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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH

Lori A. Weaver
Commissioner

Iain N. Watt
Director

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-4501 1-800-852-3345 Ext. 4501
Fax: 603-271-4827 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

May 22, 2026

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, Division of Public Health, to enter into a **Sole Source** contract with MaineHealth New Hampshire Ambulatory Care (VC #177129-B003), Portland, ME, in the amount of $1,197,000 for the operation and management of poison information and control hotline services, with the option to renew for up to two (2) additional years, effective July 1, 2026, upon Governor and Council approval through June 30, 2028. 7% Federal Funds. 89% General Funds. 4% Other Funds (Department of Safety).

Funds are available in the following accounts for State Fiscal Years 2027 and are anticipated to be available in SFY 2028, upon the availability and continued appropriation of funds in the current operation budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

See attached fiscal details.

EXPLANATION

This request is **Sole Source** because the Contractor is the only vendor qualified to provide poison information and poison control hotline services in the northern New England region and is accredited by America's Poison Centers (APC). The Contractor's service area includes Maine, New Hampshire, and Vermont.

The purpose of this request is to ensure the continued operation and management of the poison information and control hotline through utilization of APC's established national, toll-free hotline. The Contractor will provide timely and accurate clinical guidance to New Hampshire residents, health care professionals, and emergency medical personnel related to poisoning. Services are available 24 hours per day, seven days per week, 365 days per year. Additionally, the Contractor will provide a New Hampshire-dedicated poison prevention educator to conduct outreach and poison prevention activities in various community settings such as businesses, community-based organizations, and schools, upon request.

In State Fiscal Years 2027 and 2028, the Department anticipates the poison control hotline will process more than 8,000 New Hampshire cases annually, based on historical averages.

The Department will monitor services through review and assessment of monthly, quarterly, and annual progress and performance reports required of the Contractor, which will include the inbound call activity.

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As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up two (2) 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, New Hampshire residents will not be able to access poison control services through the national toll-free hotline, which may harm health, increase response time to urgent health needs, and increase healthcare costs due to individuals visiting emergency rooms for potentially non-emergent health matters.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number 93.069, FAIN NU90TU000009 and Assistance Listing Number 93.136, FAIN NU17CE010211.

Respectfully submitted,

for:

Lori A. Weaver
Commissioner

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MAINEHEALTH D/B/A NORTHERN NEW ENGLAND POISON CENTER
SS-2027-DPH-02-PCNTL-01
Fiscal Detail Sheet

MaineHealth New Hampshire Ambulatory Care - Vendor Code 177129-B003

05-95-90-902010-1228 HEALTH AND SOCIAL SERVICES, DEFT OF HEALTH AND HUMAN SVS, HHS; PUBLIC HEALTH DIV, BUREAU OF FAMILY HEALTH AND NUTRITION, POISON CONTROL CENTER
100% GENERAL FUNDS

State Fiscal Year	Class/Account	Class Title	Job Number	Current Budget	Increase (Decrease) Amount	Revised Budget
2027	102-500731	Contracts for Prog Svc	90001228	$520,000	$0	$520,000
2028	102-500731	Contracts for Prog Svc	90001228	$520,000	$0	$520,000
		SubTotal:		**$1,040,000**	**$0**	**$1,040,000**

05-95-90-902010-1228 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF FAMILY HEALTH AND NUTRITION, POISON CONTROL CENTER
100% OTHER FUNDS-DEPT OF SAFETY

State Fiscal Year	Class/Account	Class Title	Job Number	Current Budget	Increase (Decrease) Amount	Revised Budget
2027	102-500731	Contracts for Prog Svc	90079102	$25,000	$0	$25,000
2028	102-500731	Contracts for Prog Svc	90079102	$25,000	$0	$25,000
		SubTotal:		**$50,000**	**$0**	**$50,000**

05-95-90-902510-1114 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF EMERG PREP RESPONSE & RECOV, PH EMERGENCY PREPAREDNESS
69% Federal Fund & 31%General Funds
65% FEDERAL FUNDS & 35% GENERAL FUNDS
ALN 93.069 FAIN #NU9TP000009 Award Date 7/1/24 CDC

State Fiscal Year	Class/Account	Class Title	Job Number	Current Budget	Increase (Decrease) Amount	Revised Budget
2027	102-500731	Contracts for Prog Svc	90077410	$43,500	$0	$43,500
2028	102-500731	Contracts for Prog Svc	90077410	$43,500	$0	$43,500
		SubTotal:		**$87,000**	**$0**	**$87,000**

005-95-90-904510-3167 HEALTH AND SOCIAL SERVICES, DEFT OF HEALTH AND HUMAN SVS, HHS; PUBLIC HEALTH DIV, BUREAU OF PREVENTION AND WELLNESS, OPIOID SURVEILLANCE
100% FEDERAL FUNDS
ALN 93.136 FAIN# NU17CE010211 AWARD DATE 8/28/25 CDC

State Fiscal Year	Class/Account	Class Title	Job Number	Current Budget	Increase (Decrease) Amount	Revised Budget
2027	102-500731	Contracts for Prog Svc	90050400	$10,000	$0	$10,000
2028	102-500731	Contracts for Prog Svc	90050400	$10,000	$0	$10,000
		SubTotal:		**$20,000**	**$0**	**$20,000**
		TOTALS		**$1,197,000**	**$0**	**$1,197,000**

FORM NUMBER P-37 (version 2/23/2023)

Subject: Poison Control Serivces (SS-2027-DPH-02-PCNTL-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 MaineHealth New Hampshire Ambulatory Care		1.4 Contractor Address 110 Free Street, Portland, ME 04101	
1.5 Contractor Phone Number (207) 662-3538	1.6 Account Unit and Class TBD	1.7 Completion Date June 30, 2028	1.8 Price Limitation $1,197,000
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: Kelly Elkins 08C69DD1A7EE400... Date: 5/28/2026		1.12 Name and Title of Contractor Signatory Kelly Elkins — Chief Operating Officer	
1.13 State Agency Signature DocuSigned by: Iain Watt D778BB63F9704C7... Date: 5/28/2026		1.14 Name and Title of State Agency Signatory Iain Watt — Director - DPH	
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: DocuSigned by: Robyn Guarino 748734844941480...		On: 5/29/2026	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

Contractor Initials DS KE

Date 5/28/2026

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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.

Contractor Initials DS kE

Date 5/28/2026

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8. EVENT OF DEFAULT/REMEDIES.

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

8.1.1 failure to perform the Services satisfactorily or on schedule;

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

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

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

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) 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.

Contractor Initials DS KE

Date 5/28/2026

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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.

Contractor Initials DS kE
Date 5/28/2026

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EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Subparagraph 3.1., Effective Date/Completion of Services, is amended as follows:

3.1. Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, this Agreement, and all obligations of the parties hereunder, shall become effective on July 1, 2026 ("Effective Date").

1.2. Paragraph 3, Effective Date/Completion of Services, is amended by deleting subparagraph 3.3., in its entirety and replacing it as follows:

3.3. Contractor must complete all Services by the Completion Date specified in block 1.7. The parties may extend the Agreement for up to two (2) 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.

1.3. Paragraph 6, Compliance by Contractor with Laws and Regulations/Equal Employment Opportunity, Subparagraph 6.1., is amended as follows:

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, RSA 151:21 Patients' Bill of Rights, 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.

1.4. Paragraph 9, Subparagraph 9.1, Termination, is amended as follows:

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by ninety (90) calendar days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

1.5. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.5., as follows:

12.5. 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 if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as

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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.

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EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor must provide poison control services following the established guidelines of the national accredited America's Poison Centers (APC)[1], which includes a twenty-four (24) hours per day, seven (7) days per week, 365 days per year national, toll-free Poison Help[2] hotline (1-800-222-1222) accessible to the general public and healthcare professionals.

1.2. The Contractor must ensure Poison Control Services include:

1.2.1. Respond to poisoning emergencies and non-emergency toxicology concerns;

1.2.2. Provide basic poison prevention information.

1.2.3. Coordinate CHEMPACK cache[3] consultation and deployment during a public health emergency.

1.3. The Contractor must ensure its call management system and staff are capable of processing more than 12,000 calls annually. Functions of the call management staff must include:

1.3.1. Triage of emergent and non-emergent cases and calls;

1.3.2. Ongoing case and call monitoring, and clinical consultation;

1.3.3. Home-based support for non-emergent poisoning and medication errors; and

1.3.4. Providing general poison information.

1.3.5. Coordination with hospital emergency departments for emergent cases and calls, including:

1.3.5.1. Notifying the receiving hospital emergency department of the patients arrival;

1.3.5.2. Communicating the poison involved, circumstances of exposure, expected clinical effects, and recommended management; and

1.3.5.3. Monitoring the patient's case throughout treatment and adjusting clinical recommendations as needed during assessment and reassessment;

1.3.6. Documenting all incoming calls for data collection purposes, which may include:

[1] Poisoncenters.org
[2] Poisonhelp.org
[3] https://chemm.hhs.gov/chempack.htm

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1.3.6.1. Caller/Patient full name;

1.3.6.2. Phone number;

1.3.6.3. Town/Zip Code;

1.3.6.4. Date and time of call;

1.3.6.5. Caller site (e.g., health care facility, school, workplace, first responder, residence);

1.3.6.6. Patient age group;

1.3.6.7. Patient gender;

1.3.6.8. Type of poison;

1.3.6.9. Method of exposure (e.g., ingestion, dermal, inhalation);

1.3.6.10. Place of exposure (e.g., home, work, school, public place);

1.3.6.11. Reason for call (e.g., self-harm attempt, medication error, unintentional poisoning, environmental exposure, general information request);

1.3.6.12. Site of exposure management (e.g., health care facility, ambulance, on-site, school nurse's office); and

1.3.6.13. Exposure outcome (e.g., minimal effect, severe effect, death).

1.3.7. Documenting all outgoing follow-up calls as needed, for triaged emergent poisoning cases, which must include:

1.3.7.1. Caller/Patient full name;

1.3.7.2. Phone number;

1.3.7.3. Address;

1.3.7.4. Date and time of call;

1.3.7.5. Name and designation of clinical representative responding;

1.4. The Contractor must comply with all HIPAA privacy regulations regarding any data containing PHI/PII, including emergent poisoning data containing PHI/PII.

1.5. The Contractor must prohibit use of personal devices by Contractor staff for unencrypted data handling activities.

1.6. The Contractor must notify the Department of any customer service disruption lasting more than 60 minutes, including disruptions caused by technical failures, scheduled maintenance, or unforeseen events (e.g., weather-related incidents).

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1.7. The Contractor must ensure its call management system includes the following features/functionality:

1.7.1. Playback of greeting messages for all incoming calls, including:

1.7.1.1. “This call will be recorded for quality assurance. Your privacy is protected."

1.7.2. Greeting messages inform callers of available interpretation and communication access services for individuals with language access needs, including those whose primary language is not English or require alternative communication support.

1.7.3. Transmission of call data hourly to the National Poisoning Data System (NPDS), operated by the APC.

1.8. The Contractor must submit a call management system Disaster Recovery Plan (DRP) for bioterrorism and public health emergencies to the Department within 60 days of the Contract Effective Date, which must include the following:

1.8.1. Initiate the development of emergency messaging, in collaboration with the Department, for dissemination to the general public and health care professionals, as needed.

1.8.2. Distribute emergency messaging previously developed in collaboration with the Department to the general public and health care professionals.

1.8.3. Provision of call-surge backup to the Department, upon request, including:

1.8.3.1. Disaster Recovery training for Contractor staff, as needed;

1.8.3.2. Answering calls received by the designated national, toll-free Poison Help hotline and triaging calls based on severity;

1.8.3.3. Requesting assistance from all available personnel, including overtime or reassignment from other duties;

1.8.3.4. Providing a clinical toxicologist for calls requiring advanced technical expertise;

1.8.3.5. Providing a medical director to supervise and support personnel responding to increased poison-related inquiries;

1.8.3.6. Collaboration with the Department to identify and share aggregate or de-identified surveillance data that may serve as early warning indicators for public health threats to audiences designated by the Department.

1.8.3.7. Ongoing education, which must include but in not limited to, emergency preparedness and response training, as

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requested by the Department for designated target audiences.

1.9. The Contractor must maintain call center staffing levels that meet, at a minimum, accreditation requirements established by APC.

1.10. The Contractor must collaborate with the Department to develop New Hampshire Health Alert Network notifications related to poisoning for drills and actual events.

1.11. The Contractor must provide information on emergent poisoning issues including, but not limited to, protocols and management recommendations for poisonings with increased occurrence to the New Hampshire Health Alert Network, the Department, and other New Hampshire stakeholders,.

1.12. The Contractor must maintain a list of statewide locations where antidotes may be dispensed; and maintain the ability to mobilize poison antidotes upon request by the Department.

1.13. The Contractor must review poisoning cases with medical or clinical board-certified toxicologists, as requested by the Department.

1.14. The Contractor must coordinate education activities, as funding allows, in collaboration with the Department's Injury Prevention Program, including:

1.14.1. Participating as a member of the Department's Injury Prevention Advisory Council.

1.14.2. Development of poison prevention strategies consistent with the most current State of New Hampshire Violence and Injury Prevention 5-Year Plan[4], which includes the following activities:

1.14.2.1. Presenting at or acting on behalf of the Department as a panel member for community sessions related to reducing substance misuse and Department-hosted public meetings, which may include, but is not limited to:

1.14.2.2. Alcoholics Anonymous (AA).

1.14.2.3. Narcotics Anonymous (NA).

1.14.2.4. National Alliance of Mental Illness (NAMI).

1.14.2.5. SMART Recovery[5],

1.14.3. Providing virtual educational sessions and other outreach for the general public, health care providers, educators, legislators, media representatives, and others as directed by the Department.

[4] https://www.dhhs.nh.gov/programs-services/population-health/maternal-child-health/injury-prevention
[5] https://smartrecovery.org/

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1.14.4. Attending Department-related injury prevention meetings in NH that include a poisoning prevention component, which may include community or Department meetings.

1.14.5. Conducting other activities, as directed by the Department.

1.15. The Contractor must support the following poisoning prevention efforts:

1.15.1. Primary Prevention: Public messaging on seasonal and situational poison risks including, but not limited to:

1.15.1.1. Carbon monoxide exposure.

1.15.1.2. Medication safety.

1.15.1.3. Pesticide use.

1.15.2. Secondary Prevention: Awareness campaigns targeting children, older adults, and caregivers.

1.15.3. Tertiary Prevention: Clinical support to reduce the severity and duration of poisoning cases in healthcare settings.

1.15.4. Distribution of prevention messaging through the following channels, as appropriate for the audience:

1.15.4.1. Durable/print and digital media materials;

1.15.4.2. Webinars, trainings, and presentations;

1.15.4.3. Social media; and

1.15.4.4. Other outlets approved by the Department.

1.16. The Contractor must provide information on poisoning topics to Department use for legislative briefings or media queries to be provided within three (3) business days, or as agreed upon by both parties Upon receiving such requests, the Contractor must notify the Department's Public Information Office (PIO) via email (dhhs.pio@dhhs.nh.gov) to ensure the PIO is informed of the data requested and the requesting party.

1.17. Reporting

1.17.1. The Contractor must report aggregate, de-identified data to the Department in a format requested by the Department, which must include:

1.17.1.1. A monthly report on opioid-related poisoning calls of aggregate data only, and a report with additional information upon request by the Department;

1.17.1.2. A quarterly report on progress toward meeting the performance measures and call rates in Section 1.18

Performance measures, including call data specified in Sections 1.3.6. and 1.3.7.

1.17.1.3. An annual report on progress toward meeting the performance measures and call rates, as specified Section 1.18 below, Performance Measures.

1.17.2. The Contractor must submit an annual corrective action plan to the Department for any/all annual performance measure(s) in Section 1.19 below that is not achieved. The plan must be submitted no later than 30 business days after each State Fiscal Year End.

1.17.3. The Contractor may be required to provide other key data and metrics to the Department, as requested and in a format approved by the Department.

1.18. Performance Measures

1.18.1. The Contractor must ensure that following performance indicators are achieved annually and monitored monthly. The Contractor must:

1.18.1.1. Maintain an overall, age-adjusted annual penetrance for human exposure cases that is equal to or greater than the national age-adjusted penetrance (poison exposures per 1,000 population) as reported in the most recent NPDS annual report.

1.18.1.2. Ensure Poison Educator attends the quarterly Injury Prevention Advisory Council (IPAC) Meetings that occur four (4) times per year and provides updates on poison prevention education activities; and ensure the Poison Educator presents or serves as a panel member for at least ten (10) educational or community outreach events per year.

1.18.1.3. Ensure the following call-rate performance standards are met:

1.18.1.3.1. For all non-emergent cases, at least ninety percent (90%) of callers are managed in the home setting.

1.18.1.3.2. For all non-emergent cases regarding children under six (6) years of age, at least ninety percent (90%) are managed in the home setting.

1.18.1.3.3. For all non-emergent cases involving adults age sixty (60) and older who live independently in the community, at least ninety percent (90%) are managed in the

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home setting.

1.18.1.4. Maintain or exceed the percentage of human poisoning exposure cases managed at health care facilities at a baseline of twenty-three percent (23%) of all calls.

1.18.1.5. Respond to all Department notification alerts issued during quarterly drills within thirty (30) minutes

1.19. Background Checks

1.19.1. Prior to permitting any individual to provide services under this Agreement, the Contractor must ensure that said individual has undergone:

1.19.1.1. A criminal background check, at the Contractor's expense, and has no convictions for crimes that represent evidence of behavior that could endanger individuals served under this Agreement;

1.19.1.2. A name search of the Department's Bureau of Adult and Aging Services (BAAS) State Registry, pursuant to RSA 161-F:49, with results indicating no evidence of behavior that could endanger individuals served under this Agreement; and

1.19.1.3. A name search of the Department's Division for Children, Youth and Families (DCYF) Central Registry pursuant to RSA 169-C:35, with results indicating no evidence of behavior that could endanger individuals served under this Agreement.

1.20. Confidential Data

1.20.1. 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.

1.20.2. 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.

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1.21. Privacy Impact Assessment

1.21.1. 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, 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:

1.21.1.1. How PII is gathered and stored;

1.21.1.2. Who will have access to PII;

1.21.1.3. How PII will be used in the system;

1.21.1.4. How individual consent will be achieved and revoked; and

1.21.1.5. Privacy practices.

1.21.2. 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.

1.22. Website and Social Media

1.22.1. The Contractor must work with the Department's Communications Bureau to ensure that any social media or website designed, created, or managed on behalf of the Department meets all Department and NH Department of Information Technology (DoIT) website and social media requirements and policies.

2. Exhibits Incorporated

2.1. The Contractor must comply with all Exhibit D Federal Requirements, which are attached hereto and incorporated by reference herein.

2.2. The Contractor must manage all confidential data related to this Agreement in accordance with the terms of Exhibit E, DHHS Information Security Requirements.

2.3. 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 F, Business Associate Agreement, which has been executed by the parties.

3. Additional Terms

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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. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor must submit:

3.2.1.1. A detailed description of the language assistance services, within ten (10) days of the Effective Date of the Agreement, to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.2.1.2. A written attestation, within forty-five (45) days of the Effective Date of the Agreement and annually thereafter, that all personnel involved the provision of services to individuals under this Agreement have completed, within the last twelve (12) months, the Contractor Required Training Video on Civil Rights-related Provisions in DHHS Procurement Processes, which is accessible on the Department's website (https://www.dhhs.nh.gov/doing-business-dhhs/civil-right-compliance-dhhs-vendors); and

3.2.1.3. The Department's Federal Civil Rights Compliance Checklist within ten (10) days of the Effective Date of the Agreement. The Federal Civil Rights Compliance Checklist must have been completed within the last twelve (12) months and is accessible on the Department's website (https://www.dhhs.nh.gov/doing-business-dhhs/civil-right-compliance-dhhs-vendors).

3.3. Credits and Copyright Ownership

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3.3.1. 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 a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

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

3.3.3. The Department must retain copyright ownership for any and all original materials produced, including, but not limited to reports, protocols, guidelines, brochures, posters, and resource directories.

3.3.4. 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. Statistical records, which must include records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

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

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4.3. If, upon further review, 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 as are disallowed or to recover such sums from the Contractor.

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Payment Terms

1. This Agreement is funded by:
   1.1. 7% Federal funds, from:
      1.1.1. 5% from NH Public Health Emergency Preparedness and Response, as awarded on July 1, 2024, by the Centers for Disease Control and Prevention (CDC), ALN 93.069, FAIN NU90TP000009; and
      1.1.2. 2% from NH Implementation of the Overdose Data to Action in States, as awarded on August 28, 2025, by the CDC, ALN 93.136, FAIN NU17CE010211.
   1.2. 89% General funds.
   1.3. 4% Other funds (Department of Safety).
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, based on criteria specified in 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
   2.3. The Indirect Cost Rate for this Agreement in the attached Budget Sheet(s).
3. Payment shall be on a cost reimbursement basis for actual allowable expenditures incurred under this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget.
4. The Contractor shall submit an invoice 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 format as provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment in accordance with Section 3, above.
   4.4. Includes supporting documentation with each invoice, including, but not limited to, proof of allowable expenditures, itemized receipts for purchases, time sheets, and payroll records with position or staff detail, as applicable.
   4.5. Is completed, dated and returned to the Department to initiate payment.
   4.6. Is assigned an electronic signature and is emailed to DHHS.DPHS.Contract@dhhs.nh.gov or mailed to:

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

5. The Department shall make payments to the Contractor within thirty (30) calendar days only upon receipt and approval of the submitted invoice and required supporting documentation.

6. The final invoice and any required supporting documentation shall be due to the Department no later than forty (40) calendar 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 direct and indirect cost amounts within the price limitation between budget class lines, as well as adjusting encumbrances between State Fiscal Years 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 is subject to a Single Audit pursuant to 2 CFR 200.501 Audit Requirements.

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 Securities 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

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annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. The Contractor, regardless of the funding source and/or whether Conditions A, B, or C exist, may be required to submit annual financial audits performed by an independent CPA upon request by the Department.

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, within sixty (60) days.

9. If applicable, the Contractor must request disposition instructions from the Department for any equipment, as defined in 2 CFR 200.313, purchased using funds provided under this Agreement, including information technology systems.

