e.g., WISP, Presidential Scholars)

Name	Date	Program	Role
Oren F. Wilcox	2015	Dartmouth College Neuroscience Elective	Research mentor
Gabi H. Wozniak	2015	Tufts Neuroscience Undergraduate	Research mentor
Nick Streltsoff	2016	Department of Neurology, Dartmouth-Hitchcock	Research mentor

B. Graduate Students (e.g., MS, PhD—thesis committees, qualifying exam committees, but not primary advisor)

Name	Date	Program	Role
Kristy Johnson	2018	MIT Media Lab	Research mentor
Sean Guillory	2011	Psychology and Brain Science, Dartmouth College	Research mentor
Scotty Alexander	2015	Psychology and Brain Science, Dartmouth College	Research mentor

C. Medical (UME Learners; roles beyond instructor in official teaching activities that should be in Section IX)

D. Residents/Fellows (GME Learners; roles beyond instructor in official teaching activities that should be in Section IX)

E. Non-degree Program Students (e.g., post-baccalaureate or certificate programs)

F. Faculty

Name: Krzysztof Bujarski

G. Others (define)

XII. Engagement, Advocacy, Community Service, Community Education

Name	Date	Program	Role
Hanover High School	2021	Psychology Elective	Speaker
New England Epilepsy Foundation	2019	Annual Epilepsy Walk	Walker
Twin State Soccer Club	2019	Soccer	Concussion Specialist

X. RESEARCH ACTIVITIES (REVERSE CHRONOLOGICAL ORDER:

A. SPONSORED ACTIVITY

Date	Title	Role	Effort	Sponsor	Costs
2021	Amygdala stimulation for perception of valence 1R21MH124674-01A1	PI	15%	NIH	Y1-\$232,669 Y2-\$194,797
2021	TMS Research	PI	0%	Patient Donation	\$20,000
2021	Thalamic Stimulation to Prevent Impaired Consciousness in Epilepsy	Sub-I	0%	NIH	\$60,204

Name: Krzysztof Bujarski

2021	Using Direct Brain Stimulation to Study Cognitive Electrophysiology	Sub-I	Pending	NIH	Y1:\$130,891 Y2:\$131,387 Y3:\$131,892
2018	Suicidality in the epilepsy clinic	Co-PI	0%	Hitchcock Foundation	\$40,000
2016	Transcranial Magnetic Stimulation for treatment of depression in epilepsy	PI	10%	Diamond Foundation	\$124,929
2015	Safety and Efficacy of Intranasal Midazolam in the EMU	Site PI	0%	UCB	n/a
2013	Alzheimer Management by Albumin Replacement	Site PI	0%	Grifolos	n/a
2010	Non-verbal communication deficits in epilepsy.	PI	0%	Hitchcock Foundation	\$40,000

B. Pending submissions

C. Clinical Faculty: Activities for which you have been provided protected time (but not funding)

XIV. PROGRAM DEVELOPMENT

Title	Type	Mission	Role	Dates	Cohort
Stowe Annual Epilepsy Retreat	Clinical and educational	To organize the DH Epilepsy Center	Organizer	2015 to now	Section of epilepsy

Name: Krzysztof Bujarski

Epilepsy Surgery Conference	Clinical	To organize surgical program at DH Epilepsy Center	Organizer	2013 to now	Section of epilepsy
Director of the Epilepsy Monitoring Unit	Clinical	Organize video EEG admissions at DH	Director	2013 to now	Section of epilepsy
Mayo/Dartmouth Epilepsy Conference	Clinical and educational	Video conference with Mayo Clinic	Organizer	2013 to 2016	Section of epilepsy
Manchester Epilepsy Clinic	Clinical	Satellite epilepsy clinic	Organizer	2011 to now	Section of epilepsy
Concussion at Dartmouth College athletes	Clinical	Concussion management for Dartmouth College	Faculty	2013 to 2016	Dartmouth College athletes
High density EEG	Clinical	Obtain high density EEG in epilepsy patients	Co-director	2015 to present	Epilepsy surgery patients
Behavioral Neurology Course for residents	Educational	Educate neurology residents in behavioral neurology	Organizer	2008 to 2013	Neurology residents
Epilepsy Fellowship – Non ACGME accredited year	Educational	Provide more extensive epilepsy education	Director	2021 - present	Epilepsy fellows

XII. ENTREPRENEURIAL ACTIVITIES

Name: Krzysztof Bujarski

Date	Activity	Place
2019	Phillips Neuroscience Advisory Board	Warsaw, Poland
2018	Neuropace Advisory Board	Chicago, IL
2014	Simplified Neuroscience Executive Advisory Board	Houston, TX

XII. MAJOR COMMITTEE ASSIGNMENTS:

National/international

Dates	Committee	Role	Institution
2018 to present	Scientific Review Committee	Member	American Epilepsy Society
2019 to present	Junior Investigators Grant Review Committee	Member	American Epilepsy Society

Institutional

Dates	Committee	Role	Institution
2011 to 2015	DHMC Department of Neurology - Scientific Review Committee	Active Member	DHMC
2012 to 2014	Geisel School of Medicine at Dartmouth Faculty Council	Member	DHMC
2012 to 2021	Dartmouth Residency Clinical competency Committee	Member	DHMC

Name: Krzysztof Bujarski

2012 to 2021	Department of Neurology Educational Committee	Member	DHMC
2014 to present	Epilepsy Fellowship Clinical Competency Committee	Chair	DHMC
2014 to present	Epilepsy Fellowship Program Evaluation Committee	Chair	DHMC