Exhibit C-1

New Hampshire Department of Health and Human Services		
Contractor Name:	MaineHealth New Hampshire Ambulatory Care Services	
Budget Request for:	Poison Control Services	
Budget Period:	7/1/2026 through 6/30/2028	
Average Indirect Cost Rate (if applicable)	10%	
Line Item	**Program Cost - Funded by DHHS - SFY 27** [7/1/2026 - 6/30/2027]	**Program Cost - Funded by DHHS - SFY 28** [7/1/2027 - 6/30/2028]
1. Salary & Wages	399,715.64	399,935.96
2. Fringe Benefits	122,512.84	122,580.37
3. Consultants		
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*		
5.(a) Supplies - Educational		
5.(b) Supplies - Lab		
5.(c) Supplies - Pharmacy		
5.(d) Supplies - Medical		
5.(e) Supplies - Office		
6. Travel	6,480.00	6,192.00
7. Software	10,395.20	10,395.20
8. (a) Other - Marketing/Communications		
8. (b) Other - Education and Training	2,400.00	2,400.00
8. (c) Other - Other (specify below)		
Other-Telephone	287.23	287.38
Other-Subscriptions	2,300.00	2,300.00
Other (please specify)		
Other (please specify)		
Other (please specify)		
Other (please specify)		
Other (please specify)		
9. Subrecipient Contracts		
Total Direct Costs	544,090.91	544,090.91

Total Indirect Costs	54,409.09	54,409.09
	10.00%	10.00%
Subtotals	**$598,500.00**	**$598,500.00**
	TOTAL	**$1,197,000.00**

Contractor Initials DS kE

Date 5/28/2026

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New Hampshire Department of Health and Human Services
Exhibit D – Federal Requirements

SECTION A: CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR CONTRACTORS OTHER THAN INDIVIDUALS

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

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by contractors (and by inference, sub- contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a contractor (and by inference, sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each Agreement during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the Agreement. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of Agreements, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6505

1. The Contractor certifies that it will or will continue to provide a drug-free workplace by:
   1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   1.2. Establishing an ongoing drug-free awareness program to inform employees about
      1.2.1. The dangers of drug abuse in the workplace;
      1.2.2. The Contractor's policy of maintaining a drug-free workplace;
      1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
      1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   1.3. Making it a requirement that each employee to be engaged in the performance of the Agreement be given a copy of the statement required by paragraph (a);
   1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the Agreement, the employee will
      1.4.1. Abide by the terms of the statement; and
      1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

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1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every contract officer on whose contract activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected Agreement;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The Contractor may insert in the space provided below the site(s) for the performance of work done in connection with the specific Agreement.

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

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

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SECTION B: CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, loan, or cooperative agreement (and by specific mention sub- contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, see https://omb.report/icr/201009-0348-022/doc/20388401

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

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

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SECTION C: CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 12689 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this Agreement, the prospective primary participant is providing the certification set out below.

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

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

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

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See https://www.govinfo.gov/app/details/CFR-2004-title45-vol1/CFR-2004-title45-vol1-part76/context.

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

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

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties) https://www.ecfr.gov/current/title-22/chapter-V/part-513.

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9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

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SECTION D: CERTIFICATION OF COMPLIANCE WITH FEDERAL REQUIREMENTS

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

The Contractor will comply, and will require any subcontractors to comply, with any applicable federal requirements, which may include but are not limited to:

1. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR 200).
2. The Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;
3. The Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;
4. The Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);
5. The Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;
6. The Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;
7. The Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;
8. The Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;
9. 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;
10. 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.
11. The Clean Air Act (42 U.S.C. 7401-7671q.) which seeks to protect human health and the environment from emissions that pollute ambient, or outdoor, air.

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12. The Clean Water Act (33 U.S.C. 1251-1387) which establishes the basic structure for regulating discharges of pollutants into the waters of the United States and regulating quality standards for surface waters.
13. Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) (41 U.S.C. 1908) which establishes administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provide for such sanctions and penalties as appropriate.
14. Contract Work Hours and Safety Standards Act (40 U.S.C. 3701–3708) which establishes that all contracts awarded by the non-Federal entity in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5).
15. Rights to Inventions Made Under a Contract or Agreement 37 CFR § 401.2 (a) which establishes the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that “funding agreement,” the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, “Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements,” and any implementing regulations issued by the awarding agency.

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

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

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

1. By signing and submitting this Agreement, the Contractor agrees to comply with the provisions indicated above.

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SECTION E: CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

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

1. By signing and submitting this Agreement, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

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SECTION F: CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $30,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $30,000 or more. If the initial award is below $30,000 but subsequent grant modifications result in a total award equal to or over $30,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any sub award or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique Entity Identifier (SAM UEI; DUNS#)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC. Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

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FORM A

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

1. The UEI (SAM.gov) number for your entity is:_____

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

   _____NO _____YES

   If the answer to #2 above is NO, stop here
   If the answer to #2 above is YES, please answer the following:

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

   _____NO _____YES

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

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

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

Contractor Name: MaineHealth

5/28/2026
_____
Date:

DocuSigned by:
Kelly Elkins
08C69DD1A7EE400...
Name: Kelly Elkins
Title: Chief Operating Officer

New Hampshire Department of Health and Human Services

Exhibit E

DHHS Information Security Requirements

A. Definitions

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

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" 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, 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 an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss

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or misplacement of hardcopy documents, and misrouting of physical or electronic mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

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

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. 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.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User 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. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User 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 End User 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. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User 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 End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.

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8. Open Wireless Networks. End User 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 End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User 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 the 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 permitted under this Contract. 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.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department 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, the latest anti-viral, antihacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

Contractor Initials DS

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

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. 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.
3. 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.).

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3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will 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.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of 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.

7. 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.

8. 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.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. 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.

11. Data Security Breach Liability. In the event of any security 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.

12. 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 requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. 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.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. 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.

15. 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.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. 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 and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. 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;

Contractor Initials DS kE

4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

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

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov B.

DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

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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

Contractor Initials KE

Date 5/29/2026

limited to all its directors, officers, employees, and agents, shall protect any PHI as required by HIPPA 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 or other 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

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security breach as described above and communicate the risk assessment to the Covered Entity. The risk assessment shall include, but not be limited to:

I. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

II. The unauthorized person who accessed, used, disclosed, or received the protected health information;

III. Whether the protected health information was actually acquired or viewed; and

IV. How the risk of loss of confidentiality to the protected health information has been mitigated.

e. The Business Associate shall complete a risk assessment report at the conclusion of its incident or breach investigation and provide the findings in a written report to the Covered Entity as soon as practicable after the conclusion of the Business Associate's investigation.

f. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the US Secretary of Health and Human Services for purposes of determining the Business Associate's and the Covered Entity's compliance with HIPAA and the Privacy and Security Rule, and Part 2, if applicable.

g. Business Associate shall require all of its business associates that receive, use or have access to PHI under the BAA to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein.

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) 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.

VI. 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

a. 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.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this BAA, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination of Agreement for Cause

a. 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,

Contractor Initials DS

Date 5/29/2026

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herein, shall refer to those laws and regulations as amended from time to time. A reference in the Agreement, as amended to include this Business Associate Agreement, 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 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) g. and (3) n.l., and the defense and indemnification provisions 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	MaineHealth
The State	Name of the Contractor
DocuSigned by: Iain Watt D778BB63F9704C7...	DocuSigned by: Kelly Elkins 08C69DD1A7EE400...
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Kelly Elkins
Name of Authorized Representative	Name of Authorized Representative
Director - DPH	Chief Operating Officer
Title of Authorized Representative	Title of Authorized Representative
5/31/2026	5/29/2026
Date	Date

Contractor Initials DS KE

Date 5/29/2026

Docusign Envelope ID: E99F83D2-441A-851B-821E-142A4B5040F1

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 MAINEHEALTH NEW HAMPSHIRE AMBULATORY CARE is a Maine Nonprofit Corporation registered to transact business in New Hampshire on January 31, 2025. 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; and the attached is a true copy of the list of documents on file in this office.

Business ID: **985727**
Certificate Number: **0007928971**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 14th day of May A.D. 2026.

David M. Scanlan
Secretary of State

Docusign Envelope ID: E99F83D2-441A-851B-821E-142A4B5040F1

CERTIFICATE OF AUTHORITY

I, Cecilie MacIntyre, being the duly elected Assistant Secretary of MaineHealth, a corporation organized and existing under and by virtue of the Laws of the State of Maine (hereinafter called this Corporation) do hereby certify as follows:

1. The Chief Executive Officer/President or the Treasurer has the authority to execute deeds, contracts and other documents on behalf of the Corporation pursuant to Section 11.1 of the Corporation's bylaws which remain in full force and effect on the date hereof as follows:

> Execution of Papers. All deeds, leases, transfers, contracts, bonds, notes, checks, drafts and other obligations made, accepted or endorsed by the Corporation shall be signed by the CEO/President or the Treasurer, or by persons designated in writing by the CEO/President or Treasurer, except that the Board of Trustees may by resolution restrict such power or authorize others to execute such documents.

2. Each of the following officers has been duly elected or appointed and is now legally holding the office opposite his or her name:

NAME	OFFICE
Dr. Andrew T. Mueller	Chief Executive Officer/President
Charles Richard Bayman	Treasurer

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

DATED: 5/18/20

Cecilie MacIntyre, Assistant Secretary
MaineHealth
110 Free Street
Portland, ME 04101
207-661-7010

Docusign Envelope ID: E99F83D2-441A-851B-821E-142A4B5040F1

CERTIFICATE OF AUTHORITY

I, Beth Kelsch, being the duly elected Secretary of MaineHealth New Hampshire Ambulatory Care, a corporation organized and existing under and by virtue of the Laws of the State of Maine (hereinafter called this Corporation) do hereby certify as follows:

1. The Chair, President, Treasurer and Chief Financial Officer have the authority to execute deeds, leases, transfers, contracts, bonds, notes, checks, drafts and other obligations on behalf of the Corporation pursuant to Section 8.1 of the Corporation's bylaws which remain in full force and effect on the date hereof as follows:

> Execution of Papers. All deeds, leases, transfers, contracts, bonds, notes, checks, drafts and other obligations made, accepted or endorsed by the Corporation shall be signed by the Chair, President, the Treasurer or the Chief Financial Officer except that the Board may by resolution restrict such power or authorize others to execute such documents.

2. Each of the following officers has been duly elected or appointed and is now legally holding the office opposite his or her name:

NAME	OFFICE
Kelly Elkins	President
Charles Richard Bayman	Treasurer

DATED: 5/28/2026

Beth Kelsch, Secretary
MaineHealth New Hampshire
Ambulatory Care
110 Free Street
Portland, ME 04101
207-661-7010

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 06/02/2026

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

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER

Medical Mutual Insurance Company of Maine
One City Center PO Box 15275
Portland, ME 04112

CONTACT NAME:
PHONE (A/C, No, Ext): 2077752791 **FAX (A/C, No):** 2075238320
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Medical Mutual Ins Co of Maine	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

MaineHealth Services
110 Free Street

Portland ME 04101

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:			ME CHL 004693	10/01/2025	10/01/2026	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 50,000 $ 5,000 $ 2,000,000 $ 12,000,000 $ 12,000,000
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N N / A					PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A	Professional Liability			ME CHL 004693	10/01/2025	10/01/2026	$2,000,000/$12,000,000	

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

MaineHealth NH Ambulatory Care is an additional insured under the described policy.

CERTIFICATE HOLDER

MaineHealth NH Ambulatory Care
1976 White Mountain Hwy, Suite 105
North Conway, New Hampshire 03860

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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Client#: 1000594 MAINE

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/19/2026

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

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services, LLC
75 John Roberts Road, Building C
South Portland, ME 04106
855 874-0123

CONTACT NAME: Mary Roy
PHONE (A/C, No, Ext): 855 874-0123 **FAX (A/C, No):** 877-775-0110
E-MAIL ADDRESS: Mary.Roy@usi.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Travelers Casualty Company of CT	36170
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
MaineHealth Services
22 Bramhall Street
Portland, ME 04102-3175

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N	N / A		UB5K2905132643G	03/01/2026	03/01/2027	X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
This Certificate is issued for insured operations usual to MaineHealth Services.

CERTIFICATE HOLDER
State of NH
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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NONPROFIT COVER SHEET

A. Entity Name: MaineHealth New Hampshire Ambulatory Care

B. Entity's Contact Information:

For Records Requests (e.g., resumes of key personnel; audited financial statements):

Name / Phone / Email: Karen Simone/207-662-7221/karen.simone@mainehealth.org

Person responsible for Accuracy and Completeness of information provided:
Name: Karen E. Simone Title: Director, Northern New England Poison Center
Signature: Karen E Simone

C. List Board of Directors and Affiliations

Name (Identify any additional role(s) in Parentheses) E.g., John Doe (President)	Affiliations
Andrew T. Mueller, MD (Chief Exec. Officer)	MaineHealth
Marie McCarthy (Chair)	L.L. Bean
Rich Bayman (Treasurer)	MaineHealth
Beth Kelsch (Secretary)	MaineHealth
Lisa Tran, MD (Trustee)	MaineHealth
Ann Bresnahan (Trustee)	MaineHealth
L.Clint Boothby (Trustee)	Boothby Silver LLC
Matthew Chin (Trustee)	Harvesting Good
Chris Cimino (Trustee)	CM Cimino Realty Inc
Katherine Coster (Trustee)	Maine Community Bank
Morris Fisher (Trustee)	Boulos Asset Management
Nancy Hasenfus, MD (Trustee)	MaineHealth Behavioral Health
Quincy Hentzel (Trustee)	Portland Regional Chamber of Commerce
Kathleen Herlihy, MD (Trustee)	MaineHealth Stephens Hospital
Jennifer Kent (Trustee)	MEA Benefits Trust
David James Kumaki, MD (Trustee)	MaineHealth
Brett Loffredo, MD (Trustee)	MaineHealth Primary Care
Dan Loiselle, MD (Trustee)	InterMed
Peter Manning, MD (Trustee)	MaineHealth
Brian Noyes (Trustee)	R.M. Davis Inc.
Matthew Orlando (Trustee)	Bowdoin College
Amanda Rand (Trustee)	Spinnaker Trust
Thomas Ryan, MD, FACC (Trustee)	MaineHealth
Linda Terry (Trustee)	MaineHealth
Stuart Watson (Trustee)	zFlo Inc.
Peter Wood (Trustee)	MaineHealth

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D. List Key Personnel (Resumes must be available upon request to the person(s) listed in section B or may be attached**):**

Name	Role	Annual Salary	Amount Paid From This Contract
Karen Simone	Director NNEPC	$221,415	$44,290.23
Mark Neavyn, MD	Medical Director	$387,482	$46,497.88

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DISCLOSURE OF LEGAL ACTIVITIES INVOLVING THE STATE OF NEW HAMPSHIRE OR ANOTHER GOVERNMENT ENTITY

E. Check one of the following:

[x] The entity is **not currently or has not been** party to any legal proceeding involving the State of New Hampshire (or any agency or subdivision thereof) or any other state/federal government entity before any adjudicative body in any jurisdiction **OR**

[ ] The entity is or has been party to one or more legal proceedings as set forth above. Identify the jurisdiction, court or other adjudicative body, case number, and briefly describe the nature of the proceeding (Attached extra sheet if necessary).

_____

_____

_____

CHARITABLE TRUSTS UNIT COMPLIANCE CERTIFICATION

F. Check one of the following:

[ ] is registered and in good standing with the New Hampshire Department of Justice Charitable Trusts Unit (** see note below) **or** has submitted a complete application for registration to the Charitable Trusts Unit and is awaiting a registration determination **OR**

[x] MaineHealth New Hampshire Ambulatory Care is not required to register with the Charitable Trusts Unit because it is neither tax-exempt under section 501(c)(3) of the Internal Revenue Code nor engages in charitable solicitations in the State of New Hampshire **OR**

[ ] is exempt from registration with the Charitable Trusts Unit because it is a federal or state government, agency, or subdivision or is a religious organization, an integrated auxiliary of a religious organization, or is a convention or association of churches.

** Note: Attached screen shot from the DOJ Registered Charities List found at:

https://mm.nh.gov/files/uploads/doj/remote-docs/registered-charities.pdf

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FINANCIAL DISCLOSURES

G. Check one the following:

[x] The organization hired an outside firm to audit its financial statements or to prepare GAAP-compliant financial statements for its most recently completed fiscal year. If so, please ensure that the financial statements and audit results are available to be requested from the contact listed on Page 1 (audited financials may be attached) **OR**

[ ] The above does not apply, but the organization filed an IRS Form 990 or Form 990-EZ for its most recently completed fiscal year. Please attach that IRS Form 990 or Form 990-EZ to the submission. (Form 990 Schedule B is not required) **OR**

[ ] ***If neither of the above apply***, complete the Income Statement and Balance Sheet below with the following basic financial information from the organization's most recently completed fiscal year:

1. INCOME STATEMENT

Revenue		Expenses	
Grants		*Compensation of officers, directors, and key personnel*	
Donations			
Program Services Revenue		*Other salaries & wages*	
		Payroll taxes & employee benefits	
Interest & Dividends			
All other Revenue		*Occupancy, rent, utilities, and insurance*	
Total Revenue		*Printing, publications, postage, office supplies, and IT*	
		All other expenses	
		Total Expenses	

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2. BALANCE SHEET

Assets	
Cash & Equivalents	
Investments	
Real Estate (less any depreciation)	
Other Property & Equipment (less any depreciation)	
All other assets	
Total Assets	

Liabilities	
Accounts Payable	
Loans Payable	
All other liabilities	
Total Liabilities	

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Our Mission, Vision and Values

Vision

Working together so our communities are the healthiest in America.

Mission

MaineHealth is a not-for-profit health system dedicated to improving the health of our patients and communities by providing high-quality affordable care, educating tomorrow's caregivers, and researching better ways to provide care.

Values

Wherever and whenever you interact with MaineHealth, you can expect our team members to embody the following values in action:

Patient Centered: We focus on each individual's unique needs, and partner with the people we care for, their families and care teams to develop a shared plan.

- Act with compassion and kindness
- Listen actively and validate concerns; focus on the individual’s needs
- Communicate effectively with patients, clients and families
- Treat everyone with respect and courtesy; acknowledge cultural differences
- Be empowered to advocate and speak up for patient and client safety
- Partner with the people we care for, their families and care teams to develop a shared plan

Respect: We embrace diversity and recognize the value of each person.

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- Recognize all the people we care for, their family, visitors and co-workers as valued members of the health care team
- Listen actively and respond thoughtfully
- Treat others as you would want to be treated
- Embrace diversity, acknowledging each person's uniqueness
- Be empathetic, compassionate and kind
- Foster a professional and healing atmosphere

Integrity: We are honest, transparent and ethical, and maintain a culture of trust and accountability.

- Demonstrate professionalism at all times, regardless of the behavior of others
- Maintain confidentiality and respect the privacy of all
- Develop and maintain a culture of trust and accountability
- Act with honesty and transparency at all levels of the organization
- Model behavior that is consistently honest and ethical
- Acknowledge mistakes as opportunities to learn and grow

Excellence: We set high standards and always strive to exceed expectations.

- Consistently seek improvements in processes and performance
- Set high standards
- Strive to exceed expectations with every interaction
- Lead by example
- Work collaboratively as a team
- Pursue opportunities to learn and grow personally and professionally

Ownership: We take responsibility for our actions, follow through on our commitments, and approach challenges with optimism.

- Follow up and follow through
- Look beyond our individual roles to do what is necessary to get the job done successfully

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- Take responsibility for our actions and our collective outcomes
- Approach challenges with optimism
- Represent our organization in a positive light
- Promote an accountable, fair and supportive environment

Innovation: We welcome diverse perspectives, embrace change, and are committed to lifelong learning.

- Welcome change with a positive attitude
- Inspire others and foster creativity
- Be courageous
- Encourage diverse perspectives
- Invest in people, technology and research
- Commit to lifelong learning and educating

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ATTORNEY GENERAL
DEPARTMENT OF JUSTICE

ONE GRANITE PLACE SOUTH
CONCORD, NEW HAMPSHIRE 03301

JOHN M. FORMELLA
ATTORNEY GENERAL

JAMES T. BOFFETTI
DEPUTY ATTORNEY GENERAL

August 1, 2025

MaineHealth New Hampshire Ambulatory Care
110 Free Street
Portland, ME 04101

Re: MaineHealth New Hampshire Ambulatory Care

Dear Cecilie:

Please be advised that organizations that have *not* been determined by the Internal Revenue Service to be 501(c)(3) organizations and whose primary purpose is *not* charitable in nature are not required to register with this office pursuant to RSA 7:19, *et seq*., unless they hold trust funds of a charitable nature, or they conduct fundraising from the general public for a charitable purpose. *See* N.H. Admin. R. Jus 402.01.

Feel free to contact this office if you have any questions.

Very truly yours,

Jean M. Smith
Paralegal
Charitable Trusts Unit
(603) 271-1286
jean.m.smith@doj.nh.gov

JMS

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BAKER NEWMAN NOYES

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

Consolidated Financial Statements,
Supplementary Information, and Government
Reports Required by Uniform Guidance

Years Ended September 30, 2024 and 2023
With Independent Auditors' Report

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

HLB
THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

Consolidated Financial Statements,
Supplementary Information, and Government
Reports Required by Uniform Guidance

September 30, 2024 and 2023

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BAKER NEWMAN NOYES

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INDEPENDENT AUDITORS' REPORT

Board of Directors
MaineHealth Services and Subsidiaries

Opinion

We have audited the consolidated financial statements of MaineHealth Services and Subsidiaries (the System), which comprise the consolidated balance sheets as of September 30, 2024 and 2023, the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively, the financial statements).

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the System as of September 30, 2024 and 2023, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* (GAS), issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. 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 Financial Statements

Management is responsible for the preparation and fair presentation of the 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 financial statements that are free from material misstatement, whether due to fraud or error.

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

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Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the 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 GAAS and GAS 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 financial statements.

In performing an audit in accordance with GAAS and GAS, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the 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 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 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 financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the 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.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedule of expenditures of federal awards, as required by Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements.

Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the financial statements as a whole.

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Board of Directors
MaineHealth Services and Subsidiaries

Other Reporting Required by *Government Auditing Standards*

In accordance with GAS, we have also issued our report dated February 7, 2025 on our consideration of the System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with GAS in considering the System's internal control over financial reporting and compliance.