XIV. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

Dates	Society	Role
2013 to 2015	Northern New England Neurological Society	President
2006 to present	American Epilepsy Society	Active Member
2006 to present	American Neurological Association	Active Member

XV. EDITORIAL BOARDS:

2013 to present	Journal of Epileptology	Editorial Board
2016 to present	Rwandan Journal of Medicine	Editorial Board

XVI. JOURNAL REFEREE ACTIVITY:

Date	Society/Journal	Role	Frequency
2018 to present	Neurology	Reviewer	2-3 per year
2015 to present	Epilepsia	Reviewer	2-3 per year

Name: Krzysztof Bujarski

2019 to present	Social Cognitive Affective Neuroscience	Reviewer	1 per year
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XVII. AWARDS AND HONORS

Date	Award	Institution	Place
2013	Peter D. Williamson Teacher of the Year	Dartmouth-Hitchcock Neurology	Lebanon, NH
2003	Frank A. Rubino, M.D. Clinical Neurology Award	Neurology Residency	Chicago, IL
2000	Dean's Award for Excellence in Clinical Studies	Poznan University of Medical Sciences	Poznan, Poland
1997	Wanda Blerska Award Excellence in Basic Medical Sciences	Poznan University of Medical Sciences	Poznan, Poland

XXI. INVITED PRESENTATIONS

National/International Meetings

Date	Course	Type	Place
2021	Neuromodulation for cognitive and psychiatric disorders in epilepsy	Grand Rounds	UNC Chapel Hill, North Carolina
2020	Cognitive and memory disorders in epilepsy	Course co-chair	American Epilepsy Society, On line
2019	Analysis of seizure semiology	APP Symposium American Epilepsy Society	New Orleans, LA
2019	Choice of brain stimulation	Chinese Symposium American Epilepsy Society	New Orleans, LA
2018	Amygdala stimulation disrupts emotion perception and emotional memory	European Neuroscience Society	Warsaw, Poland

Name: Krzysztof Bujarski

2017	Meet the Specialist Symposium	Course co-chair American Academy of Neurology	Boston, MA
2017	Neurophysiology Course	Course Co-chair AES Annual Meeting	Philadelphia, PA
2017	Use of TMS in treatment of Depression in patients with epilepsy	Northern New England Neurological Society	Stowe, VT
2016	Treatment of Epilepsy in Sub-Saharan Africa	Centre Hospitalier Universitaire de Kigali	Kigali, Rwanda
2016	Treatment of Headache	King Faisal Hospital	Kigali, Rwanda
2016	Dementia	Centre Hospitalier Universitaire de Butare	Huye, Rwanda
2016	Concepts in Neuro-urology	King Faisal Hospital	Kigali, Rwanda
2016	Treatment of Epilepsy	Kanombe Military Hospital	Kigali, Rwanda
2016	Beyond basics in intracranial EEG analysis	7 th Annual Electrophysiology Workshop	Houston, TX
2014	Cognition and Epilepsy Course 2014 AAN Annual Meeting,	Course Co-chairman	Philadelphia, PA
2015	Analysis of seizure semiology in surgical treatment of epilepsy	American Academy of Neurology	Washington, DC
2012	Practical issues in video EEG monitoring	American Epilepsy Society	Baltimore, MD

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Regional/local MEETING:

2022	DBS and TMS: Neuromodulation for cognitive dysfunction	Department of Neurology Grand Rounds	DHMC
2021	Amygdala stimulation and perception of valence in epilepsy	Department of Neurology Grand Rounds	DHMC
2020	Stimulation of the amygdala and valence	EAEFG	DHMC
2019	Stereo-EEG for refractory epilepsy	Department of Neurology Grand Rounds	DHMVC
2017	Ten-weeks of general neurology in Rwanda	Dartmouth- Hitchcock Medical Center	Lebanon, NH
2016	Electrical Stimulation of the Amygdala	Dartmouth- Hitchcock Medical Center	Lebanon, NH
2013	Primary Care Issues in Dementia	Northern New England Neurological Society	North Conway, NH
2013	Treatment of Memory Problems in Epilepsy	Dartmouth Epilepsy Day	DHMC

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2013	Amygdala Evoked Potentials	Psychology and Brain Science – Dartmouth College	Hanover, NH
2012	Update in Epilepsy	Department of Medicine Grand Rounds, DHMC	Lebanon, NH
2012	Optimizing Cognitive Performance in Patients with Epilepsy	Northern New England Neurological Society	North Conway, NH
2011	Social Cognition and Epilepsy	Department of Neurology, DHMC	Lebanon, NH
2011	Update in Epilepsy	Department of Medicine, St. Joseph's Hospital	Nashua, NH
2011	Update in Epilepsy	Department of Medicine Grand Rounds, Rutland Regional Hospital	Rutland, VT
2011	Update in Epilepsy	Department of Internal Medicine, Androscogen Valley Hospital	Berlin, NH
2010	Mirror Neurons	Northern New England Neurological Society	Portland, ME

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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 and Clinics

NAME	JOB TITLE	ANNUAL AMOUNT PAID FROM THIS CONTRACT	ANNUAL SALARY
Brian Fidali, MD	Staff Physician	\$0.00	
George Culler IV MD	Staff Physician	\$0.00	
Nicole Odom MD	Staff Physician	\$0.00	
Jared Quast MD	Staff Physician	\$0.00	
Krzysztof Bujarski MD	Epelipsy Section Chief	\$0.00	