Baker Newman + Noyes LLC

Portland, Maine
February 7, 2025, except as to the Supplementary
Schedule of Expenditures of Federal Awards and
Report on Compliance for each Major Federal Program
for which the date is June 23, 2025

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED BALANCE SHEETS

September 30, 2024 and 2023
(In thousands)

Assets	2024	2023
Current assets:		
Cash and cash equivalents	$ 318,905	$ 351,113
Investments	1,078,450	889,112
Patient accounts receivable	533,191	458,943
Current portion of investments whose use is limited	15,442	28,098
Inventories, prepaid expenses and other current assets	163,851	135,974
Total current assets	2,109,839	1,863,240
Investments whose use is limited by:		
Debt agreements	37,940	24,701
Board designation	180,671	151,639
Self-insurance trust agreements	34,496	37,548
Specially designated specific purpose funds	105,429	95,347
Plant replacement funds	5,757	4,866
Funds functioning as endowment funds	152,942	127,250
Pooled life income funds	2,049	1,884
Beneficial interest in perpetual and charitable remainder trusts	58,294	50,397
	577,578	493,632
Less current portion	(15,442)	(28,098)
	562,136	465,534
Property, plant and equipment - net	1,665,076	1,584,348
Right of use assets	133,321	150,927
Other assets	232,107	202,961
Total assets	$ 4,702,479	$ 4,267,010

Liabilities and Net Assets	2024	2023
Current liabilities:		
Current portion of long-term debt	$ 42,242	$ 41,824
Current portion of lease obligation	16,690	18,103
Accounts payable and other current liabilities	191,690	169,621
Accrued payroll, payroll taxes and amounts withheld	140,062	100,325
Accrued earned time	105,064	103,954
Accrued interest payable	6,603	5,312
Estimated amounts payable under reimbursement regulations	68,655	86,943
Self-insurance reserves	42,546	44,256
Deferred revenue	34,991	23,264
Total current liabilities	648,543	593,602
Accrued retirement benefits	249,881	221,356
Self-insurance reserves – less current portion	67,385	67,546
Long-term debt, less current portion	837,127	740,453
Long-term lease obligation – less current portion	123,634	138,998
Other liabilities	33,969	31,041
Total liabilities	1,960,539	1,792,996
Net assets:		
Without donor restrictions	2,416,338	2,188,281
With donor restrictions	325,602	285,733
Total net assets	2,741,940	2,474,014
Total liabilities and net assets	$ 4,702,479	$ 4,267,010

See accompanying notes to consolidated financial statements.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2024 and 2023
(In thousands)

	2024	2023
Revenue:		
Patient service revenue	$3,856,373	$3,425,497
Research revenue	27,404	26,907
Other revenue	446,184	492,547
Total revenue and other support	4,329,961	3,944,951
Expenses:		
Salaries	2,064,087	1,864,213
Employee benefits	526,701	467,372
Supplies	768,069	698,394
Professional fees and purchased services	524,477	551,979
Facility and other costs	155,025	141,737
State taxes	59,491	60,373
Interest	23,875	15,389
Depreciation and amortization	167,613	163,124
Total expenses	4,289,338	3,962,581
Income (loss) from operations	40,623	(17,630)
Nonoperating gains:		
Gifts and donations – net of related expenses	721	3,237
Interest and dividends	49,196	34,674
Recognized (loss) gain on cash flow hedge instruments	(2,069)	1,892
Nonservice periodic pension costs	2,411	9,035
Equity in earnings (losses) of joint ventures	2,533	(461)
Increase in fair value of investments	121,475	48,109
Other	5,933	4,333
Total nonoperating gains - net	180,200	100,819
Excess of revenue and nonoperating gains – net over expenses	220,823	83,189
Net assets released from restrictions for property, plant and equipment	10,432	11,477
Retirement benefit plan adjustments	(3,198)	15,772
Increase in net assets without donor restriction	$ 228,057	$ 110,438

See accompanying notes to consolidated financial statements.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2024 and 2023
(In thousands)

	2024	2023
Net assets without donor restrictions:		
Excess of revenue and nonoperating gains – net over expenses	$ 220,823	$ 83,189
Net assets released from restrictions for property, plant and equipment	10,432	11,477
Retirement benefit plan adjustments	(3,198)	15,772
Increase in net assets without donor restriction	228,057	110,438
Net assets with donor restrictions:		
Gifts and donations	22,987	26,402
Interest and dividends	3,957	551
Change in value of perpetual and beneficial interest trusts	7,870	3,421
Realized and unrealized gains on investments	30,176	17,508
Net assets released for operations	(14,689)	(14,053)
Net assets released for property, plant and equipment	(10,432)	(11,477)
Increase in net assets with donor restrictions	39,869	22,352
Increase in net assets	267,926	132,790
Net assets – beginning of year	2,474,014	2,341,224
Net assets – end of year	$2,741,940	$2,474,014

See accompanying notes to consolidated financial statements.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2024 and 2023
(In thousands)

	2024	2023
Cash flows from operating activities:		
Increase in net assets	$ 267,926	$ 132,790
Adjustment to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	167,580	163,497
Accretion of bond issuance cost and premium, net	(3,533)	(2,925)
Equity in earnings of joint ventures	(2,533)	461
Net realized and change in unrealized gains on investments	(151,651)	(65,617)
Net gain on cash flow hedge instruments	2,069	(1,892)
Net gain on charitable remainder and perpetual trusts	(7,897)	(3,218)
(Loss) gain on disposal of fixed assets	1,085	(2,885)
Noncash lease expense	15,833	20,546
Restricted contributions and investments income	(26,944)	(26,953)
Retirement benefit plan adjustments	3,198	(15,772)
Increase in asset retirement obligations	94	(22)
Increase (decrease) in cash resulting from a change in:		
Patient accounts receivable	(74,248)	(102,687)
Inventories, prepaid expenses and other current assets	(27,877)	3,832
Other assets	(34,611)	(31,759)
Accounts payable and other current liabilities	85,763	(67,786)
Operating lease liability	(15,004)	(19,418)
Amounts payable under reimbursement regulations	(18,288)	17,689
Self-insurance reserves	(1,871)	5,057
Accrued retirement benefits	25,327	1,886
Other liabilities	(730)	(539)
Net cash provided by operating activities	203,688	4,285
Cash flows from investing activities:		
Purchase of investments	(939,798)	(1,235,979)
Proceeds from sale of investments	826,062	1,474,904
(Decrease) increase in other assets	(105)	250
Distributions from joint ventures	9,599	4,696
Contributions to joint ventures	(166)	(9,500)
Purchases of property, plant and equipment	(259,236)	(249,490)
Proceeds from sale of fixed assets	–	5,085
Net cash used by investing activities	(363,644)	(10,034)
Cash flows from financing activities:		
Payments of long-term debt	(34,894)	(49,730)
Payments of finance lease obligations	(1,440)	(1,408)
Proceeds from issuance of long-term debt	137,038	77,000
Restricted contributions and investment income	27,044	27,235
Net cash provided by financing activities	127,748	53,097
Net (decrease) increase in cash and cash equivalents	(32,208)	47,348
Cash and cash equivalents – beginning of year	351,113	303,765
Cash and cash equivalents – end of year	$ 318,905	$ 351,113

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

Years Ended September 30, 2024 and 2023
(In thousands)

	2024	2023
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 36,026	$ 28,506
Supplemental disclosure of noncash activities:		
Right of use assets obtained in exchange for lease obligations:		
Operating leases	$ 1,773	$ 12,493
Financing leases	$ –	$ 344
Purchases of property, plant and equipment in accounts payable and other current liabilities	$ 13,281	$ 23,110

See accompanying notes to consolidated financial statements.

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1. Reporting Entity

Organization

The MaineHealth System (the System) is comprised of MaineHealth Services, the parent organization, and its subsidiaries. The subsidiaries of MaineHealth Services include MaineHealth, NorDx, MaineHealth Care at Home, and The Memorial Hospital at North Conway, N.H. In the fiscal year ending September 30, 2023, the subsidiary MaineHealth included nine acute care hospitals. In 2024, two of the nine hospitals (Maine Medical Center and Southern Maine Health Care) merged into one hospital. These hospitals are now local health systems within the subsidiary named MaineHealth utilizing d/b/a's of Maine Medical Center (or MMC), Mid Coast–Parkview Health (Mid Coast Hospital), LincolnHealth, Western Maine Healthcare (Stephens Hospital), Franklin Community Health Network (Franklin Hospital), Maine Behavioral Healthcare (Spring Harbor Hospital), and Coastal Healthcare Alliance (Waldo County General Hospital and Pen Bay Medical Center). The merger enables the combined resources of the merging entities to be allocated in a manner that is consistent with the System's vision of helping make the communities it serves the healthiest in America.

MaineHealth Services, together with its controlled subsidiaries, MaineHealth and The Memorial Hospital at North Conway, N.H., maintained a controlling interest in MaineHealth Accountable Care Organization, LLC (MaineHealth ACO), a value based contracting entity.

The purpose of the System is to lead the development of a premier community care network that provides a broad range of integrated health care services for populations in Maine and northern New England. The System's network provides services along the full continuum of care as necessary to improve the health status of the populations it serves. As such, revenue includes those generated from direct patient care services, amounts earned from incentive and risk arrangements, the provision of medical education and training services, federal and state grants and contracts, sundry revenue generated from the operations of the subsidiaries, fund-raising conducted to support the activities of the System and its subsidiaries, and investment earnings.

COVID-19 Pandemic and CARES Act and Other Relief Funding

On March 11, 2020, the World Health Organization declared the outbreak of coronavirus (COVID-19) a pandemic. Over the past four fiscal years the COVID-19 pandemic has significantly affected employees, patients, systems, communities and business operations, as well as the U.S. economy and financial markets. Consolidated patient volumes and revenues experienced gradual improvement beginning in the latter part of April 2020, and continuing through fiscal year 2024. The System has taken precautionary steps since that time to enhance its operational and financial flexibility, and react to the risks the COVID-19 pandemic presents in its operations.

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1. Reporting Entity (Continued)

Since the declaration of the pandemic, the System has received approximately $363,561,000 related to the CARES Act Provider Relief Funds (PRF) which included supplemental funding from FEMA through the CARES Act. Distributions from the PRF are not subject to repayment, provided the System is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants, and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the PRF and the impact of the pandemic on operating results through September 30, 2024 and 2023, the System recognized $14,292,000 and $37,740,000, respectively, related to these PRF, and these payments are recorded within other revenues in the consolidated statements of operations and changes in net assets for the years ended September 30, 2024 and 2023. Federal Emergency Management Funds of approximately $13,355,000 and $12,776,000, respectively, were included in these funds at September 30, 2024 and 2023 with the remainder recognized from State grants.

The System will continue to monitor compliance with the terms and conditions of the PRF, and other potential assistance programs and available grants, and the impact of the pandemic on revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, the System's ability to retain some or all of the distributions received may be impacted.

2. Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of the System. The consolidated financial statements have been presented in conformity with accounting principles generally accepted in the United States of America (GAAP) consistent with the Financial Accounting Standards Board Accounting Standards Codification (ASC) Topic 954, *Health Care Entities*, and other pronouncements applicable to health care organizations. Upon consolidation, intercompany transactions and balances have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates are made in the areas of patient accounts receivable, the fair value of financial instruments, amounts receivable and payable under reimbursement regulations, asset retirement obligations (AROs), retirement benefits and self-insurance reserves.

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2. Significant Accounting Policies (Continued)

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt securities purchased with a maturity at the date of purchase of three months or less, excluding amounts classified as investments whose use is limited.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Balances that are still outstanding after management has used reasonable collection efforts are written off.

When the System has an unconditional right to payment, subject only to the passage of time, the right is treated as a receivable. Patient accounts receivable, including billed accounts and unbilled accounts for which there is an unconditional right to payment, and estimated amounts due from third-party payors for retroactive adjustments, are receivables if the right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. For patient accounts receivable, the estimated uncollectible amounts are generally considered implicit price concessions that are a direct reduction to patient accounts receivable. Patient accounts receivable amounted to $533,191,000, $458,943,000 and $356,256,000 as of September 30, 2024, 2023 and 2022, respectively.

Investments

Investments are stated at fair value. The recorded value of investments in hedge funds and limited partnerships is based on fair value as estimated by management using information provided by external investment managers. The System has applied the provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities that Calculate Net Asset Value (NAV) per Share (or its Equivalent)*. This standard allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using NAV per share or its equivalent as a practical expedient. The System has utilized the NAV reported by each of the underlying funds as a practical expedient to estimate the value of the investment for each of these funds. The System believes that these valuations are a reasonable estimate of fair value as of September 30, 2024 and 2023, but are subject to uncertainty and, therefore, may differ from the value that would have been used had a market for the investments existed. Such differences could be material. Certain of the hedge fund and limited partnership investments have restrictions on the withdrawal of the funds (see Note 8). Investments are classified as current assets based on the availability of funds for current operations. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in the excess of revenues and nonoperating gains – net over expenses, unless the income or loss is restricted by donor or law. The accounting for the pension plan assets is disclosed in Note 8.

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2. Significant Accounting Policies (Continued)

As provided for under ASC Topic 825, *Financial Instruments*, the System made the irrevocable election to report investments and investments whose use is limited at fair value with changes in value reported in the excess of revenues and nonoperating gains – net over expenses. As a result of this election, the System reflects changes in the fair value, including both increases and decreases in value whether realized or unrealized, in its excess of revenues and nonoperating gains – net over expenses.

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

Investments Whose Use is Limited

Investments whose use is limited primarily include investments held by trustees under debt agreements, self-insurance trust agreements, and designated investments set aside by the Board of Trustees (or member Boards) for purposes over which those Boards retain control and may at their discretion subsequently use for other purposes. In addition, investments whose use is limited include investments restricted by donors for specific purposes or periods, as well as investments restricted by donors to be held in perpetuity by the System, and the related appreciation on those investments. Amounts required to meet current liabilities of the System have been classified as current assets.

Property, Plant and Equipment

Property, plant, and equipment are recorded at cost, or at fair value at the date of acquisition, if acquired in a business combination accounted for using the acquisition method of accounting. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Interest costs incurred on borrowed funds during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets. MaineHealth recorded capitalized interest of $9,909,000 and $10,192,000 for the years ended September 30, 2024 and 2023, respectively.

Gifts of long-lived assets, such as land, building, or equipment, are reported as increases in net assets without restrictions and are excluded from the excess of revenues and nonoperating gains – net over expenses. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment of Long-Lived Assets

Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less cost to sell.

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2. Significant Accounting Policies (Continued)

Asset Retirement Obligations

AROs, which are included in other liabilities in the accompanying consolidated balance sheets, are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, the System records period-to-period changes in the ARO liability resulting from the passage of time, increases or decreases in interest expense, and revisions to either the timing or the amount of the original expected cash flows to the related assets.

Leases

The System determines if an arrangement is a lease at the inception of a contract. Leases with an initial term of twelve months or less are not recorded on the consolidated balance sheets.

Right-of-use assets represent the System's right to use an underlying asset during the lease term and lease liabilities represent the System's obligation to make lease payments arising from the lease. Right-of-use assets and liabilities are recognized at the commencement date, based on the net present value of fixed lease payments over the lease term. The System's lease terms include options to extend or terminate the lease when it is reasonably certain that the options will be exercised.

The System determines the present value of future lease payments using the rate implicit in the lease or, if that rate cannot be readily determined, its incremental borrowing rate at the lease commencement date. As most of the System's operating leases do not provide an implicit rate, the System generally uses its incremental borrowing rate based on the information available at the commencement date in determining the present value of lease payments. The System considers recent debt issuances, as well as publicly available data for instruments with similar characteristics, when calculating its incremental borrowing rate.

Operating fixed lease expense and finance lease depreciation expense are recognized on a straight-line basis over the lease term. Variable lease costs consist primarily of common area maintenance and are not significant to total lease expense.

Accounting for Defined Benefit Pension and Other Postretirement Plans

The System recognizes the overfunded or underfunded status of its defined benefit and postretirement plans as an asset or liability in its consolidated balance sheets. Changes in the funded status of the plans are reported as a change in net assets without restrictions presented below the excess of revenues and nonoperating gains – net over expenses in its consolidated statements of operations and changes in net assets in the year in which the changes occur.

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2. Significant Accounting Policies (Continued)

The measurement of benefit obligations and net periodic benefit cost is provided by third-party actuaries based on estimates and assumptions approved by the System's management. These valuations reflect the terms of the plans and use participant-specific information, such as compensation, age, and years of service, as well as certain assumptions, including estimates of discount rates, expected long-term rate of return on plan assets, rate of compensation increases, interest-crediting rates, and mortality rates.

Beneficial Interests in Perpetual Trusts

Beneficial interests in perpetual trusts consist of the System's proportionate share of the fair value of assets held by trustees in trust for the benefit of the System in perpetuity, the income from which is available for distribution to the System periodically. The assets held in trust consist primarily of cash equivalents and marketable securities. The fair values of perpetual trusts are measured using the net asset value as a practical expedient. Such amounts are included in investments whose use is limited in the accompanying consolidated balance sheets. Distribution from beneficial interests in perpetual trusts is included in nonoperating gains, unless restricted by donors.

Excess of Revenues and Nonoperating gains – Net Over Expenses

The consolidated statements of operations include excess of revenues and nonoperating gains net over expenses as the performance indicator. Changes in net assets without donor restrictions, which are excluded from excess of revenues and nonoperating gains – net over expenses, consistent with industry practice, include retirement benefit plan adjustments, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and capital grants.

Consolidated Statements of Operations

For purpose of display, transactions deemed by management to be ongoing, major, or central to the provision of health care and related services are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating gains and losses.

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2. Significant Accounting Policies (Continued)

Patient Service Revenue

Revenues generally relate to contracts with patients in which the System's performance obligations are to provide health care services to patients. Revenues are recorded during the period obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over a period of days. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by Medicare and Medicaid or negotiated with managed care health plans and commercial insurance companies, the third-party payors. The payment arrangements with third-party payors for the services provided to related patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for prospective payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the revenue recognition process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

The collection of outstanding receivables for Medicare, Medicaid, managed care payors, other third-party payors and patients is the System's primary source of cash and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of hospital revenues and accounts receivable as a primary source of information in estimating the collectibility of our accounts receivable. Management believes its regular updates to the estimated implicit price concession amounts provide reasonable estimates of revenues and valuations of accounts receivable. These routine, regular changes in estimates have not resulted in material adjustments to the valuations of accounts receivable or period-to-period comparisons of operations. At September 30, 2024 and 2023, estimated implicit price concessions of $156,975,000 and $174,662,000, respectively, had been recorded as reductions to patient service revenue to enable the System to record revenues and accounts receivable at the estimated amounts expected to be collected.

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2. Significant Accounting Policies (Continued)

Free Care

The System provides care without charge to patients who meet certain criteria under its Board-established free care policies. Because the System does not pursue collection of amounts determined to qualify as free care, they are not reported as patient service revenue. MaineHealth hospitals provide full free care to all patients at or below 200% of the Federal Poverty Guidelines.

Direct and Indirect Research Revenue and Related Expenses

Revenue related to research grants and contracts is recognized as the related costs are incurred. Indirect costs relating to certain government grants and contracts are reimbursed at fixed rates negotiated with the government agencies. Research grants and contracts are accounted for as exchange transactions or contributions. Amounts received in advance of incurring the related expenditures are recorded as unexpended research grants and are included in deferred revenue for exchange contracts or net assets with donor restrictions for contributions.

Other Revenue

Revenue which is not related to patient medical care but is central to the day-to-day operations of the System is included in other revenue. This revenue includes pharmacy sales, cafeteria sales, medical school revenue, grant revenue, rental revenue, net assets released from restrictions for operations, COVID-19 relief revenue and other support services revenue.

Gifts and Donations

Unconditional promises to give cash and other assets to the System are reported at fair value at the date the promise is received. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The discounts on those amounts are computed using a risk-free rate applicable to the year in which the promise is received. Amortization of the discount is included in contribution revenue. Conditional promises to give are recognized when the conditions are substantially met. The gifts are reported as net assets 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 as net assets released from donor restrictions, which is included in other revenue. Donor-restricted contributions whose restrictions are met within the same year received are reported as unrestricted contributions in the accompanying consolidated financial statements.

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2. Significant Accounting Policies (Continued)

Self-Insurance Reserves

The liabilities for outstanding losses and loss-related expenses and the related provision for losses and loss-related expenses include estimates for losses incurred but not reported as well as losses pending settlement. Such liabilities are based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be greater than or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making the workers compensation and malpractice estimates and the resulting liability are actuarially reviewed on an annual basis, and any necessary adjustments are reflected in current operations.

Income Tax Status

The Internal Revenue Service has previously determined that the System and its subsidiaries (except Maine Medical Partners (MMP) (a subsidiary of MaineHealth) are organizations as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the IRC. MMP had significant net operating loss carryovers as of September 30, 2024 and 2023. A valuation allowance has been provided for the entire deferred tax benefit for the net operating losses due to uncertainty of realization. MMP did not have material taxable income in 2024 and 2023. Accordingly, a provision for income taxes has not been made in the accompanying consolidated financial statements.

The System recognizes the effect of income tax positions only if those positions are more likely than not to be sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in measurement are reflected in the period in which the change in judgment occurs. The System did not recognize the effect of any income tax positions in either 2024 or 2023.

Subsequent Events

Events occurring after the consolidated balance sheet date are evaluated by management to determine whether such events should be recognized or disclosed in the consolidated financial statements. Management has evaluated subsequent events through February 7, 2025, which is the date the consolidated financial statements were available to be issued.

3. Liquidity and Availability of Financial Assets

The System's working capital and cash flows are subject to variability during the year attributable to changes in volume and cash receipts. The System maintains investments portfolios without donor restrictions to manage fluctuations in cash flow.

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3. Liquidity and Availability of Financial Assets (Continued)

The following table (in thousands) reflects the System's financial assets for the period ending September 30, 2024, reduced by amounts not available for general use within one year because of contractual or donor-imposed restrictions or internal designations. Investment amounts would be available, subject to liquidity of the underlying investments.

Cash and cash equivalents	$ 318,905
Investments	1,078,450
Patient accounts receivable	533,191
Financial assets available to meet cash needs for general expenditures within one year	$1,930,546

In addition to the amounts listed above, the System has available to it a line of credit in the amount of approximately $145,901,000 which it could draw upon to meet the current needs of the System.

4. Community Benefit Programs

As a nonprofit organization dedicated to community health improvement, the System provides many services for the community in addition to its range of health care services and programs. The System supports improvement in community health by implementing best practice interventions ranging from prevention and wellness to disease management. These services include evidence-based programs to improve care and outcomes for people suffering from chronic diseases such as pre-diabetes, diabetes, and behavioral health issues. The System also provides training and education opportunities for physicians and other providers that focus on achieving patient-centered healthcare. In addition, the System works to ensure patients receive excellent coordination of care through transitions of care programs. The System also offers, through its Access to Care program, donated healthcare services and free or low-cost medications to low-income and uninsured patients in addition to supporting access to health insurance coverage.

A wide range of community health improvement and prevention programs support the efforts to promote healthy lifestyles. The System's healthy lifestyle programs include initiatives that target both children and adults. Engaging community health professionals and provider organizations, community partners, family members and local and state government is a key component to the successful implementation and continued effectiveness of these programs. The System's tobacco treatment program, through highly trained Tobacco Treatment Educators, provides ongoing support to the community healthcare providers with the goal of reducing tobacco use. This program also offers a free confidential counseling service in support of Maine residents who seek to quit the use of tobacco. The System also has increased focus on efforts to address social determinants of health for the community including opening the third hospital-based food pantry in Maine. Other community health programs include healthy lifestyle, oral health, healthy eating and active living, childhood immunization initiatives, healthy aging and multiple evidence-based self-management programs such as Living Well with Diabetes and the Diabetes Prevention Program.

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5. Patient Service Revenue

The System records patient service revenue at the amount that reflects the consideration to which the System expects to be entitled to in exchange for providing patient care. Patient service revenue consists of amounts charged for services rendered less estimated discounts for contractual and other allowances for patients covered under Medicare, Medicaid and other health plans and discounts offered to patients under the System's uninsured discount program.

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

Medicare and State Medicaid Programs

Maine Medical Center, Pen Bay Medical Center, Mid Coast—Parkview Health and Franklin Hospital (a sole community hospital until it transitioned to a Critical Access Hospital during 2024) are paid at prospectively determined rates for inpatient and outpatient services rendered to Medicare and Medicaid beneficiaries. Inpatient rates vary according to a patient classification system that is based on clinical diagnosis and other factors. Outpatient services are paid based on a prospective rate per ambulatory visit or procedure. LincolnHealth, Waldo County General Hospital, Stephens Hospital, Franklin Hospital and The Memorial Hospital are Critical Access Hospitals reimbursed at cost for services provided to Medicare and Medicaid beneficiaries for certain services. Cost reimbursable services are paid at an interim rate with final settlement determined after submission, review and audit of annual cost reports by the System and audit thereof by the Medicare administrative contractor, the State of Maine and the State of New Hampshire.

Several System hospitals receive Disproportionate Share Hospital (DSH) payments. These payments are made to qualifying hospitals to cover the costs of providing care to low income patients. These payments are subject to audit by CMS and are, therefore, subject to change. These amounts are recorded as patient service revenue.

In 2004, the State of Maine established several health care provider taxes (State taxes). The enactment of the State taxes allowed the State of Maine to add revenues to the State of Maine General Fund while minimizing the potential of lost federal matching funds in the MaineCare program. The hospital-specific portion of the State taxes on Maine hospitals is based on a percentage of patient service revenue. Taxes on nursing homes are based on 6.0% of patient service revenue.

The State of New Hampshire established a Medicaid Enhancement Tax program in 1991. This program taxes hospital services at approximately 2.3% of patient service revenue. The State of New Hampshire also levies a tax on intermediate care facilities at approximately 5.5%.

For the years ended September 30, 2024 and 2023, the System recorded State taxes of $59,491,000 and $60,373,000, respectively.

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5. Patient Service Revenue (Continued)

Nongovernmental Payors

The System also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the System under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Uninsured Patients

For uninsured patients who do not qualify for free care, the System recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). Based on historical experience, a significant portion of uninsured patients will be unable or unwilling to pay for the services provided.

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. The System has determined it has provided self-pay allowances to uninsured patients and patients with other uninsured balances (e.g., copays and deductibles). The self-pay allowances included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with those patients.

The System provides care without charge to patients who meet certain criteria under its Board-established free care policy. Because the System does not pursue collection of amounts determined to qualify as free care, they are not reported as patient service revenue. The System estimates the costs associated with providing free care by calculating a ratio of total cost to total gross charges, and then multiplying that ratio by the gross charges associated with providing care to patients eligible for free care. The estimated cost of caring for free care patients for the years ended September 30, 2024 and 2023, was $44,984,000 and $46,960,000, respectively. Funds received from gifts and grants to subsidize free care services provided for the years ended September 30, 2024 and 2023, were $1,551,000 and $1,823,000, respectively.

Patient service revenue from these major payor sources recognized during the years ended September 30, 2024 and 2023 was as follows (in thousands):

	2024	2023
Medicare	$1,289,558	$1,186,103
State Medicaid Programs	526,559	452,696
Anthem Blue Cross and Blue Shield	832,094	730,557
Other third-party payors	1,148,096	991,737
Patients	60,066	64,404
Total patient service revenue	$3,856,373	$3,425,497

Patient service revenue in 2024 and 2023 included $15,387,000 and $1,766,000, respectively, of favorable settlements with third-party payors regarding prior year activities.

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6. Concentration of Credit Risk

Receivables

Financial instruments, which potentially subject the System to concentration of credit risk, consist of patient accounts receivable, estimated amounts receivable under reimbursement regulations, and certain investments. Investments, which include government and agency securities, stocks, and corporate bonds, are not concentrated in any corporation or industry. The System grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at September 30, 2024 and 2023, was as follows:

	2024	2023
Medicare	41%	39%
State Medicaid Programs	18	15
Anthem Blue Cross and Blue Shield	9	9
Other third-party payors	17	20
Patients	15	17
Total patient receivables	100%	100%

Cash

The System maintains its cash accounts at various financial institutions. As of September 30, 2024 and 2023, the System had cash balances of $35,149,000 and $5,001,000, respectively, in uninsured accounts. The System has not experienced any losses in such accounts and evaluates the credit worthiness of the financial institutions with which it conducts business. Management believes the System is not exposed to any significant credit risk with respect to its cash balances.

Investments

The System's investment in one fund, the Vanguard Total Stock Market Index Fund, exceeds 10% of total System investments as of September 30, 2024.

Labor Force

The System's unionized labor workforce at Maine Medical Center and MaineHealth Care at Home are members of the Maine State Nurses Association/National Nurses Organizing Committee/National Nurses United, while the System Interpreters are represented by the Maine Service Employees Association/Services Employees Internal Union. The three employee groups represent approximately 9.4% of the System's total workforce. The collective bargaining agreement for Maine Medical Center's bargaining unit is in effect and expires December 31, 2025. The collective bargaining agreement for MaineHealth Care at Home's bargaining unit expired on October 1, 2024, and the parties are actively negotiating a new contract which is expected to have a three-year term. The first collective bargaining agreement for the System Interpreters is also currently being negotiated.

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7. Investments and Investments Whose Use is Limited

The composition of investments and investments whose use is limited at September 30, 2024 and 2023, is set forth as follows (in thousands):

	2024	2023
Investments (current assets)	$1,078,450	$ 889,112
Investments whose use is limited	577,578	493,632
	$1,656,028	$1,382,744
Cash equivalents	$ 99,467	$ 68,848
Fixed income securities – bonds	594,923	514,707
Equity investments – stocks	658,673	490,002
Investment in real property	1,683	1,430
Common/collective trusts	33,851	29,967
Limited partnerships	83,383	92,721
Hedge funds	125,754	134,672
Beneficial interest in perpetual and charitable remainder trusts	58,294	50,397
	$1,656,028	$1,382,744

Investments whose use is limited include amounts required by debt agreements, amounts restricted by donors, assets designated by the Board for future capital improvements, and other Board Designated items, assets to fund self-insured professional and general liability and workers' compensation risks, and to provide for other specific purposes.

Investments whose use is limited by debt agreements include debt service funds, which are composed of semiannual deposits to fund principal and interest payments, and construction funds. These investments are held pursuant to the requirements of the outstanding Revenue Bonds and Revenue Refunding Bonds.

The amounts reported as trusteed under debt agreements consisted of construction funds from the 2023B Series bond issue, capitalized interest funds that will be used to pay future payments on the 2018A and 2018B Series bond issues, and funds accumulated for future principal and interest payments on various revenue bonds.

Fair Value Measurements

The System classifies its investments into Level 1, which refers to securities valued using quoted prices from active markets for identical assets, Level 2, which refers to securities not traded on an active market, but for which observable market inputs are readily available, and Level 3, which refers to securities with unobservable inputs that are used when little or no market data is available. Assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

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8. Fair Value of Financial Instruments

Asset Valuation Techniques

Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs. The following is a description of the valuation methodologies used for assets measured at fair value:

Cash equivalents – The investment strategy for these are low-risk, low-return, highly liquid investments, typically with a maturity of three months or less, including U.S. Government, T-bills, bank certificates, corporate commercial paper or other money market instruments that are based on quoted prices and are actively traded.

Fixed income securities-bonds – These securities are investments in corporate or sovereign bonds and notes, certificates of deposit, or other loans providing a periodic payment and eventual return of principal at maturity. Certain corporate bonds and notes are valued at the closing price reported in the active market in which the bond is traded. Other corporate bonds and notes are valued based on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for identical or similar bonds, the bond is valued under a discounted cash flow approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks.

*Equity investments-stock*s – These investments include marketable equity securities, mutual funds, exchange traded, and closed-end funds. The fair value of marketable equity securities is principally based on quoted market prices. Exchange-traded funds and closed-end funds are valued at the last sale price or official closing price on the exchange or system on which they are principally traded. Investments in mutual funds are valued at their NAV at year end. These funds are required to publish their daily NAV and to transact at that price. The mutual funds held are deemed to be actively traded.

Investment in real property – Investments in real property are valued yearly at fair value, using the market approach, as determined by comparable sales data beginning on the date of acquisition.

Common/collective trusts – These include diverse investments in securities issued by the U.S. Treasury and global bond funds using the Common Collective Trust vehicle to obtain lower expense ratios. These investments are designed to generate attractive risk-adjusted returns. The fair value of common collective trusts is based on the NAV of the fund, representing the fair value of the underlying investments, which are generally securities traded on an active market. The NAV as provided by the trustee, is used as a practical expedient to estimate fair value.

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8. Fair Value of Financial Instruments (Continued)

Limited partnerships – These include investments in offshore and private equity funds. They have objectives of capital appreciation with absolute returns over the medium and long term. These investments are designed to generate attractive risk-adjusted returns. The estimated fair values of limited partnerships for which quoted market prices are not readily available are determined based upon information provided by the fund managers. Such information is generally based on the NAV of the fund, which is used as a practical expedient to estimate fair values. The limited partnerships invest primarily in readily available marketable equity securities. The limited partnerships allocate gains, losses, and expenses to the partners based on ownership percentage as described in the respective partnership agreements.

Hedge funds – The investments are inclusive of a variety of types of equity, debt, and derivative investments, designed to mitigate volatility while generating equity like returns. The estimated fair values of limited partnerships and hedge funds, for which quoted market prices are not readily available, are determined based upon information provided by the fund managers. Such information is generally based on the NAV of the fund, which is used as a practical expedient to estimate fair value. The hedge funds invest primarily in readily marketable equity securities. The hedge funds allocate gains, losses, and expenses to the partners based on ownership percentage as described in the respective hedge fund agreements.

The following methods and assumptions were used by the System in estimating the fair value of the System's financial instruments that are not measured at fair value on a recurring basis for disclosures in the consolidated financial statements:

Interest rate swaps – The System uses inputs other than quoted prices that are observable to value the interest rate swaps. The System considers these inputs to be Level 2 inputs in the context of the fair value hierarchy. The fair value of the net interest rate swap liabilities was $3,157,000 and $1,088,000 at September 30, 2024 and 2023, respectively. These values represent the estimated amounts the System would receive or pay to terminate agreements, taking into consideration current interest rates and the current creditworthiness of the counterparty. The fair value of the interest rate swap agreements is reported in other long-term liabilities.

Pledges receivable – The current yields for 1 to 10-year U.S. Treasury notes are used to discount pledges receivable. The System considers these yields to be a Level 2 input in the context of the fair value hierarchy. Pledges received were discounted at rates ranging from 3.58% to 4.55% in fiscal year 2024 and from 4.59% to 5.46% in fiscal year 2023. Outstanding pledges receivable in 2024 and 2023, which have been recorded within other current and long-term assets at fair value, totaled $11,307,000 and $15,228,000, respectively.

Receivables and payables – The carrying value of the System's receivables and payables approximate fair value, as maturities are very short term.

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8. Fair Value of Financial Instruments (Continued)

The System's investments at fair value set forth by level within the fair value hierarchy as of September 30, 2024 and 2023 are as follows (in thousands):

	Invest-ments Measured at NAV	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Unob-servable Inputs (Level 3)	Total
September 30, 2024					
Cash equivalents	$ –	$ 99,467	$ –	$ –	$ 99,467
Investments:					
Fixed income securities – bonds	–	245,649	349,274	–	594,923
Equity investments – stocks	–	658,673	–	–	658,673
Investment in real property	1,683	–	–	–	1,683
Common/collective trusts	33,851	–	–	–	33,851
Limited partnerships	83,383	–	–	–	83,383
Hedge funds	125,754	–	–	–	125,754
Beneficial and charitable remainder trusts	–	–	–	58,294	58,294
Total investments	244,671	904,322	349,274	58,294	1,556,561
Total cash equivalents and investments	$244,671	$1,003,789	$349,274	$58,294	$1,656,028
September 30, 2023					
Cash equivalents	$ –	$ 68,848	$ –	$ –	$ 68,848
Investments:					
Fixed income securities – bonds	–	203,365	311,342	–	514,707
Equity investments – stocks	–	490,002	–	–	490,002
Investment in real property	1,430	–	–	–	1,430
Common/collective trusts	29,967	–	–	–	29,967
Limited partnerships	92,721	–	–	–	92,721
Hedge funds	134,672	–	–	–	134,672
Beneficial and charitable remainder trusts	–	–	–	50,397	50,397
Total investments	258,790	693,367	311,342	50,397	1,313,896
Total cash equivalents and investments	$258,790	$ 762,215	$311,342	$50,397	$1,382,744

The net change in the beneficial interest in perpetual and charitable remainder trusts of $7,897,000 and $3,218,000 in 2024 and 2023, respectively, represents the change in the fair value of the trusts, net of distributions.

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8. Fair Value of Financial Instruments (Continued)

The information regarding the fair value measurements of the assets held by the System's defined benefit pension plan (see Note 13) at September 30, 2024 and 2023, is as follows (in thousands):

	Invest-ments Measured at NAV	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Unob-servable Inputs (Level 3)	Total
September 30, 2024					
Cash equivalents	$ –	$ 14,357	$ –	$ –	$ 14,357
Investments:					
Fixed income securities – bonds	–	55,841	47,786	–	103,627
Equity investments – stocks	–	457,336	–	–	457,336
Limited partnerships	45,528	–	–	–	45,528
Hedge funds	172,067	–	–	–	172,067
Total investments	217,595	513,177	47,786	–	778,558
Total cash equivalents and investments	$217,595	$527,534	$47,786	$ –	$792,915
September 30, 2023					
Cash equivalents	$ –	$ 8,157	$ –	$ –	$ 8,157
Investments:					
Fixed income securities – bonds	–	26,199	28,916	–	55,115
Equity investments – stocks	–	336,712	–	–	336,712
Common/collective trusts	19,451	–	–	–	19,451
Limited partnerships	71,818	–	–	–	71,818
Hedge funds	191,523	–	–	–	191,523
Total investments	282,792	362,911	28,916	–	674,619
Total cash equivalents and investments	$282,792	$371,068	$28,916	$ –	$682,776

Liquidity

Equity investments, fixed income investments, investments in real property, common collective trusts, limited partnerships and hedge funds are redeemable at NAV under the terms of the subscription and/or partnership agreements. Investments, including short-term investments, with daily liquidity generally do not require any notice prior to withdrawal. Investments with monthly, quarterly or annual redemption frequency typically require notice periods ranging from 30 to 180 days. The long-term investments' fair values are broken out below by their redemption frequency as of September 30, 2024 and 2023 for both the investments and the System's defined benefit pension plan (in thousands):

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8. Fair Value of Financial Instruments (Continued)

Investments

Liquidity – NAV Measured Investments	Daily	Bi-Monthly	Monthly	Quarterly	Illiquid	Annually	Total
September 30, 2024							
Common/collective trusts	$ –	$ –	$33,851	$ –	$ –	$ –	$ 33,851
Investment in real property	–	–	–	–	1,683	–	1,683
Limited partnerships	–	38,070	2,517	12,896	29,900	–	83,383
Hedge funds	–	–	15,856	109,616	282	–	125,754
	$ –	$38,070	$52,224	$122,512	$31,865	$ –	$244,671
September 30, 2023							
Common/collective trusts	$ –	$ –	$29,967	$ –	$ –	$ –	$ 29,967
Investment in real property	–	–	–	–	1,430	–	1,430
Limited partnerships	–	45,751	9,976	13,305	23,689	–	92,721
Hedge funds	–	–	26,425	107,667	580	–	134,672
	$ –	$45,751	$66,368	$120,972	$25,699	$ –	$258,790

Defined Benefit Pension Investments

Liquidity – NAV Measured Investments	Daily	Bi-Monthly	Monthly	Quarterly	Illiquid	Annually	Total
September 30, 2024							
Limited partnerships	$ –	$42,933	$ –	$ 2,595	$ –	$ –	$ 45,528
Hedge funds	39,531	–	5,476	127,060	–	–	172,067
	$39,531	$42,933	$ 5,476	$129,655	$ –	$ –	$217,595
September 30, 2023							
Common/collective trusts	$ –	$ –	$19,451	$ –	$ –	$ –	$ 19,451
Limited partnerships	–	57,638	–	14,180	–	–	71,818
Hedge funds	32,598	–	33,683	125,242	–	–	191,523
	$32,598	$57,638	$53,134	$139,422	$ –	$ –	$282,792

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8. Fair Value of Financial Instruments (Continued)

Investments with a redemption frequency of illiquid may include lock-ups with definite expiration dates, restricted shares and side pockets, as well as private equity and real assets funds where the System has no liquidity terms until the investments are sold by the fund manager. The System has total capital commitments for alternative investments outstanding of $53,158,000 and $45,186,000 as of September 30, 2024 and 2023, respectively. These commitments will be funded from a re-allocation of investments from the applicable investment portfolio. Investments associated with beneficial interests in perpetual trust agreements have been categorized as illiquid because they are not available to support operations.

Transfers Between Levels

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. There were no transfers between Level 1 and Level 2 for the years ended September 30, 2024 and 2023.

The valuation methods as described above may produce a fair value calculation that may not be indicative of what management would realize upon disposition or reflective of future fair values. Furthermore, although management believes its valuation methods are appropriate and consistent with methods employed by other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

9. Property, Plant and Equipment

Property, plant, and equipment at September 30, 2024 and 2023, consist of the following (in thousands):

	2024	2023
Land and land improvements	$ 124,007	$ 123,457
Buildings	2,250,542	1,839,563
Equipment	1,651,114	1,515,058
Construction in progress	73,534	372,927
	4,099,197	3,851,005
Less accumulated depreciation and amortization	(2,434,121)	(2,266,657)
Total property, plant and equipment, net	$ 1,665,076	$ 1,584,348

As of September 30, 2024 and 2023, the remaining commitment on construction contracts was approximately $74,589,000 and $62,864,000, respectively. The value of property, plant, and equipment acquisitions in accounts payable at September 30, 2024 and 2023, was $13,281,000 and $23,110,000, respectively.

10. Long-Term Debt and Revolving Lines of Credit

Long-term debt at September 30, 2024 and 2023 consists of the following (in thousands):

Name of Issue	Interest Rate	Type of Rate	Final Maturity	2024	2023
Notes payable:					
MaineHealth	5.38%	Fixed	2033	$ 60,000	$ 60,000
MaineHealth	4.58%	Fixed	2043	16,154	16,697
MaineHealth	SOFR + 1.03% (5.88%)	Variable	2031	5,943	6,742
MaineHealth	SOFR + 1.03% (5.88%)	Variable	2031	5,711	6,478
MaineHealth	5.73%	Fixed	2030	65,000	–
Mid Coast-Parkview Health	3.20%	Fixed	2027	9,875	13,166
Revenue bonds:					
Maine Health and Higher Educational Facilities Authority (MHHEFA):					
Franklin Hospital – Series 2016A	3.00%-5.00%	Fixed	2034	6,194	6,754
Maine Medical Center – MaineHealth – Series 2020	4.00%-5.00%	Fixed	2050	205,213	205,213
Maine Medical Center – Series 2018A	5.00%	Fixed	2048	164,330	164,330
Maine Medical Center – Series 2018B	3.84%-3.94%	Fixed	2028	10,930	10,930
Maine Medical Center – Series 2018C	4.85% SOFR	Variable	2036	36,735	36,735
MaineHealth – Series 2021A	1.47%	Fixed	2031	12,105	14,385
MaineHealth – Series 2022	1.55%	Fixed	2031	9,730	11,105
MaineHealth – Series 2022B	2.49%-3.05%	Fixed	2037	84,150	87,130
MaineHealth - Series 2023B	4.75%-5.25%	Fixed	2053	72,038	–
Quarry Hill – Series 2017A	4.00%-5.00%	Fixed	2030	3,894	4,614
Pen Bay Medical Center – Series 2017B	3.00%-5.00%	Fixed	2038	4,138	4,668
Waldo County General Hospital – Series 2014A	3.00%-5.00%	Fixed	2028	1,577	2,067
Southern Maine Health Care – MaineHealth – Series 2020	4.00%-5.00%	Fixed	2050	7,487	7,487
Southern Maine Health Care – Series 2016A	4.00%-5.00%	Fixed	2026	295	190
Finance Authority of Maine:					
MaineHealth – Series 2017	2.11%	Fixed	2027	17,748	24,838
MaineHealth – Series 2014	2.36%	Fixed	2025	13,404	25,478
New Hampshire Health and Education Facilities Authority:					
The Memorial Hospital at North Conway (sub. of TMH) – Series 2016	4.00%-5.50%	Fixed	2036	10,670	11,295
Other, including finance leases				11,321	16,032
Total bonds, loans, notes payable and finance leases before bond issuance costs and premiums				834,642	736,334
Less unamortized bond issuance costs				(6,885)	(6,051)
Unamortized premiums net of discounts				51,612	51,994
Total bonds, loans, notes payable and finance leases				879,369	782,277
Less portion classified as current liabilities				(42,242)	(41,824)
				$837,127	$740,453

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10. Long-Term Debt and Revolving Lines of Credit (Continued)

Annual principal maturities of long-term debt for the five fiscal years after September 30, 2024, and the years thereafter, are as follows (in thousands):

	Bonds and Notes	Finance Lease Obligation
2025	$ 38,973	$ 1,652
2026	32,373	1,408
2027	32,193	1,405
2028	35,676	344
2029	31,998	35
Years thereafter	659,047	–
	$830,260	4,844
Less amounts representing interest under finance lease obligations		(462)
		$ 4,382

The eight Maine hospitals of MaineHealth merged into the Maine Medical Center EIN with the surviving entity then renamed MaineHealth and with Mid Coast Hospital merging later. MaineHealth became a subsidiary of the corporate parent, MaineHealth Services. For ease of reference, this paragraph refers to these corporate names as currently structured, despite operating under different names at certain points in time referenced herein. In 1999, the Board of Trustees of MaineHealth Services adopted a Parent Model Master Trust Indenture (the Indenture) and the Boards of Trustees of MaineHealth Services, MaineHealth and other MaineHealth Subsidiaries adopted a System Funding Agreement. Under the Indenture, MaineHealth Services is the sole corporate member of the Obligated Group and is required to use reasonable efforts to cause affiliates of MaineHealth Services to make payments to MaineHealth Services in such amounts as are necessary for MaineHealth Services to make payments due under guaranty notes issued under the Indenture. The System Funding Agreement memorialized the obligation of the Master Trust Indenture Designated Affiliates to fund such amounts. All obligations issued under the Indenture are secured by pledges of gross revenues of MaineHealth Services. As of September 30, 2024 and 2023, debt issued under the System Funding Agreement was $761,622,000 and $635,262,000, respectively. Debt issued under the Indenture as of September 30, 2024 and 2023 was $761,622,000 and $635,262,000, respectively. As of September 30, 2024 and 2023, $800,457,000 and $698,991,000, respectively, of debt obligations were covered by a pledge of gross revenues.

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10. Long-Term Debt and Revolving Lines of Credit (Continued)

In October 2023, the System closed on a $65,000,000 taxable term loan with a 5.73% fixed interest rate. Annual principal payments based on a 25-year amortization begin July 1, 2026, with the remaining balance payable in full July 1, 2030. This loan was secured to support working capital and the loan requires an amount equal to 50% of the outstanding principal balance of the loan to be on deposit in a mutually agreed-upon interest bearing deposit account, or other investment vehicle of the borrower, with the bank. In December 2023, MaineHealth was a recipient of tax-exempt bond proceeds issued through MHHEFA in the amount of $72,038,000. The bond issuance includes both serial and term bonds with interest rates ranging from 4.75% - 5.25% and a final maturity in 2053. The bond proceeds will be utilized to support master facility planning projects at Maine Medical Center, Franklin Hospital and Stephens Hospital.

In September 2023, the System closed on a taxable term loan for $60,000,000, the proceeds of which will be utilized to support working capital. The loan has a maturity date of 2033 and a fixed interest rate of 5.38%. Annual principal payments based on a 25-year amortization begin July 1, 2026, with the remaining balance payable in full July 1, 2033.

In January 2023, MaineHealth closed on a taxable term loan for $17,000,000, the proceeds of which were used to purchase land and buildings currently used as a retail plaza that is adjacent to the Maine Medical Center Bramhall Campus in Portland. While there are no immediate plans to convert its use, the property could become an important future site for direct healthcare services, other patient and family support services or education training and research activities. The loan has a maturity date of 2043 and a fixed interest rate of 4.58%.

In September 2022, MaineHealth advanced the defeasance of the 2014 MHHEFA tax-exempt bond with a taxable loan to TD Bank. The TD Bank loan is a forward purchase agreement with principal amounts paid to TD Bank by MaineHealth to be held until the MHHEFA bonds can be called, at which time MHHEFA will issue new tax exempt bonds to be purchased by TD Bank at a lower interest cost than the prior bonds. The defeasance of the 2014 MHHEFA bonds was financed with a $91,645,000 TD Bank loan with a forward purchase agreement date of July 1, 2024, herein referred to as "Series 2022B". The Series 2022B taxable TD Bank loan is secured by the Indenture, the System Funding Agreement and MaineHealth Gross Revenue Pledge.

In September 2020, MaineHealth advanced the defeasance of the 2011A, 2011C and 2012A MHHEFA tax-exempt bonds with two taxable loans payable to TD Bank. The two TD Bank loans are forward purchase agreements with principal amounts paid to TD Bank by MaineHealth to be held until the MHHEFA bonds can be called, at which time MHHEFA will issue new tax exempt bonds to be purchased by TD Bank at a lower interest cost than the prior bonds. The defeasance of the 2011A and 2011C MHHEFA bonds was financed with a $21,115,000 TD Bank loan with a forward purchase agreement date of July 1, 2021, herein referred to as "Series 2020A". The defeasance of the 2012A MHHEFA bonds was financed with a $15,260,000 TD Bank loan with a forward purchase agreement date of July 1, 2022, herein referred to as "Series 2020B". On April 5, 2021, in an in-kind exchange, the Series 2020A taxable loan was prepaid in full with the MHHEFA Series 2021A tax-exempt bonds purchased by TD Bank, in the amount of $21,115,000. On April 4, 2022, in an in-kind exchange, the Series 2020B taxable loan was prepaid in full with the MHHEFA Series 2022 tax-exempt bonds purchased by TD Bank, in the amount of $13,755,000. Both the Series 2021A and Series 2022 tax-exempt TD Bank direct purchase bonds are secured by the Indenture, the System Funding Agreement and MaineHealth Gross Revenue Pledge.

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10. Long-Term Debt and Revolving Lines of Credit (Continued)

In July 2020, MHHEFA issued Series 2020 bonds for the amount of $212,700,000, with the proceeds being used to fund a portion of the MMC master facilities project and the construction of an inpatient behavior health unit at the MMC Sanford campus. Of the Series 2020 bonds, $205,214,000 will be used to fund MMC's master facilities project that includes a seven story patient tower, now called the Malone Family Tower, consisting of 96 single patient rooms that are both private and universal allowing standard, intermediate and critical care in addition to updated clinical procedure rooms and a 108,000 square foot ambulatory care building at its Scarborough campus. Of the Series 2020 bonds, $7,487,000 will be used to fund the renovation and construction of 42 inpatient behavioral health beds at the MMC Sanford campus. This debt is secured by the Indenture, the System Funding Agreement and the MaineHealth Gross Revenue Pledge.

In July 2018, MHHEFA issued its Series 2018A and 2018B bonds totaling $175,260,000, the proceeds of which were used to fund a portion of the MMC master facilities project. The project includes the financing, construction, renovation and equipment of 64 new patient rooms, additional visitor parking, a new employee parking garage, and the acquisition and renovation of an office building. This debt was issued under the Indenture and the System Funding Agreement.

In August 2018, MHHEFA issued its Series 2018C term bonds totaling $36,735,000 for private placement with TD Bank, N.A., the proceeds of which were used to refinance MMC's outstanding MHHEFA Series 2008A Revenue Bonds. This debt was issued under the Indenture and the System Funding Agreement.

MHHEFA Revenue Bonds, including the Series 2018A, 2018B and 2018C Bonds, are generally secured under a Bond Indenture. These Bond Indentures are contracts among MHHEFA, the Bond Trustee and the bondholders of that series of bonds, and the respective pledges and covenants made therein are for the equal and ratable benefit and security of the bondholders. The Bond Indentures for the Series 2018A, 2018B and 2018C Bonds provide that such bonds shall be special obligations of MHHEFA, payable solely from and secured solely by the payments made by MMC under the respective Bond Indenture, and the funds available in the Bond Fund established under such Bond Indenture.

In January 2015, MHHEFA issued its Series 2014 bonds totaling $85,105,000 for the benefit of MMC and Stephens Hospital. The MMC portion, $79,675,000, was used to finance renovations and equipment for the Bean Building and to refinance a portion of MHHEFA's Series 2008A bonds totaling $42,760,000. The Stephens Hospital portion, $5,430,000, was used to finance construction of and equipment for a new medical office building. Stephens Hospital, a subsidiary at the time of Western Maine Health Care Corporation, has since been merged into MMC as part of the unification merger. This debt was issued under the Indenture and the System Funding Agreement.

Deferred financing costs of $6,885,000 in 2024 and $6,051,000 in 2023 are reported as a component of long-term debt and represent the costs incurred in connection with the issuance of the bonds. These costs are being amortized over the term of the bonds. Amortization expense for the years ended September 30, 2024 and 2023 was $620,000 and $611,000, respectively. The original issue discount/ premium is amortized/accreted over the term of the related bonds using the effective interest method.

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10. Long-Term Debt and Revolving Lines of Credit (Continued)

The System has a single line of credit totaling $150,000,000 in 2024 and 2023. The renewed line of credit is due to expire on August 31, 2025. The line of credit is secured by a MaineHealth gross revenue pledge. There were no amounts outstanding on this line of credit as of September 30, 2024 and 2023, however the available line of credit was approximately $145,901,000 due to three outstanding standby letters of credit secured by the line.

11. Leases

The System utilizes operating and finance leases for the use of certain equipment and buildings. All lease agreements generally require the System to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the right of use (ROU) asset or lease liability. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation. Most leases include one or more options to renew the lease at the end of the initial term, with renewal terms that generally extend the lease at the then market rate of rental payment. Certain leases also include an option to buy the underlying asset at or a short time prior to the termination of the lease. All such options are at the System's discretion and are evaluated at the commencement of the lease, with only those that are reasonably certain of exercise included in determining the appropriate lease term.

The following table presents lease-related assets and liabilities at September 30, 2024 and 2023 (in thousands):

Balance Sheet Classification

		2024	2023
Assets:			
Operating leases:	Right of use assets	$133,321	$150,927
Finance leases:	Property, plant and equipment:		
	Buildings	$ 11,211	$ 11,211
	Equipment	1,849	1,994
		13,060	13,205
	Less accumulated depreciation and amortization	(10,368)	(9,533)
	Property, plant and equipment, net	$ 2,692	$ 3,672
Total assets		$136,013	$154,599

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11. Leases (Continued)

		2024	2023
Liabilities:			
Current:			
Operating lease liabilities	Current portion of lease obligation	$ 16,690	$ 18,103
Finance lease obligations	Current portion of long-term debt	1,652	1,373
Long-term:			
Operating lease liabilities	Long-term lease obligation	123,634	138,998
Finance lease obligations	Long-term debt	2,730	4,265
Total liabilities		$144,706	$162,739

The components of lease cost and rent expense for the years ended September 30 are as follows (in thousands):

Statement of Operations Classification

		2024	2023
Operating lease expense	Facility and other costs	$ 23,933	$ 25,678
Short-term lease cost	Facility and other costs	825	1,172
Finance lease expense:			
Amortization of ROU assets	Depreciation and amortization	$ 1,734	$ 1,746
Interest on finance lease liabilities	Interest expense	389	494

The weighted-average lease terms and discount rates for operating and finance leases are as follows for the years ended September 30:

	2024	2023
Weighted-average remaining lease term:		
Operating leases	20.2 years	19.5 years
Finance leases	3.8 years	4.7 years
Weighted-average discount rate:		
Operating leases	3.5%	3.4%
Financing leases	6.2%	6.4%

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11. Leases (Continued)

Supplemental cash flow and other information related to leases as of and for the years ended September 30 is as follows (in thousands):

	2024	2023
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases (liability reduction)	$18,263	$19,418
Operating cash flows from finance leases (interest payments)	388	494
Financing cash flows from finance leases (liability reduction)	1,155	1,408
Right-of-use assets obtained in exchange for lease obligations:		
Finance lease	–	344
Operating lease	1,773	12,493

Commitments relating to noncancellable operating and finance leases obligations for each of the next five fiscal years after September 30, 2024, and the years thereafter, are as follows (in thousands):

	Operating Leases	Finance Leases
2025	$ 23,446	$ 1,652
2026	21,048	1,408
2027	17,997	1,405
2028	14,419	344
2029	13,444	35
Thereafter	141,964	–
Total minimum future payments	232,318	4,844
Less imputed interest	(91,994)	(460)
Total liabilities	140,324	4,384
Less current portion	(16,690)	(1,652)
Long-term liabilities	$123,634	$ 2,732

12. Self-Insurance Trusts and Reserves

Coverage for professional and general liabilities is through an excess coverage plan whereby the System is responsible for the first $200,000 of a liability claim; 50% of amounts between $200,000 and $2,000,000; and 25% of amounts over $2,000,000 and up to $7,000,000. Excess risks are covered by an insurance policy with an insurance carrier. The System funds a professional liability trust based upon actuarial valuations and historical experience. Self-insurance reserves for self-insured unpaid claims and incidents are estimated using actuarial valuations, historical payment patterns, and current trends. Self-insurance reserves are recorded in the period the claim or incident occurs and adjusted in future periods as additional data becomes known. As of September 30, 2024 and 2023, there are no known claims outstanding, which, in the opinion of management, will be settled for amounts in excess of insurance coverage. As of September 30, 2024 and 2023, an accrual for estimated claims incurred but not reported was recorded. An estimated recovery related to such claims is included in the consolidated financial statements as of September 30, 2024 and 2023.

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12. Self-Insurance Trusts and Reserves (Continued)

The System provides health and dental insurance for its employees through a self-insured plan. Self-insurance reserves have been accrued for unpaid claims and incidents.

The System provides workers' compensation insurance for the majority of its employees through a self-insured plan. Self-insurance reserves are accrued for unpaid claims and settlements based on estimates using actuarial valuations. Self-insurance reserves are recorded in the period the incident occurs and adjusted in future periods as additional data becomes known.

13. Retirement Benefits

Defined Benefit Pension Plan

The System sponsors a defined benefit pension plan (the Plan), which was previously sponsored by Maine Medical Center, covering all grandfathered employees that work 750 or more hours in a plan year. Effective January 1, 2014, the Plan was amended to exclude from participation all employees hired on or after January 1, 2014. Such employees are eligible to participate in the defined contribution plan (the MaineHealth 403(b) Retirement Plan). The Plan was also amended effective January 1, 2011, to change the basis of a participant's accrued benefit. Prior to January 1, 2011, accrued benefits were based on the highest five years of final average pay. Effective January 1, 2011, for participants hired on or before December 31, 2009, there is a benefit based on the participant's final average pay through December 31, 2020, and years of service through December 31, 2010. This final average pay benefit is frozen as of December 31, 2020.

For participants that were currently employed or hired on or after January 1, 2010, but before January 1, 2014, accrued benefits are based on a cash balance formula that became effective January 1, 2011. A participant's cash balance account is increased by an annual cash balance contribution for participants with 750 hours of service, and interest credits in accordance with the terms of the amended Plan Document. The annual cash balance contribution is determined by applying a rate based on age and years of service to the participant's annual compensation. Interest credits are equal to a percentage of the participant's cash balance account on the first day of the Plan year and are credited on the last day of the Plan year prior to payment of the annual cash balance contribution. Except for certain instances, the rate of interest used to determine the interest credit for a Plan year is 5%. Retiring or terminating employees have the option to receive a lump-sum payment, annuity, or transfer to another qualified plan in accordance with the terms of the amended Plan Document.

The System's funding policy is to contribute amounts to fund current service cost and to fund over 30 years the estimated accrued benefit cost arising from qualifying service prior to the establishment of the Plan. The assets of the Plan are held in trust and are invested in a diversified portfolio that includes temporary cash investments, marketable equity securities, mutual funds, U.S. Treasury notes, corporate bonds and notes, hedge funds, and other funds.

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13. Retirement Benefits (Continued)

Defined Benefit Postretirement Medical Plan

As of May 1, 2015, eligible retirees who were enrolled in the Over 65 Retiree Group Companion Plan have transitioned to supplemental retiree health insurance options offered through a private Medicare Exchange engaged by the System and the Companion Plan was curtailed. Transitioned retirees, and certain future retirees, are eligible for an employer contribution to a Health Reimbursement Account (HRA) if they meet certain eligibility requirements. All other eligible System retirees who become Medicare eligible are also eligible to obtain supplemental coverage through the private Medicare Exchange but are not eligible for the employer contribution to the HRA.

Effective January 1, 2016, under age 65 retirees no longer have the option to enroll in the Under 65 Retiree Medical Plan. Retirees enrolled in the plan on or before December 1, 2015 are grandfathered until such time as they age into Medicare coverage at age 65. Grandfathered retirees continue to pay 100% of the cost (with the exception of those retirees enrolled as a result of the Voluntary Early Retirement Window in 2013). These retirees by a special arrangement pay the active employee rate for either three years or until they turn 65, whichever is sooner.

The activity in the Plan and Postretirement Medical Plan using valuation dates of September 30, 2024 and 2023, consists of the following (in thousands):

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2024	2023	2024	2023
Net periodic benefit cost:				
Service cost	$ 28,098	$ 28,229	$ –	$ –
Interest cost	44,496	41,387	121	131
Expected return on plan assets	(52,990)	(53,495)	–	–
Amortization of actuarial loss	6,083	3,074	(35)	(6)
Prior service credit	–	–	(193)	(199)
Net periodic benefit cost	$ 25,687	$ 19,195	$ (107)	$ (74)
Change in benefit obligation:				
Benefit obligation, beginning of year	$756,025	$ 763,389	$ 2,108	$ 2,488
Service cost	28,098	28,229	–	–
Interest cost	44,496	41,387	121	131
Actuarial loss (gain)	99,316	(3,330)	(57)	(215)
Benefits paid	(66,283)	(67,979)	(277)	(296)
Expenses paid	(6,771)	(5,671)	–	–
Benefit obligation, end of year	854,881	756,025	1,895	2,108

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13. Retirement Benefits (Continued)

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2024	2023	2024	2023
Change in plan assets:				
Net assets of plan, beginning of year	$682,776	$ 653,979	$ –	$ –
Actual return on plan assets	143,194	62,847	–	–
Employer contribution	40,000	39,600	277	296
Benefits paid	(66,283)	(67,979)	(277)	(296)
Expenses paid	(6,771)	(5,671)	–	–
Net assets of plan, end of year	792,916	682,776	–	–
Net amount recognized	$ (61,965)	$ (73,249)	$ (1,895)	$ (2,108)

The additional defined benefit pension plan and Postretirement Medical Plan disclosure information for the years ended September 30, 2024 and 2023, is as follows (in thousands):

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2024	2023	2024	2023
Amounts recognized in the consolidated balance sheets – accrued retirement benefits	$ (61,965)	$ (73,249)	$ (1,895)	$ (2,108)
Additional information – accumulated benefit obligation	(813,005)	(724,624)	–	–

Net assets without donor restrictions at September 30, 2024 and 2023, include unrecognized losses of $214,380,000 and $211,182,000, respectively, related to the Plan. The aggregate gain in 2024 and 2023 was due to a change in the discount rate.

The assumptions of the Plan as of September 30, 2024 and 2023 are as follows:

	2024	2023
Measurement date	September 30	September 30
Census date	January 1	January 1
Used to determine net periodic pension cost:		
Discount rate	6.19%	5.68%
Rate of compensation increase	5.00%/4.00%	5.00%/3.50%
Expected long-term rate of return on plan assets	6.50%	7.00%
Used to determine benefit obligation:		
Discount rate	5.05%	6.19%
Rate of compensation increase	5.00%/4.00%	5.00%/4.00%

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13. Retirement Benefits (Continued)

The expected long-term rate of return on plan assets for the Plan reflects the System's estimate of future investment returns (expressed as an annual percentage) taking into account the allocation of plan assets among different investment classes and long-term expectations of future returns on each class.

The targeted allocation for the Plan investments are: debt securities – 40.0%, U.S. equity securities – 22.5%, international equity securities – 11.2%, emerging market equity securities – 3.8%, natural resources – 5.0%, and alternative investments – 17.5%. The Plan's investments as of September 30, 2024 and 2023 are disclosed in Note 8.

The Plan's overall financial objective is to provide sufficient assets to satisfy the retirement benefit requirements of the Plan's participants. This objective is to be met through a combination of contributions to the Plan and investment returns. The primary long-term investment objective of the Plan is to attain the average annual nominal total return, net of investment management fees, assumed in the Plan's most recent actuarial assumptions over the long term. The nature and duration of benefit obligations, liquidity requirements, financial condition, operating margins, risk posture, and Plan funded status are considered when determining an appropriate asset allocation to achieve the investment objectives.

Investment policies and strategies governing the assets of the Plan are designed to achieve the financial objectives within prudent risk parameters. Risk management practices include the use of external investment managers, the maintenance of a portfolio diversified by asset class, investment approach, and security holdings, and the maintenance of sufficient liquidity to meet benefit obligations as they come due.

All of the Postretirement Medical Plan participants are over age 65 and are receiving, or are eligible to receive when they retire, medical coverage through a private healthcare exchange. The Plan provides them with a subsidy in the form of an HRA of $1,100 - $1,600 per year. Per capita costs and medical inflation trend assumptions are no longer relevant for this Plan's valuation.

Future benefits are expected to be paid as follows at September 30, 2024 (in thousands):

	Defined Benefit Pension Plan	Postretirement Medical Plan (net of Retiree Contributions)
Years ended September 30:		
2025	$ 64,198	$ 269
2026	61,597	255
2027	60,913	236
2028	63,359	218
2029	64,092	200
2030 – 2034	317,521	748

The estimated expected contribution to be made during the year ending September 30, 2025 is $40,269,000.

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13. Retirement Benefits (Continued)

Defined Contribution Pension Plans

The System sponsors the MaineHealth 403(b) Retirement Plan, which benefits substantially all of their employees. This plan assumed the Maine Medical Center 403(b) Retirement Plan and subsequently over the course of several years merged in the various 403(b) plans of the various subsidiaries. Amounts expensed under these plans were $76,612,000 and $61,120,000 in 2024 and 2023, respectively.

Nonqualified Deferred Compensation Plan

The System offers a 457(b) nonqualified deferred compensation plan to certain eligible employees. Eligible employees may elect up to the maximum dollar amount as defined by Section 402(g) of the Internal Revenue Service code. The plan is funded solely by employee contributions that are invested in various marketable securities at the direction of the employees. These investments are classified as Level 1 and Level 2 investments which are valued using quoted prices for active markets of identical assets. The assets of the plan are the legal assets of the System until they are distributed to participants, and therefore the plan assets and corresponding liability are reported as other assets and accrued retirement benefits in the accompanying consolidated balance sheet. As of September 30, 2024 and 2023 the balances of the plan were $186,021,000 and $145,999,000, respectively.

14. Net Assets

Resources are classified for reporting purposes as net assets without donor restrictions and net assets with donor restrictions, according to the absence or existence of donor-imposed restrictions. Resources arising from the results of operations or assets set aside by the Board of Trustees are not considered to be donor restricted. Net assets with donor restrictions represent funds including contributions and accumulated investment returns, whose use has been restricted by donors to a specific period or purpose or that have been restricted by donors to be maintained in perpetuity to provide a permanent source of income. Generally, the donors of these donor-restricted assets permit the use of part of the income earned on related investments for specific purposes. Net assets are as follows at September 30 (in thousands):

	2024	2023
Without donor restrictions	$2,416,338	$2,188,281
With donor restrictions:		
Perpetual in nature	118,906	125,534
Purpose restricted	188,040	144,361
Time restricted	18,656	15,838
Net assets	$2,741,940	$2,474,014

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14. Net Assets (Continued)

Endowment Funds

The System's endowment consists of funds established for a variety of purposes. For the purposes of this disclosure, endowment funds include donor-restricted endowment funds. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

The System has interpreted state law as requiring realized and unrealized gains on net assets with donor restrictions to be retained in a net assets with donor restrictions classification until appropriated by the Board and expended. State law allows the Board to appropriate so much of the net appreciation of net assets with donor restrictions as is prudent considering the System's long- and short-term needs, present and anticipated financial requirements, and expected total return on its investments, price level trends, and general economic conditions.

As a result of this interpretation, the System classifies as net assets with donor restrictions (a) the original value of the gifts donated to the endowment when explicit donor stipulations requiring permanent maintenance of the historical fair value are present and (b) the original value of the subsequent gifts to the endowment when explicit donor stipulations requiring maintenance of the historical fair value are present. The remaining portion of the donor-restricted endowment fund composed of accumulated gains not required to be maintained in perpetuity is classified as net assets with donor restrictions until those amounts are appropriated for expenditure in a manner consistent with the donor's stipulations. The System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: duration and preservation of funds, purposes of the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the System, and the investment policies of the System.

Endowment Investment Return Objectives

The System has adopted investment policies for endowment assets that attempt to provide a predictable stream of funding to the programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the System must hold in perpetuity or for a donor-specified period(s) as well as board-designated funds. Under this policy, the endowment assets are invested in a manner to attain a total return (net of investment management fees) of at least 5.0% per year in excess of inflation, measured by the Consumer Price Index. To satisfy its long-term rate of return objectives, the System targets a diversified asset allocation that places a greater emphasis on equity-based investments within prudent risk constraints.

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14. Net Assets (Continued)

Endowment Investment Activity

The following is a summary of the endowment activity by type of fund at September 30, 2024 and 2023, and the changes therein for the years then ended (in thousands):

	With Donor Restrictions
Endowment investment, end of year, September 30, 2022	$119,584
Investment return, net	15,981
Contributions	843
Interest and dividends transferred to specific purpose	(3,141)
Appropriation of endowment assets for expenditure	(6,017)
Endowment investment, end of year, September 30, 2023	127,250
Investment return, net	28,117
Contributions	7,169
Interest and dividends transferred to specific purpose	(4,573)
Appropriation of endowment assets for expenditure	(5,021)
Endowment investment, end of year, September 30, 2024	$152,942

Funds With Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the System to retain as a fund of perpetual duration.

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15. Functional Expenses

The System provides health care services through its acute care, specialty care, and ambulatory care facilities. Expenses relating to providing these services for the years ended September 30, 2024 and 2023, are as follows (in thousands):

	Program Services		Supporting Activities	
	Healthcare Services	Research	Management and General	Total Expenses
September 30, 2024				
Salaries, wages and fringe benefits	$1,998,583	$23,179	$569,026	$2,590,788
Patient care supplies	593,003	6,852	168,214	768,069
Professional fees and purchased services	404,750	4,686	115,041	524,477
Depreciation and amortization	129,277	1,500	36,836	167,613
Other operating expenses	165,152	1,932	47,432	214,516
Interest expense	18,414	214	5,247	23,875
	$3,309,179	$38,363	$941,796	$4,289,338
September 30, 2023				
Salaries, wages and fringe benefits	$1,623,839	$23,740	$684,006	$2,331,585
Patient care supplies	674,132	1,966	22,296	698,394
Professional fees and purchased services	500,313	6,844	44,822	551,979
Depreciation and amortization	122,908	1,142	39,074	163,124
Other operating expenses	126,156	1,780	74,174	202,110
Interest expense	8,919	–	6,470	15,389
	$3,056,267	$35,472	$870,842	$3,962,581

16. Contingencies

The System is subject to complaints, claims, and litigation, which have risen in the normal course of business. In addition, the System is subject to compliance with laws and regulations of various governmental agencies. Recently, governmental review of compliance with these laws and regulations has increased resulting in fines and penalties for noncompliance by individual health care providers. Compliance with these laws and regulations is subject to future government review, interpretation, or actions, which are unknown and un-asserted at this time.

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SUPPLEMENTARY INFORMATION

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended September 30, 2024

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development:				
Direct Awards – National Institutes of Health – Research and Development				
Increasing Clinical Trial Opportunities and Enrollment of Non-English Speaking Research Subjects: A Revised Research Pathway	93.103		$ –	$ 18,620
Environmental Chemicals, Adiposity, and Bone Accrual Across Adolescence	93.113		63,685	312,162
Exposure Pathways and Mental Health Impact of PFAS – Contaminated Biosolids	93.113		55,215	246,631
A Period Seroprevalence (SARS-CoV-2) Survey in MHCCN Cancer Healthcare Workers (HCWs) Providing Patient Care During the Height of the Outbreak: A Registry Study	93.394		–	(8,890)
Defining the Roles of Bone Marrow Adipocytes and FABP4/5 Signaling in Multiple Myeloma Drug Resistance	93.395		–	426,889
Research Specialist Support for Defining the Roles of Bone Marrow Adipocytes and FABP 4/5 Signaling in Multiple Myeloma	93.395		–	102,017
Lipid Metabolism-Driven Drug Resistance in Multiple Myeloma	93.398		–	18,120
MaineHealth Cancer Care Network (MHCCN) and NCORP Activities Across the Lifespan	93.399		128,203	1,076,556
Effect of CTHRC1 on Endothelial Cell Survival After Acute Ischemia	93.837			292,460
Enhancing Research Training for Maine Track / Tufts Medical Students	93.837		–	66,015
Molecular Determinants of the Fate of Human Heart Mesenchymal Progenitor Cells	93.837		–	23,881
Neuregulin Signaling in Myeloid Cells	93.837		–	127,880
Protective Adaptive Immune Mechanisms After Cardiac Arrest	93.837		–	302,352
Rab27a Functions in the Vascular Microenvironment	93.837		–	21,156
Regulation of Arterial Phenotype By Perivascular Adipose Tissue in Cardiometabolic Disease	93.837		–	461,506
A Novel Cell-Autonomous Role for Adrenergic Receptor Signaling in Osteoclasts	93.846		36,776	399,403
Investigating miRNA-Medicated Bone Loss From Morphine Treatment	93.846		–	17,378
Investigating the Impact of Social Isolation on Bone Metabolism	93.846		–	128,761
Molecular and Cellular Mechanisms of Prevention of Bone Loss by Beta Blockers	93.846		250,805	478,632
The Role of Irisin in Initiating Resorption During the Skeletal Response to Exercise	93.846		–	117,686
miR-27 Mediated Regulation of Mitochondrial Function in Thermogenic Adipocytes	93.847		–	508,453
Transgenerational Epigenetic Programming of the Thyroid Axis	93.847		–	15,005
Center of Biomedical Research Excellence in Acute Care Research and Rural Disparities	93.859		64,806	2,389,868
Mesenchymal and Neural Regulation of Metabolic Networks	93.859		–	1,961,420
Mesenchymal and Neural Regulation of Metabolic Networks – Metabolic Phenotyping Equipment	93.859		–	9,749
Mesenchymal and Neural Regulation of Metabolic Networks – Phase II	93.859		–	161,411
Northern New England Clinical and Translational Research Network	93.859		3,069,309	5,152,920
Northern New England Clinical and Translational Research Network – Data Science Supplement	93.859		–	22,064
Northern New England Clinical and Translational Research Network – EHR Supplement	93.859		–	640,971
Northern New England Clinical and Translational Research Network – N3C Initiative	93.859		–	195,594
Mitochondrial Function Regulates ROS-Mediated Patterning Following Injury	93.865		49,598	140,882
Total Direct Awards – National Institutes of Health – Research and Development			3,718,397	15,827,552

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2024

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development:				
Long-Term Prospective Associations of PFAS with Musculoskeletal and Cardiovascular Health Among Older Adults – Harvard Pilgrim Health Care, Inc.	93.113	AH000955	$ –	$ 101,243
The National Drug Abuse Clinical Trials Network: New England Consortium Node CTN-0099 – Yale University	93.279	CON-80004205 (GR119396)	–	183,366
The National Drug Abuse Clinical Trials Network: New England Consortium Node CTN-0099 – Yale University	93.279	CON-80005258 (GR125119)	–	131,032
Medical Marijuana, Pain, and Opioid Use in Patients with Chronic Non-cancer Pain – The General Hospital Corporation d/b/a Massachusetts General Hospital	93.279	2020A009718	–	29,186
SVS: A Cost-Effective Stochastic Vibrotactile Stimulation Device to Improve the Clinical Course of Infants With Neonatal Abstinence Syndrome – Tufts Medical Center, Inc.	93.279	5024311_SERV	–	(17,039)
The National Drug Abuse Clinical Trials Network: New England Consortium Node - Yale University	93.279	CON-80005250 (GR124632)	–	51,943
Master Regulators of Unexplained Variation in Disease Risk – Van Andel Research Institute	93.310	40530A-1	–	708,732
Tufts Clinical and Translational Science Institute – Trustees of Tufts College	93.350	EP0228048	–	66,716
Tufts Clinical and Translational Science Institute – Trustees of Tufts College	93.350	EP0242241	–	11,411
CTSA K12 Program at Tufts University – Trustees of Tufts College	93.350	EP0238754	–	195,573
Integration and Implementation of PROs for Symptom Management in Oncology Practice – Dana-Farber Cancer Institute, Inc.	93.353	1204505	–	19,915
Integration and Implementation of PROs for Symptom Management – Dana-Farber Cancer Institute, Inc.	93.353	1332505	–	5,760
Preparation of Lung Transplant Discussions and Decisions Among People With Cystic Fibrosis – University of Washington	93.361	UWSC14682	–	24,583
Delineating the Mechanisms Underlying Heart Value Endothelial Repair – The Medical College of Wisconsin, Inc.	93.387	Not identified	–	23,456
Survivor Care: A Digital Health Solution to Support Long-Term Cancer Survivorship Using Patient Navigation – Damagi, Inc.	93.393	01-0238552	–	140,052
COG NCTN Network Group Operations Center – Public Health Institute	93.395	AR64196	–	6,895
COG NCTN Network Group Operations Center – Public Health Institute	93.395	AR72911	–	8,141
Network for Cardiothoracic Surgical Investigations in Cardiovascular Medicine: Anticoagulation for New-Onset Post-Operative Atrial Fibrillation After CABG – Icahn School of Medicine at Mount Sinai	93.837	0255-A348-4605-4605	–	6,641
1/2 ICECAP: Influence of Cooling Duration on Efficacy in Cardiac Arrest Patients - Tufts Medical Center, Inc.	93.837	Not identified	–	41,721
Fetal Cerebrovascular Autoregulation in Congenital Heart Disease and Association with Neonatal Neurobehavior – University of Utah	93.837	10064134-04-MH	–	599
Advancing Cardiothoracic Surgical Trials in Rural Health Populations – The Feinstein Institutes for Medical Research	93.837	AWD00001723-MaineHealth	–	183,028
The Rhythm Evaluation for Anticoagulation With Continuous Monitoring of Atrial Fibrillation Trial (REACT-AF) – Northwestern University	93.837	60066435 MH	–	5,492

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2024

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development (Continued):				
Improving Outcomes in Vascular Disease – Aortic Dissection (IMPROVE-AD) – Duke University	93.837	SPS-277265 WBSE-303001994	$ –	$ 320
Metabolic Dysfunction, Viral Persistence and Bioenergetic T Cell Fatigue in Post-Acute SARS-CoV2 – West Virginia University Board of Governors on Behalf of West Virginia University	93.838	PATHO-PH2-SUB-12-23	–	410,057
Metabolic Dysfunction, Viral Persistence and Bioenergetic T Cell Fatigue in Post-Acute SARS-CoV2 – New York University Grossman School of Medicine	93.838	PATHO-PH2-SUB-12-23	330,938	425,087
CCC for NHLBI Prevention and Early Treatment of Acute Lung Injury (PETAL) Network (ASTER Protocol) – Baystate Medical Center, Inc.	93.838	21-210	–	1,240
CCC for NHLBI Prevention and Early Treatment of Acute Lung Injury (PETAL) Network (ASTER Protocol) – Baystate Medical Center, Inc.	93.838	239080-21-197	–	(1,642)
RECOVER-ENERGIZE: A Platform Protocol for Evaluation of Interventions for Exercise Intolerance in Post-Acute Sequelae of SARS-CoV-2 Infection (PASC) – Duke University	93.838	SPS-281825, WBSE-383001221	–	23,751
1/2 Pulmonary Embolism: Thrombus Removal With Catheter Directed Therapy (PE TRACT Trial) – New York University Grossman School of Medicine	93.839	21-A2-00-1004666	–	1,088
A Phase III Randomized Trial Comparing Unrelated Donor Bone Marrow Transplantation With Immune Suppressive Therapy for Newly Diagnosed Pediatric and Young Adult Patients With Severe Aplastic Anemia (TransIT) – National Marrow Donor Program	93.839	Not identified	–	2,444
Dissemination and Implementation of the Bright Bodies Intervention for Childhood Obesity - Yale University	93.840	CON-80004603 (GR121585)	–	95,613
Dissemination and Implementation of the Bright Bodies Intervention for Childhood Obesity - Yale University	93.840	CON-80005217 (GR124973)	–	34,936
Mechanism of Action of PTH: New Signaling Components That Regulate Bone Formation and Bone Marrow Fat – President and Fellows of Harvard College o/b/o Harvard Medical School	93.846	158299.5113827.0002	–	127,213
Environmental Factors Associated With the Development of Osteoarthritis – University of Massachusetts Chan Medical School	93.846	SUB00000471	–	66,435
Metabolism and functions of One Marrow Adipose Tissue in the Marrow Niche – Regents of the University of Michigan	93.847	SUBK00019202	–	37,110
Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial (CREST-2) – Mayo Clinic Jacksonville	93.853	MAI-187276-01	–	6,764
Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial – Hemodynamics (CREST-H) – Mayo Clinic Jacksonville	93.853	MAI-232483-06	–	1,051
Brain Oxygen Optimization in Severe TBI Phase -3 (BOOST-3) – University of Michigan	93.853	SUBK11612CSPR-002	–	48,142
PREcision Care In Cardiac ArrEst - ICECAP (PRECICECAP) – Regents of the University of Michigan	93.853	SUBK00016042	–	5,739
PREcision Care In Cardiac ArrEst - ICECAP (PRECICECAP) – Board of Trustees of The Leland Stanford Junior University	93.853	62563991-179030	–	62,828
Long-Term Observational Extension of Participants in the CREST-2 Randomized Clinical Trial – Mayo Clinic Jacksonville	93.853	MAI-290195	–	368
Repeated Assessment of Survivors in ICH (REASSESS ICH) – John Hopkins University, The	93.853	2005884330	–	8,141

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Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development (Continued):				
PRECICE CAP Stanford Supplement – Stanford University	93.853		$ –	$ 10,568
Emergence of Tick Borne Encephalitis in North America – The Trustees of Tufts College	93.855	102222-00002 / NIH062	–	17,966
Hybrid ELISA: Simple and Specific One-Tier Assay for Lyme Disease – Kephera Diagnostics, LLC	93.855	AI142903-MHIR-02	–	25,350
Comparative Biology of Tissue Repair, Regeneration and Aging – MDI Biological Laboratory	93.859	P20GM 104318-10/Carter	–	34,305
Comparative Biology of Tissue Repair, Regeneration and Aging – MDI Biological Laboratory	93.859	P20GM 104318-1 OS 1/Hernandez	–	288,435
Effect of Immulina Supplements on Inflammatory Biomarkers Correlated with Clinical Systems in Patients with Long COVID (PASC) – University of Mississippi Medical Center	93.859	SP14544-SB23	–	9,211
The IDeA State Consortium for a Clinical Research Resource Center: Increasing Clinical Trials in IDeA States Through Communication of Opportunities, Effective Marketing, and Workforce Development – University of West Virginia Research Corporation	93.859	23-278-MH	–	52,916
The IDeA State Consortium for a Clinical Research Resource Center: Increasing Clinical Trials in IDeA States Through Communication of Opportunities, Effective Marketing, and Workforce Development – University of West Virginia Research Corporation	93.859	23-278-MH-Yr1	–	118,105
GlyCORE: Glycoscience Center of Research Excellence – University of Mississippi	93.859	24-11-32	–	215,032
Arkansas Integrative Metabolic Research Center – University of Arkansas	93.859	UA2024-454	–	31,316
Physiological Mechanisms of Action Relating to Immediate and Long-Term Therapeutic Horseback Riding Intervention Effects in a Psychiatric Population of Youth with Autism Spectrum Disorder – University of Colorado | Anschutz Medical Campus	93.865	FY20.557.002	–	8,557
Cellular Metabolism at the Crossroads of Skeletal Regeneration – The Administrators of the Tulane Educational Fund d/b/a Tulane University	93.865	TUL-HSC-560695-22/23	–	2,915
Cellular Metabolism at the Crossroads of Skeletal Regeneration – Mayo Clinic	93.865	MAI-326914	–	7,251
Cellular Metabolism at the Crossroads of Skeletal Regeneration – Mayo Clinic	93.865	MAI-326914-01; MAI-326914-02	–	5,433
Longitudinal Assessment of Specificity in Adolescent-Dog Relationships and Adaptive Coping for Youth with Social Anxiety – Trustees of Tufts College	93.865	EP0227259	–	14,731
FSH – An Aging Hormone? – Icahn School of Medicine at Mount Sinai	93.866	0255-B450-4609	–	99,061
Beta1-Selective Blockade for Prevention of Postmenopausal Bone Loss: A Randomized Controlled Trial - Mayo Clinic	93.866	MAI-277060-04	–	116,214
Beta1-Selective Blockade for Prevention of Postmenopausal Bone Loss: A Randomized Controlled Trial - Mayo Clinic	93.866	MAI-277060/06	–	297,546
Comparative Effectiveness and Safety of Osteoporosis Drug Therapies – Mayo Clinic	93.866	MAI-306092-01	–	9,813
Comparative Effectiveness and Safety of Osteoporosis Drug Therapies – Mayo Clinic	93.866	MAI-306092-02	–	3,616
Decision of Trajectories of Patients at the End of Life: An Epidemiological Exploration of MAID and the Impact on Caregivers and Clinicians – University of Colorado | Anschutz Medical Campus	93.866	FY23 622.002	–	20,550

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development (Continued):				
A Randomized, Double-Blind, Placebo-Controlled, Clinical Trial of a Probiotic Supplement for the Dietary Management of Age-Related Bond Loss – Hebrew Rehabilitation Center	93.866	90121	$ –	$ 12,312
Total Pass-Through Awards – National Institutes of Health – Research and Development			330,938	4,686,334
Total National Institutes of Health – Research and Development			4,049,335	20,513,886
Department of Defense – Research and Development:				
U.S. Army Medical Command – Research and Development:				
Direct Awards:			–	4,366
Use of Tranexamic Acid to Reduce Tissue Edema and Prevent Burn Wound Conversion	12.420			
Development of a Novel Ovarian Cancer Treatment Targeting a Crytic ECM Component With a Unique Antibody Conjugate	12.420		–	75,734
Total Direct Awards U.S. Army Medical Command – Research and Development				80,100
Pass-Through Awards:				
Biomarkers in the Brain Oxygen Optimization in Severe TRI Trial (Bio-BOOST) – Regents of the University of Michigan	12.420	SUBK00013509	–	91
Total Department of Defense - Research and Development			–	80,191
U.S. Environmental Protection Agency:				
Pass-Through Awards:				
Climate Change Impacts on Tick-Borne Diseases: Exploring Tick Phenology, Pathogen Prevalence, and Host Associations for Targeting Management – University of Maine System Acting as the University of Maine	66.202	UMS2264	–	43,649
Total Research and Development Cluster			4,049,335	20,637,726
Department of Health and Human Services – Medicaid Cluster:				
Centers for Medicare and Medicaid Services:				
Pass-through Awards:				
MaineHealth/Poison Control – State of Vermont	93.778	03420-09070	–	122,393
Medicaid Administration Payments – State of Maine	93.778	ECE-24-1507	–	43,597
Medical Assistance program – Seattle Children's Hospital d/b/a Seattle Children's Research Center	93.778	Not identified	–	21,864
Total Medicaid Cluster			–	187,854
Department of Health and Human Services – 477 Cluster:				
Administration for Children and Families Pass-through Awards:				
Temporary Assistance for Needy Families - Maine Children's Trust	93.558	Sub CD0-23-4230	–	124,825
Total 477 Cluster			–	124,825

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
United States Department of Agriculture – SNAP Cluster				
Pass-through Awards:				
Supplemental Nutrition Assistance Program - University of New England	10.561	29032H-08	$ –	$ (11)
Supplemental Nutrition Assistance Program - University of New England	10.561	29032H-09	–	2,644
Supplemental Nutrition Assistance Program - University of New England	10.561	29032H-12	–	(53)
Supplemental Nutrition Assistance Program - University of New England	10.561	29032H-15	–	(101)
Supplemental Nutrition Assistance Program - University of New England	10.561	29032H-71738	–	165,001
Supplemental Nutrition Assistance Program - University of New England	10.561	29032J-08	–	139,521
Supplemental Nutrition Assistance Program - University of New England	10.561	29032J-09	–	85,818
Supplemental Nutrition Assistance Program - University of New England	10.561	29032J-11	–	75,891
Total SNAP Cluster			–	468,710
Department of Health and Human Services – CARES Act				
Direct Awards:				
COVID-19 Provider Relief Fund – HRSA	93.498		–	3,045,575
Pass-through Awards:				
Model State Supported Area Health Education Centers (AHEC) Program – University of New England	93.107	23004F-02	–	14,656
Model State Supported Area Health Education Centers (AHEC) Program – University of New England	93.107	23004E-05; 23004G-08	–	120,121
Total Pass-through Awards			–	134,777
Total Department of Health and Human Services - CARES Act			–	3,180,352
Department of the Treasury – CARES Act:				
Pass-through Awards:				
Maine Apprenticeship Program ARPA Grant – State of Maine	21.027	20220727*0301	–	383,684
Comprehensive Addiction Medicine Program (CAMP) – City of Portland, Maine	21.027	Not Identified	–	187,583
Maine Medical Center – Preble Street Learning Collaborative (MMC-PSLC) Connections Clinic – Psychiatry Outreach Program (CC-POP) – City of Portland, Maine	21.027	Not Identified	–	373,177
Broadening the Healthcare Labor Workforce in the State of Maine – City of Portland, Maine	21.027	597054-78050	–	10,065
Total Department of the Treasury – CARES Act			–	954,509*
Department of Health and Human Services –Other Programs				
Centers for Disease Control and Prevention:				
Direct Awards:				
Drug-Free Communities (DFC) Support Program – New	93.276		–	73,225

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs (Continued)				
Centers for Disease Control and Prevention (Continued):				
Pass-Through Awards:				
Public Health Emergency Preparedness - State of New Hampshire	93.069	Not identified	$ –	$ 39,714
Public Health Emergency Preparedness - State of Maine	93.069	CD3-23-1309	–	750
Public Health Emergency Preparedness - State of Maine	93.069	CD0-23-1319A	–	69,194
Public Health Emergency Preparedness - State of Maine	93.069	CD0-23-1319	–	18,487
Asthma Control & Prevention – State of Maine	93.070	CD0-23-4550	–	123,773
Environmental Public Health and Emergency Response – State of New Hampshire	93.070	Not identified	–	39,714
Community Counts: Public Health Surveillance for Bleeding Disorders – Boston Children's Hospital	93.080	GENFD0002269885	–	25,335
Suppression of Host-Seeking Ixodes Scapularis Abundances and Interruption of Pathogen Transmission Through Orally Delivered Systemic Acaricide Treatment of White-tailed Deer and Peromyscus spp. – Connecticut Agricultural Experiment Station	93.084	CAES-2023-23140-1	–	165,922
Harnessing Electronic Health Records for Surveillance of Lyme – Massachusetts General Hospital	93.084	244266	–	160,854
Strengthening Training, Evaluation, and Partnerships in the Prevention and Control of Vector-Borne Diseases – Cornell University	93.084	147945-22384	–	68,323
Injury Prevention and Control Research and State and Community Based Programs – State of Maine	93.136	OSA-23-4007	–	38,953
Injury Prevention and Control Research and State and Community Based Programs – State of Maine	93.136	OSA-23-500	–	122,737
Strategic Prevention Framework for Prescription Drugs 2021 (SPF-Rx 2021) – State of Maine	93.243	CD0-24-4430	–	4,372*
AAMC Improving Clinical and Public Health Outcomes Through National Partnerships to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats – Association of American Medical Colleges	93.318	GT-32021-10	–	(4,677)
Epidemiology and Laboratory Capacity for Infectious Diseases – State of New Hampshire	93.323	90183509	–	6,581
Epidemiology and Laboratory Capacity for Infectious Diseases – State of New Hampshire	93.323	CD0-23-5170; CD0-23-5170A; CD0-23-5170B	–	326,632
Public Health Emergency Response: Cooperative Agreement for Emergency Response: Public Health Crisis Response – State of Maine	93.354	CD4-22-4401A	–	198
Public Health Emergency Response: Cooperative Agreement for Emergency Response: Public Health Crisis Response – State of Maine	93.354	CD4-22-4401	–	(5,289)
Maine Tobacco Control Programs - State of Maine	93.387	CD1-23-4425B	1,590	11,193
Maine Tobacco Control Programs - State of Maine	93.387	CD1-25-4425	–	4,134
Maine Tobacco Control Programs - State of Maine	93.387	CD0-24-4499	–	61,245
Maine Tobacco Control Programs - State of Maine	93.387	CD3-23-4425A	5,083	11,850
Maine Tobacco Control Programs - State of Maine	93.387	CD3-25-4425	–	3,635
Maine Tobacco Control Programs - State of Maine	93.387	CD4-23-4425	1,577	8,402
Maine Tobacco Control Programs - State of Maine	93.387	CD4-25-4425	–	3,435

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Department of Health and Human Services – Other Programs (Continued)				
Centers for Disease Control and Prevention (Continued):				
Pass-Through Awards (Continued):				
Maine's Initiative to Enhance Community Health Workers for COVID Response and Resilient Communities – State of Maine	93.495	CDM-23-4573	$ –	$ 63,410
Maine Rural GME Education (MERGE) Collaborative – State of Maine	93.495	COM-23-7023	–	293,506
PrevME Community Informed Care Initiative – State of Maine	93.495	DCM-23-4576A	–	102,098
Building-ME Network – State of Maine	93.495	COM-23-7022	–	150,529
National Bioterrorism Hospital Preparedness Program - State of Maine	93.889	CD0-23-1319A	–	69,194
National Bioterrorism Hospital Preparedness Program - State of Maine	93.889	CD0-25-1319	–	18,487
Cancer Prevention and Control Programs for State, Territorial and Tribal Organizations – State of New Hampshire	93.898	Not identified	–	55,197
Total Pass-Through Awards			8,250	2,057,888
Total Centers for Disease Control and Prevention			8,250	2,131,113
Health Resources and Services Administration:				
Direct Awards:				
Preventive Medicine Residencies	93.117		–	362,417
Telehealth Network Grant Program	93.211		–	298,985
Evidence-Based Tele-Behavioral Health Network Program	93.211		–	134,773
Poison Control Stabilization and Enhancement Program	93.253		–	247,664
Community Project Funding/Congressionally Directed Spending – Construction	93.493		–	2,685,042*
Rural Communities Opioid Response – Implementation	93.912		–	503,185*
Rural Health Outreach and Rural Network Development Program	93.912		–	798,987*
Rural Health Care Services Outreach Grant Program	93.912		–	273,630*
Rural Health Network Development Program	93.912		–	430,242*
Rural Communities Opioid Response – Neonatal Abstinence Syndrome	93.912		–	224,116*
Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement	93.912		–	87,186*
Rural Communities Opioid Response – Overdose Response	93.912		–	170,795*
Total Direct Awards			–	6,217,022
Pass-through Awards:				
Leadership Education in Neurodevelopmental and Related Disorders Training Program - University of New England	93.110	230065C-11	–	2,231
Leadership Education in Neurodevelopmental and Related Disorders Training Program - University of New England	93.110	23065E-03	–	17,782
Pediatric Mental Health Care Access - State of Maine	93.110	CBH-24-4221; CBH-24-4221A	–	135,385
Hemophilia Treatment Centers (SPRANS) - Icahn School of Medicine at Mount Sinai	93.110	0253-7152-4609	–	12,910
Hemophilia Treatment Centers (SPRANS) - Icahn School of Medicine at Mount Sinai	93.110	0253-7153-4609	–	6,683

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs (Continued)				
Health Resources and Services Administration (Continued):				
Pass-through Awards (Continued):				
State Maternal Health innovation Program – Maine Medical Association Center for Quality Improvement	93.110	Not identified	$ –	$ 23,043
Maternal and Child Health Federal Consolidated Programs – Maine Medical Association Center for Quality Improvement	93.110	Not identified	–	17,493
AIDS Education and Training Centers Program - University of Massachusetts, Worcester	93.145	OSP29994-05	–	59,147
Sickle Cell Treatment Demonstration Program – Johns Hopkins University	93.365	2005403449	–	5,000
Maternal, Infant and Early Childhood Home Visiting Grant Program – Maine Children's Trust	93.870	Sub CD0-23-4230	–	542,651
Rural Communities Opioid Response-Implementation – Western Maine Addiction Recovery Initiative	93.912	Not identified	–	42,336*
Geriatrics Workforce Enhancement Program - University of New England	93.969	23015C02	–	21,207
Maternal and Child Health Services Block Grants to States - State of Maine	93.994	CD0-24-4282	–	179,902
Total Pass-through Awards			–	1,065,770
Total Health Resources and Services Administration			–	7,282,792
Substance Abuse and Mental Health Services Administration:				
Direct Awards:				
Expanding EMS Recruitment and Training in Franklin County, ME	93.243		–	7,461*
Mid Coast Maine Mental Health Awareness Training Program for Schools and Community	93.243		–	112,213*
Project DHARMA – Distribution of Harm Reduction Access in Rural Maine Areas	93.243		–	425,756*
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243		–	21,852*
Project REMH (Rural Education on Mental Health)	93.243		–	122,374*
Franklin's Blueprint for Mental Health Awareness	93.243		–	88,685*
Western Maine STOP Act Project	93.243		–	26,549*
2023 Rural Emergency Medical Services Training Grant	93.243		–	167,905*
Project Life Worth Living	93.243		–	293,885*
Maine Behavioral Healthcare Certified Community Behavioral Health Clinic	93.696		–	798,321
CCBHC Midcoast	93.696		–	525,429
Total Direct Awards			–	2,590,430

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs (Continued)				
Substance Abuse and Mental Health Services Administration (Continued):				
Pass-through Awards:				
Empower ME - Supporting All Maine Children & Families to Live Safe, Stable, Happy, and Healthy Lives - State of Maine	93.104	CBH-23-7004B	$ –	$ 138,898
Maine Project to Prevent Prescription Drug/Opioid Overdose-Related Deaths – Central Maine Community Health	93.243	CD3-23-4434	–	43,525*
Maine CHR-P to Improve Services and Less the Impact of Psychotic Disorders in Youth – State of Maine	93.243	MH4-23-2021	–	1,796*
Maine CHR-P to Improve Services and Less the Impact of Psychotic Disorders in Youth – State of Maine	93.243	MH4-23-2021A	–	369,164*
Substance Abuse and Mental Health Services Projects of Regional and National Significance – State of Maine	93.243	CD0-23-4430	–	4,837*
Maine Prevention Network Partnerships for Success 2022 – State of Maine	93.243	CD1-23-4425B	21,092	36,487*
Maine Prevention Network Partnerships for Success 2022 – State of Maine	93.243	CD1-25-4425	–	3,471*
Maine Prevention Network Partnerships for Success 2022 – State of Maine	93.243	CD3-23-4425A	17,477	36,419*
Maine Prevention Network Partnerships for Success 2022 – State of Maine	93.243	CD3-25-4425	–	6,462*
Maine Prevention Network Partnerships for Success 2022 – State of Maine	93.243	CD4-23-4425	25,814	41,276*
Maine Prevention Network Partnerships for Success 2022 – State of Maine	93.243	CD4-25-4425	–	3,617*
Emergency Medical Services for Children – State of Maine	93.243	20190610*3791	–	230,000*
Maine Prevention Network – Cumberland Public Health District – County of Cumberland	93.243	CD5-23-4425-M PN02	–	492*
MPN District 4 HLC – State of Maine	93.243	CD4-25-4425	816	6,624*
Maine's Tobacco Control Program – State of Maine	93.387	CD1-25-4425	124	2,026
Maine's Tobacco Control Program – State of Maine	93.387	CD3-25-4425	1,082	20,796
Maine's Tobacco Control Program – State of Maine	93.387	CD4-25-4425	269	5,678
Opioid STR - State of Maine	93.788	CD1-23-4425B	3,962	6,855
Opioid STR - State of Maine	93.788	CD3-23-4425A	3,283	6,842
Opioid STR - State of Maine	93.788	CD4-23-4425	4,850	7,754
Opioid STR - State of Maine	93.788	OSA-24-4201	–	3,885
Opioid STR - State of Maine	93.788	OSA-25-332	–	3,174
MPN District 3 HCC HA SUPS – State of Maine	93.788	CD3-25-4425	1,448	–
MPN District 3 HCC RV SUPS – State of Maine	93.788	CD3-25-4425	474	–
Block Grants for Community Mental Health Services - State of Maine	93.958	CBH-23-7004B	–	479,315
Block Grants for Community Mental Health Services - State of Maine	93.958	MH1-20-705	–	9
Block Grants for Community Mental Health Services - State of Maine	93.958	MH1-24-705B	–	104,885
Block Grants for Community Mental Health Services - State of Maine	93.958	MH4-24-2020	–	866,625
Block Grants for Community Mental Health Services - State of Maine	93.958	MH4-25-2020	–	330,738
Maine Prevention Network – Cumberland Public Health District - County of Cumberland	93.959	CD5-23-4425-M PN02	–	3,973

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Department of Health and Human Services – Other Programs (Continued)				
Substance Abuse and Mental Health Services Administration (Continued):				
Pass-through Awards (Continued)::				
Substance Abuse Block Grant – State of Maine	93.959	CD1-23-4425B	$ 29,393	$ 50,846
Substance Abuse Block Grant – State of Maine	93.959	CD3-25-4425	–	5,446
Substance Abuse Block Grant – State of Maine	93.959	CD3-23-4425A	21,953	45,746
Substance Abuse Block Grant – State of Maine	93.959	CD3-24-4482A	–	11,004
Substance Abuse Block Grant – State of Maine	93.959	CD3-25,4425	–	12,267
Substance Abuse Block Grant – State of Maine	93.959	CD4-24-4425	32,425	51,847
Substance Abuse Block Grant – State of Maine	93.959	CD4-24-4401	–	59,078
Substance Abuse Block Grant – State of Maine	93.959	CD4-25-4425	–	7,308
Substance Abuse Block Grant – State of Maine	93.959	OSA-24-332	–	11,954
Substance Abuse Block Grant – State of Maine	93.959	OSA-24-4040	–	6,005
Substance Abuse Block Grant – State of Maine	93.959	OSA-24-4042	–	10,453
Substance Abuse Block Grant – State of Maine	93.959	OSA-25-4042	–	3,397
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-23-219	–	95,628
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-23-4007	–	125,435
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-24-4080	–	28,637
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-25-219	–	70,395
MaineHealth/Poison Control – State of Vermont	93.959	03420-09070	–	60,338
MPN District 1 YH – State of Maine	93.959	CD1-25-4425	1,668	7,989
MPN District 3 HCC HA SUPS – State of Maine	93.959	CD3-25-4425	2,750	12,842
MPN District 3 HCC RV SUPS – State of Maine	93.959	CD3-25-4425	899	4,198
MPN District 4 PBYMCA SUPS – State of Maine	93.959	CD4-25-4425	2,558	10,274
Crisis Counseling Assistance and Training Program – State of Maine	97.032	MH4-24-CCP1	–	27,271
Crisis Counseling Assistance and Training Program – State of Maine	97.032	MH4-24-CCP4	–	9,901
Crisis Counseling Assistance and Training Program – State of Maine	97.032	MH4-24-CCP5	–	377
Crisis Counseling Assistance and Training Program – State of Maine	97.032	MH4-24-CCP6	–	44,752
Total Pass-through Awards			172,337	3,539,011
Total Substance Abuse and Mental Health Services Administration			172,337	6,129,441
Administration for Children and Families:				
Pass-through Awards				
Title IV-E Prevention Program – Maine Children's Trust	93.472	Sub CD0-23-4230	–	96,479
Child Care and Development Block Grant – State of Maine	93.575	Not identified	–	103,226
Diaper Distribution Demonstration and Research Pilot (DDDRP) – Maine Community Action Association	93.647	90EDA0019-01-00	–	2,915
Social Services Block Grant – State of Maine	93.667	MH4-23-009	–	163,119
Total Administration for Children and Families – Other Programs			–	365,739

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2024

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs (Continued)				
Administration for Community Living:				
Direct Awards:				
COVID-19 and Influenza Vaccine Uptake Initiative	93.048		$ –	$ 28,103
Mount Washington Valley Dementia Capable Community Program	93.470		–	212,413
MaineHealth Alzheimer's Partnership: Expanding to Meet Community Needs	93.470		–	264,916
Total Administration for Community Living			–	505,432
Centers for Medicare and Medicaid Services:				
Pass-through Awards:				
Maternal Opioid Misuse Model - State of Maine	93.687	OMS-22-604C	–	133,067
Total Department of Health and Human Services – Other Programs			180,587	16,547,584
United States Department of Justice – Other Programs:				
Office of Violence Against Women:				
Direct Awards:				
Rural Domestic Violence, Dating Violence, Sexual Assault, and Stalking Assistance Program	16.589		–	351,869
Office of Community Oriented Policing Services:				
Pass-through Awards:				
Public Safety Partnership and Community Policing Grants FY22 School Violence Prevention Program – The Franklin County Sheriffs Department, as Part of the County of Franklin	16.710	Not identified	–	15,665
Office of Juvenile Justice and Delinquency:				
Pass-through Awards:				
FY 2023 Second Chance Act Addressing the Needs of Incarcerated Parents and Their Minor Children – State of Maine	16.831	CT 03A 20221026000000001211	–	230,664
Total United States Department of Justice – Other Programs			–	598,198
United States Department of Agriculture – Other Programs:				
Direct Awards:				
Distance Learning and Telemedicine Grant Agreement	10.855		–	(13,783)

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2024

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
United States Department of Agriculture – Other Programs (Continued):				
Pass-through Awards:				
UMaine CE Tick Surveillance Program – University of Maine System Acting as the University of Maine	10.028	UMS221	$ –	$ 147,060
Gut Microbial Metabolites of Apple Polyphenois: Interrogating Individual Differences to Establish Functional Biomarker Utility – University of Maryland	10.310	133157-Z5454202	–	29,214
Maine West Outdoor Recreation Economy and Community Initiative – The Northern Forest Center, Inc.	10.446	Not identified		6,031
Full Plates Full Potential USDA – Full Plates Full Potential	10.579	Not identified	–	183,715
Total Pass-Through Awards			–	366,020
Total United States Department of Agriculture – Other Programs			–	352,237
Social Security Administration – Other Programs:				
Direct Awards:				
Northern New England Work Incentives Planning and Assistance Program	96.008		135,000	293,460
United States Department of Education – Other Programs:				
Pass-through Awards:				
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20220715*0171	–	286,187
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20230905*0613	–	288,086
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20230909*0614	–	117,816
Rehabilitation Services-Disability Innovation Fund (DIF) Grants to States – State of Maine	84.421	20240522*3356	–	2,501
Total United States Department of Education – Other Programs			–	694,590
Department of Homeland Security – Disaster Grants:				
Federal Emergency Management Agency:				
Direct Awards:				
Disaster Grants – Public Assistance (Presidentially Declared Disasters)	97.036		–	13,355,434*
Total Expenditures and Federal Awards			$ 4,364,922	$ 57,395,479

* Major program

See notes to this schedule.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended September 30, 2024

1. Reporting Entity

The accompanying Supplementary Schedule of Expenditures of Federal Awards (the Schedule) presents the activity of all federal award programs of MaineHealth Services and Subsidiaries (the System) for the year beginning October 1, 2023 and ending September 30, 2024.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying Schedule has been prepared using the accrual basis of accounting and in accordance with Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). The purpose of the Schedule is to present a summary of those activities of the System for the year ending September 30, 2024, which have been supported by the U.S. Government (federal awards). For purposes of the Schedule, federal awards include all federal assistance entered into directly between the federal government and the System and federal funds awarded to the System by a primary recipient. Because the Schedule presents only a selected portion of the activities of the System, it is not intended to and does not present the consolidated financial position, results of operations, changes in net assets, and cash flows of the System and its subsidiaries.

For purposes of the Schedule, federal awards include all grants, contracts and similar agreements entered into directly between the System and agencies and departments of the federal government and all subawards to the System by nonfederal organizations pursuant to federal grants, contracts and similar agreements.

3. Summary of Facilities and Administrative Costs

The System recovers facilities and administrative costs (indirect costs) associated with expenditures pursuant to arrangements with the federal government. The various entities under the System umbrella were awarded provisional rates ranging from 12.7% to 76%, for the year ended September 30, 2024, based on modified total direct costs. These rates are for their respective research and development grant expenditures, clinical expenditures, other sponsored activities expenditures, and nonresearch and development grant expenditures. The several entities within the System that do not have a federally negotiated rate agreement have elected to use the 10% de minimis indirect cost rate under the Uniform Guidance.

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4. Department of Health and Human Services (DHHS) Coronavirus Aid Relief and Economic Securities (CARES) Act

The Schedule includes grant activity related to the DHHS CARES Act ALN 93.498, Provider Relief Funds (PRF). As required by the 2024 OMB Compliance Supplement, the Schedule includes all PRFs received between July 1, 2022 and December 31, 2022 (Reporting Period 6) and expended by December 31, 2023, as well as PRFs received between January 1, 2023 and June 30, 2023 (Reporting Period 7) and expended by June 30, 2024. The PRF funds in the amount of $3,045,575 were used to cover direct expenditures and lost revenues and covers the following TINs:

LincolnHealth Cove's Edge	01-0382340
Memorial Hospital	02-0222156
Quarry Hill	01-0213976
Mid Coast Geriatric Services	01-0496221

5. United States Department of Homeland Security Disaster Grants – Public Assistance (Presidentially Declared Disasters)

The Schedule includes expenditures totaling $13,355,434 being reported under the United States Department of Homeland Security Federal Emergency Management Agency (FEMA) Assistance Listing Number 97.036, Department of Homeland Security Disaster Grants – Public Assistance (Presidentially Declared Disasters). These expenditures were incurred by the System during the years ended September 30, 2020 through 2023. The System's Project Worksheet covering these expenditures was approved by FEMA during the year ended September 30, 2024 and, in accordance with the 2024 OMB Compliance Supplement, these expenditures are therefore reported on the Schedule during the year ended September 30, 2024.

6. Donated Personal Protective Equipment (PPE) (Unaudited)

During the year ended September 30, 2024, the System did not receive donated PPE.

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HLB THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

INDEPENDENT AUDITORS' REPORT

Board of Directors
MaineHealth Services and Subsidiaries

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* (GAS), issued by the Comptroller General of the United States, the consolidated financial statements of MaineHealth Services and Subsidiaries (the System), which comprise the System's consolidated balance sheet as of September 30, 2024, and the related consolidated statements of operations, changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements (collectively, the financial statements), and have issued our report thereon dated February 7, 2025.

Report on Internal Control Over Financial Reporting

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

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

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

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Board of Directors
MaineHealth Services and Subsidiaries

Report on Compliance and Other Matters

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

Purpose of This Report

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

Baker Newman + Noyes LLC

Portland, Maine
February 7, 2025

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HLB THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

INDEPENDENT AUDITORS' REPORT

Board of Directors
MaineHealth Services and Subsidiaries

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited MaineHealth Services and Subsidiaries' (the System) compliance with the types of compliance requirements identified as subject to audit in the OMB *Compliance Supplement* that could have a direct and material effect on each of the System's major federal programs for the year ended September 30, 2024. The System's major federal programs are identified in the summary of Auditors' results section of the accompanying schedule of findings and questioned costs.

In our opinion, the System complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended September 30, 2024.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (GAS); and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditors' Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with 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 opinion on compliance for each major federal program. Our audit does not provide a legal determination of the System's compliance with the compliance requirements referred to above.

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Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to the System's federal programs.

Auditors' Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the System's compliance based on our audit. 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 GAAS, GAS, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the System's compliance with the requirements of each major federal program as a whole,

In performing an audit in accordance with GAAS, GAS, and the Uniform Guidance, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, 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 System's compliance with the compliance requirements referred to above and performing such other procedures as we consider necessary in the circumstances.
- Obtain an understanding of the System's internal control over compliance 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 System's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

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

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Board of Directors
MaineHealth Services and Subsidiaries

Our consideration of internal control over compliance was for the limited purpose described in the Auditors' Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

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

Baker Newman + Noyes LLC

Portland, Maine
June 23, 2025

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MAINEHEALTH SERVICES AND SUBSIDIARIES
(MaineHealth Services and Subsidiaries)

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended September 30, 2024

I. Summary of Auditors' Results

Financial Statements:

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	*Unmodified*			
Internal control over financial reporting:				
• Material weakness(es) identified?	_____	yes	X	no
• Significant deficiency(ies) identified?	_____	yes	X	none reported
Noncompliance material to financial statements noted?	_____	yes	X	no

Federal Awards:

Internal control over major federal programs:				
• Material weakness(es) identified?	_____	yes	X	no
• Significant deficiency(ies) identified?	_____	yes	X	none reported
Type of auditors' report issued on compliance for major federal programs:	*Unmodified*			
• Any audit findings disclosed that are required to be reported in accordance with Section 2 CFR 200 516(a)?	_____	yes	X	no

Identification of Major Programs:

ALN	Name of Federal Program or Cluster
21.027	Various
93.243	Various
93.912	Various
93.493	Community Project Funding/Congressionally Directed Spending – Construction
97.036	Disaster Grants – Public Assistance (Presidentially Declared Disasters)

Dollar threshold used to distinguish between type A and type B programs:	$1,721,864			
Auditee qualified as low-risk auditee?	X	yes	_____	no

II. Financial Statement Findings

Findings related to the financial statements which are required to be reported in accordance with GAS:

No matters were reported.

III. Findings and Questioned Costs for Federal Awards

Findings and questioned costs for federal awards which shall include findings as defined in Section 2 CFR 200 516(a):

No matters were reported.

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MAINEHEALTH SERVICES AND SUBSIDIARIES
(MaineHealth Services and Subsidiaries)

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS AND QUESTIONED COSTS

Year Ended September 30, 2024

None.

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CURRICULUM VITAE
Karen Simone, PharmD, DABAT, FAACT

DATE PREPARED: July 22, 2025
FULL NAME AND DEGREE/S: Karen E. Simone, PharmD, DABAT, FAACT (formerly Karen S. Krummen)
CURRENT ADMINISTRATIVE TITLE: Director, Northern New England Poison Center
OFFICE ADDRESS: Northern New England Poison Center, 22 Bramhall Street, Portland, ME 04102
OFFICE PHONE NUMBER: (207) 662-7221
FAX ADDRESS: (207) 662-5941
E-MAIL ADDRESS: karen.simone@mainehealth.org

EDUCATION AND TRAINING

Undergraduate

1992 *Bachelor of Science in Pharmacy* *University of Cincinnati*

Medical School and/or Graduate School

1994 *Doctor of Pharmacy* *University of Cincinnati*

Postdoctoral Training

Experiential

Other Professional Training

Preparedness:

Homeland Security Exercise and Evaluation Program (HSEEP), certified as trained by the Maine Emergency Management Agency
2008 *National*

Licensure and Certification

Pharmacy:

1992 – present	*Ohio*	*RPH.03219505*
2001 – present	*Maine*	*PR4981*

Toxicology:

Diplomate of the American Board of Applied Toxicology
1998 – present *National/International*

Specialist in Poison Information, Certified by American Association of Poison Control Centers
1993 - 2000 *National*

ACADEMIC APPOINTMENTS

2009 – present, Assistant Professor of Emergency Medicine, School of Medicine, Tufts University
2010 – 2013, Clinical Assistant Professor of Emergency Medicine, College of Osteopathic Medicine, University of New England
2000 – 2011, Assistant Professor of Emergency Medicine, College of Medicine, University of Vermont
1998 – 2000, Assistant Professor of Clinical Drug Information, College of Pharmacy, University of Cincinnati

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HOSPITAL APPOINTMENTS

2000 – present, Director, Northern New England Poison Center, Maine Medical Center
1994 – 2000, Manager/Clinical Coordinator of Drug and Poison Information Services, Cincinnati Drug & Poison Information Center, Cincinnati Children's Hospital Medical Center
1992 – 1994, Senior Drug and Poison Information Specialist, Cincinnati Drug & Poison Information Center, University Hospital in Cincinnati
1989 – 1992, Drug and Poison Information Provider, Cincinnati Drug & Poison Information Center, University Hospital in Cincinnati

AWARDS AND HONORS

2022, American Academy of Clinical Toxicology, Distinguished Service Award
2022, American Association of Colleges of Pharmacy Preceptor of the Year, Husson University
2020, Husson University School of Pharmacy Preceptor of the Year
2012, Advocacy in Action Award, New Futures
2011, Designation as a Fellow of the American Academy of Clinical Toxicology
2009, Award on behalf of the Northern New England Poison Center for Collaboration, Quality Service and Contribution to the Knowledge in the Field, presented at the 2009 International Symposium on Pharmaceuticals in the Home and Environment
2008, Dr. John Snow Epidemiological Contribution Award, 2008, Maine Health and Human Services, Public Health Division of Infectious Disease
2008, Arkansas Traveler Award, State of Arkansas
1994, Student Fellowship Award, Cincinnati Drug and Poison Information
1991, AB, Dolly and Ralph Cohen Scholarship, University of Cincinnati
1991, Merck Sharp and Dohme Award, University of Cincinnati
1991, Procter & Gamble Research and Scholarly Activity Award, University of Cincinnati
1991, Plough Pharmacy Scholarship, University of Cincinnati
1991, Rho Chi Society, Beta Nu Chapter, University of Cincinnati
1990, David Uhlfelder Scholarship, University of Cincinnati

HOSPITAL, MEDICAL SCHOOL, OR UNIVERSITY COMMITTEE ASSIGNMENTS:

2024 – present: Chair of the Maine Behavioral Healthcare Board
2023 – present: Member of the Quality Excellence Committee for Maine Behavioral Healthcare
2021 – 2023: Vice Chair of the Maine Behavioral Healthcare Board
2022 – 2023: Co-Chair of the Quality Excellence Committee for Maine Behavioral Healthcare
2014 – 2022: Chair of the Quality Excellence Committee for Maine Behavioral Healthcare
2013 – 2021: Member of the Board of Trustees for Spring Harbor Hospital (now a larger collaborative called Maine Behavioral Healthcare)
2006 – 2007: Maine Medical Center Pain Committee
2001 – 2005: Maine Injury Prevention Committee at Maine Medical Center

OTHER MAJOR COMMITEE ASSIGNMENTS:

2010 – present: Member of the New Hampshire Injury Prevention Advisory Council
2017 – 2025: New Hampshire Biomonitoring Technical Advisory Committee

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2006 - 2015: State of Maine Integrated Core Injury Prevention, Injury Community Planning Group
2003 – 2015: Community Epidemiology Surveillance Network, State of Maine
2008 – 2014: Strategic National Stockpile Advisory Group, State of Maine
2008 – 2012: Mushroom Task Force, State of Maine
2004 – 2010: Benzodiazepine Study Group, Steering Committee
2008 – 2009: LD1991 Workgroup, Co-Chair, Options for Ongoing Funding for the Northern New England Poison Center mandated by that State of Maine Joint Standing Committee on Appropriations and Financial Affairs, reporting to the Joint Standing Committee on Health and Human Services
2007 – 2008: Cumberland County Public Health Assessment Data Workgroup
2007 – 2008: Safe Medicine for ME Advisory Committee
2003 – 2007: Secretary, New England Chapter of the National Association of Drug Diversion Investigators

TRAINING OF GRADUATE STUDENTS/POST DOCTORAL

2023 – present: APPE Preceptor for Doctor of Pharmacy Students at Western New England University College of Pharmacy and Health Sciences
2018 – present: PGY2 Critical Care Pharmacy Resident Elective Toxicology Rotation for Dartmouth-Hitchcock Medical Center
2010 – present: Toxicology and Poisoning for Maine Medical Center Medical Pharmacy Residents in elective toxicology rotations
2000 – present: Toxicology and Poisoning for Maine Medical Center Medical Students and Residents in elective toxicology rotations
2004 - present: Doctor of Pharmacy Clerkship for Creighton University, School of Pharmacy and Health Professions in elective drug information and/or toxicology rotations
2015 – 2025: APPE Preceptor for Doctor of Pharmacy Students at Husson University College of Pharmacy
2011 – 2013: Doctor of Pharmacy Clerkship for the University of New England College of Pharmacy in elective drug information and/or toxicology rotations
2004 - 2011: Introduction to Toxicology and the Poison Center for Maine Medical Center Emergency Medicine Medical Students
1998 – 2000: Doctor of Pharmacy Drug Information Rotation for the University of Cincinnati College of Pharmacy

TEACHING RESPONSIBILITY

January 14, 2025, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME
January 30, 2024, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME
April 25, 2023, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME (virtual)
June 27, 2022, Copperhead snakebites, Pediatric Morning Report, Maine Medical Center, Portland, ME (virtual)
June 28, 2022, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME (virtual)
May 11, 2022, What you need to know about Modern Chemical Warfare, EM Didactics/Toxicology, Maine Medical Center, Portland, ME

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December 7, 2021, Substance Use of Stimulants – Licit, Illicit, and use with buprenorphine and other opioids, Psychiatry Grand Rounds, Maine Medical Center, Portland, ME (virtual)

June 22, 2021, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME (virtual)

June 24, 2020, Two Fires, A Warrant and A Giant Fish Tank – Kind of like Four Weddings and a Funeral, but not . . . Maine Medical Center Emergency Department, Toxicology Rounds, Portland, ME (virtual)

March 31, 2020, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME (virtual)

June 25, 2019, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME

January 30, 2018, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME (virtual)

July 20, 2016, Despite what you mother says, not all that is green and leafy is good for you . . . (plant and mushroom toxicity), Maine Medical Center Emergency Department, Toxicology Rounds, Portland, ME

April 5, 2016, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME

September 22, 2015, Toxicology – New Drugs, Pulmonary, Critical Care & Sleep Division Lecture Series, Tufts University School of Medicine in Boston, MA

September 18, 2015, Substance Abuse Trends in Maine, Psychobehavioral Conference, Maine Medical Center in Portland, ME

April 2, 2014, The Low-Down on Street Drugs in Maine, Social Worker Grand Rounds, Maine Medical Center in Portland, ME

April 10, 2012, Psychogenic Illness and Ticking Timebombs, Toxicology Rounds, Maine Medical Center in Portland, ME

March 4, 2014, Management of Psychotropic Drug Overdose, Psychiatry Resident Psychopharmacology Seminar, Maine Medical Center in Portland, ME

February 29, 2012, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

December 20, 2011, Bath Salts, Synthetic Cannabinoids (K2), Salvia divinorum and other natural/and not-so-natural highs, Psychiatry Rounds for Maine Medical Center in Portland, ME

December 14, 2011, Update on Significant Toxic Substances of Abuse in Maine – The Poison Center and Maine awash with Bath Salts, Grand Rounds for Mid Coast Hospital in Brunswick, ME

August 9, 2011, Opioids, Toxicology Rounds, Maine Medical Center in Portland, ME

April 28, 2011, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

November 9, 2010, Anion and Osmol Gaps, Iron and Isopropyl Alcohol – When you have more gaps than you think . . ., Toxicology Rounds, Maine Medical Center in Portland, ME

November 5, 2010, Aspirin, Toxic Alcohols, Sympathomimetics and Other Toxic Problems in the ICU, Fletcher Allen Health Care, Grand Rounds in Burlington, VT

November 5, 2010, Ethylene Glycol, Fletcher Allen Health Care, Medical Residents Morning Report in Burlington, VT

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November 5, 2010, Aspirin and Other Dialyzable Toxins, Fletcher Allen Health Care, Lunch Conference with Nephrology and Pulmonary Residents, Fellows and Attendings in Burlington, VT

September 29, 2010, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

September 2, 2010, Substance Abuse and the Poison Center, presented to the Mercy Hospital Integrated Pain Management Group in Portland, ME

April 29, 2010, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

April 29, 2010, Drug Interactions, University of New England Medical Students, Pharmacology in Biddeford, ME

October 14, 2009, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

April 30, 2009, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

April 30, 2009, Drug Interactions, University of New England Medical Students, Pharmacology in Biddeford, ME

November 11, 2008, GI Decontamination: Evidence- and Theory-based or Magic, Maine Medical Center, Toxicology Rounds in Biddeford, ME

October 6, 2008, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

May 12, 2008, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

May 6, 2008, Drug Interactions, University of New England Medical Students, Pharmacology in Biddeford, ME

September 30, 2007, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME

September 27, 2007, Paralytic Shellfish Poisoning – Case Series, Eastern Maine Medical Center, Clinical Pathological Conference in Bangor, ME

September 18, 2007, Grapes that Bite – Toxic Spider Bites, Maine Medical Center, Toxicology Rounds in Portland, ME

July 31, 2007, Topical Cantharides Leading to Toxic Toddler, Maine Medical Center, Pediatric Morning Rounds in Portland, ME

June 14, 2007, Decontamination, and Management of Tricyclic Antidepressants, and Calcium Channel and, Beta Blocker Overdoses, Eastern Maine Medical Center, Pediatric Rounds in Bangor, ME

May 15, 2007, Pesticides – Scabies can kill; you can't get away with killing your 4th wife, 5th wife and mother; if DEET can melt your sunglasses is it OK to put on your one year old, Maine Medical Center, Toxicology Rounds in Portland, ME

May 7, 2007, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME

April 30, 2007, Drug Interactions, University of New England Medical Students, Pharmacology

April 6, 2006, Prescription Drug Abuse – In Your Backyard, University of New England Medical Students, Public Health Week on behalf of the Physicians for Social Responsibility in Biddeford, ME

April 6, 2006, Overview of Methamphetamine – Toxicological Concerns, University of New England Medical Students, Public Health Week on behalf of the Physicians for Social Responsibility in Biddeford, ME

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March 16, 2006, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME
September 30, 2005, Psychiatric Medications in Overdose, University of New England Medical Students, Psychiatry in Biddeford, ME
March 24, 2005, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME
September 24, 2004, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME
April 12, 2004, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME
September 26, 2003, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME
September 19, 2003, Kerosene Poisoning in Children, Maine Medical Center, Pediatric Morning Rounds in Portland, ME
April 12, 2003, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology in Biddeford, ME
May 21, 2003, Analgesics and Pain Relief, University of New England Medical Students, Pharmacology in Biddeford, ME
May 2, 2003, Methadone Poisoning in Children, Maine Medical Center, Pediatric Morning Rounds in Portland, ME
February 21, 2003, New Trends in Drug Abuse, Maine General Medical Center - Augusta, Grand Rounds
January 23, 2003, Unusual Acetaminophen Toxicity, Maine Medical Center, Pediatric Morning Rounds in Portland, ME
January 7, 2003, NMS/Serotonin Syndrome, Maine Medical Center, Psychiatry Grand Rounds in Portland, ME
December 17, 2002, Toxicology and the Lab, Maine Medical Center, Toxicology Rounds in Portland, ME
December 10, 2002, Herbal and OTC Medications, Maine Medical Center, Pediatric Grand Rounds in Portland, ME
October 2, 2002, Substance Abuse, University of New England Medical Students, Psychiatry in Biddeford, ME
April 26, 2002, Introduction to Toxicology – Toxicokinetics, University of New England Medical Students, Pharmacology
April 24, 2002, Introduction to Toxicology – Toxidromes, University of New England Medical Students, Pharmacology in Biddeford, ME

PROFESSIONAL SOCIETIES

American Board of Applied Toxicology
American Association of Clinical Toxicologists
America's Poison Centers

OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES

2015 – present: Nominating Committee, America's Poison Centers
2009 – present: Government Affairs Committee, renamed Government Relations Committee, America's Poison Centers
2022 – 2023: Expert Panel Member, AAPCC/AACT/CAPCCT/ACMT Acetaminophen Overdose Guideline Project
2016 – 2018: Immediate Past-President, American Academy of Clinical Toxicology

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2014 – 2016: President, American Academy of Clinical Toxicology 2012 – 2014, American Academy of Clinical Toxicology, President-Elect
2012 – 2014: President-Elect, American Academy of Clinical Toxicology
2007 – 2013: Fatality Reviewer, American Association of Poison Control Centers
2008 – 2012, American Academy of Clinical Toxicology, Secretary
2006 – 2011: American Board of Applied Toxicology Web Ad Hoc Web Task Force
2004 – 2011, American Board of Applied Toxicology, Secretary/Treasurer
2007 – 2009, American Association of Poison Control Centers Co-Chair of the Managers' Committee
2007 – 2008, American Academy of Clinical Toxicology, Member of the Board of Trustees
2006 – 2007: HRSA Poison Help/Widmeyer Campaign AAPCC Expanded Review Committee Managing Directors' Representative Professional Advisory Committee Member appointed by the American Association of Poison Control Centers
2003 – 2007, New England Chapter of the National Association of Drug Diversion Investigators, Secretary
2002 - 2004: American Association of Poison Control Centers Certified Specialists in Poison Information Exam Committee
2002 - 2003: Poison Data Book Consolidation Committee, Northeast United States

MAJOR RESEARCH INTERESTS

Research interests are varied and include work in poisoning and toxicology, substance abuse, older adult medication concerns, public health, preparedness and surveillance. A current research and practice goal is to enhance data-sharing and utilization to improve community surveillance and public health through increasing interactions between local, county, state, regional and national partners. See research below for related funded projects in all areas.

GRANT/CONTRACT/RESEARCH SUPPORT

Title: A program to prevent and improve treatment of the most serious poisonings occurring in northern New England.
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2024 – present
Role: Principal Investigator

Title: In-Market Safety Surveillance of Laundry Detergent using Poison Control Center Data
Funding Agency: Cincinnati Children's Hospital Medical Center through the Cincinnati Drug & Poison Information Center, sponsored by Procter & Gamble
Period: March 15, 2012 – present
Role: Site Coordinator (Principal Investigator at Site)

Title: Interpretation of Urine and other Substances of Abuse Monitoring to Support Clinicians Managing Patients with Pain and Psychiatric Disorders receiving Prescription Drugs with Abuse Potential
Funding Agency: blinded
Period: April 1, 2010 – present
Role: Principal Investigator

Title: Maine Pharmaceutical Cache, Consulting, and 24/7 Phone Line
Funding Agency: State of Maine, Department of Health and Human Services
Period: August 10, 2008 – present
Role: Principal Investigator

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Title: Poison Control Center: Assistance, Education and Surveillance Activities
Funding Agency: Vermont Department of Health
Period: September 1, 2004 – present
Role: Principal Investigator

Title: Poison Information Center Services
Funding Agency: State of New Hampshire, Department of Safety (initially) Department of Health and Human Services (currently)
Period: July 1, 2004 – present
Role: Principal Investigator

Title: Researched Abuse, Diversion and Addiction-Related Surveillance
Funding Agency: Denver Health and Hospital Authority
Period: November 3, 2002 – present
Role: Site Coordinator (Principal Investigator at Site)

Title: Northern New England Poison Center, Toxicology Consultation/Education Services
Funding Agency: State of Maine, Department of Health and Human Services
Period: July 1, 2000 – present
Role: Principal Investigator

Title: Northern New England Poison Prevention Project to Provide Quality Health Care Access to Hard-to-Reach Populations
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2009 – 2024
Role: Principal Investigator

Title: CARES Funding for Poison Centers
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program – Appropriations for Coronavirus Health Response and Agency Operations
Period: April 1, 2020 – March 31, 2021
Role: Principal Investigator

Title: Social Marketing Enhancement using Social Media and Chat – Targeting the Computer-Savvy and Telephone-Averse
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2010 – August 31, 2012
Role: Principal Investigator

Title: After Hours On Call Telephone Service for the Maine Center for Disease Control and Prevention
Funding Agency: State of Maine, Department of Health and Human Services, Maine Center for Disease Control & Prevention/Public Health Systems
Period: July 1, 2008 – August 9, 2008
Role: Principal Investigator

Title: Grant to Enhance Access to and Financial Stability of the Northern New England Poison Center (NNEPC) Serving Maine (ME), New Hampshire (NH) and Vermont (VT)
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2007 – August 31, 2009
Role: Principal Investigator

Title: Real Time Disease Detection

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Funding Agency: Vermont Department of Health, Division of Health Improvement
Period: January 2, 2007 – August 8, 2008
Role: Principal Investigator

Title: Maine Pharmaceutical Stockpile
Funding Agency: State of Maine, Department of Health and Human Services
Period: April 1, 2007 – August 31, 2008
Role: Principal Investigator

Title: Substance Abuse Sentinel Surveillance and Reporting System associated with Researched Abuse, Diversion and Addiction-Related Surveillance
Funding Agency: Denver Health and Hospital Authority
Period: July 1, 2005 – December 31, 2008

Title: Evaluation of the value of real-time poison center data sharing between the Northern New England Poison Center and the State Public Health Agencies in Maine, New Hampshire and Vermont
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2005 – 2007
Role: Principal Investigator

Title: Northern New England Poison Center, Toxicology Consultation/Education Services; After Hours Call Answering Service
Funding Agency: State of Maine, Department of Health and Human Services
Period: July 1, 2004 – June 30, 2008
Role: Principal Investigator

Title: Grant to Certify (initially) to Stabilize (later) the Northern New England Poison Center Serving Maine, New Hampshire and Vermont
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2004 – August 31, 2007
Role: Principal Investigator

Title: Northern New England Poison Center, Toxicology Consultation/Education Services; After Hours Call Answering Service; Maine Pharmaceutical Stockpile
Funding Agency: State of Maine, Department of Health and Human Services
Period: July 1, 2002 – June 30, 2004
Role: Principal Investigator

Title: Certification Grant to form a Northern New England Poison Center serving Maine and Vermont
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2001 – August 31, 2004
Role: Principal Investigator

Title: Rural Outreach and Poison Center Training Grant for Maine, Vermont and Northeastern New York
Funding Agency: Department of Health and Human Services, Health Resources and Services Administration, Poison Control Stabilization and Enhancement Program
Period: September 1, 2001 – August 31, 2003
Role: Principal Investigator

EDITORIAL BOARDS AND ACTIVITY

2024 – present: Peer Reviewer, JAMA Network Open.
2018 – present: Member of the Senior Editorial Board, Clinical Toxicology, The Official

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Journal of the American Academy of Clinical Toxicology, European Association of Poisons Centres and Clinical Toxicologists, American Association of Poison Control Centers and the Asia Pacific Association of Medical Toxicology

2006 - 2018: Member of the Editorial Board, Clinical Toxicology, The Official Journal of the American Academy of Clinical Toxicology, European Association of Poisons Centres and Clinical Toxicologists, and American Association of Poison Control Centers

2009 - 2014: Scientific Peer Reviewer, NIH Exploratory/Developmental Research Grant Award (R-21, R-49, U01), Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

2007 – 2013: Fatality Reviewer, American Association of Poison Control Centers

***BIBLIOGRAPHY**

a) *Fox EJ, Dalton AM, Mullins ME, Matoushek T, Ruha AM, Burns MM, Simone K, Beuhler MC, Heard KJ, Mazer-Amirshahi M, Stork CM, Varney SM, Funk AR, Cantrell LF, Cole JB, Banner W, Stolbach AI, Hendrickson RG, Lucyk SN, Sivilotti MLA, Su MK, Nelson LS, Rumack BH, Dart RC. Out-of-hospital assessment and triage of paracetamol (acetaminophen) exposure in the United States and Canada: a consensus guideline. Clinical Toxicology 2025;63(5):348-352.*

Dart RC, Mullins ME, Matoushek T, Ruha AM, Burns MM, Simone K, Beuhler MC, Heard KJ, Mazer-Amirshahi M, Stork CM, Varney SM, Funk AR, Cantrell LF, Cole JB, Banner W, Stolbach AI, Hendrickson RG, Lucyk SN, Sivilotti MLA, Su MK, Nelson LS, Rumack BH. Management of acetaminophen poisoning in the US and Canada: A consensus Statement. JAMA Netw Open 2023 Aug 1;6(8):e2327739. Daly ER, Chan BP, Talbot EA, Nassif J, Bean C, Cavallo SJ, Metcalf E, Simone K, Woolf AD. Per- and polyfluoroalkyl substance (PFAS) exposure assessment in a community exposed to contaminated drinking water, New Hampshire, 2015. International Journal of Hygiene and Environmental Health 2018; 221(3):569-577. Simone KE, "Thirty U.S. Poison Center reports Later, Greater demand, more difficult problems," Clinical Toxicology, 2014 52(2) 91-92.

DeGrasse A, Rivera V, Roach J, White K, Callahan J, Couture D, Simone K, Peredy T, Poli M. Paralytic shellfish toxins in clinical matrices: Extension of AOAC official method 2005.06 to human urine and serum and application to a 2007 case study in Maine. Deep Sea Research Part II: Topical Studies in Oceanography 2014;103:368-75.

Cavallo S, et al. Exposure to Nitrogen Dioxide in an Indoor Ice Arena – New Hampshire, 2011. Morbidity and Mortality Weekly Report 2012;61(8):139-142.

Gersheimer KF, Rea V. Mills DA, Montagna CP, Simone K. Arsenic poisoning caused by intentional contamination of coffee at a church gathering – and epidemiological approach to a forensic investigation. Journal of Forensic Sciences 2010;44(4):11116-9.

Simone KE, Spiller HA. Poison center surveillance data: the good, the bad and … the flu. Clin Toxicol 2010;48(5):415-7.

Daubert GP, Spiller H, Crouch BI, Seifert S, Simone K, Smolinske S. Pulmonary toxicity following exposure to waterproofing grout sealer. Journal of Medical Toxicology: Official Journal of the American College of Medical Toxicology 2009;4(3):125-9.

Tomassoni AJ, Simone KE. Herbal medicines for children: an illusion of safety? Curr

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Opin Pediatr 2001;13(2):162-9.

Simone KE, Tomassoni AJ. Administration of oral n-acetylcysteine intravenously. The Journal of Pediatric Pharmacology and Therapeutics 2001;6(1): 72-8.

c) Simone KE. Cyproheptadine. In: Brent J, ed. Critical Care Toxicology: Diagnosis and Management of the Critically Poisoned Patient, 2nd ed. Switzerland: Springer International Publishing, 2017:2747-2757.

Simone KE. Medical Consequences of Over-the-Counter Drug Abuse. In: Brick J, ed. Handbook of the Medical Consequences of Alcohol and Drug Abuse. 2nd ed. Routlege, New York, NY: Haworth Press, 2008:491-526.

d) Simone, KE, Peredy T. Bath Salts and Tasers, the Northern New England Poison Center's Northern Exposures. 1/12.

Wiegand T, Simone, KE, Miller R, Heinen M, Kramer M. "Suboxone" for the Northern New England Poison Center's Northern Exposures. 1/12.

Dart RC, Simone KE. The Challenge of Chronic Pain Management, newsletter with continuing pharmacy education for New Mexico pharmacists sponsored by the New Mexico Pharmacists Association and SynerMed® Communications supported by an educational grant from PriCara, Unit of Ortho McNeil, Inc. 10/08.

Simone KE. Cyanokit® To treat or not to treat? That is the question . . . Journal of Maine EMS, April 2008:23.

g) Krummen, KE. Albuterol Overdose in Children: Characterization and Management, presented at the University of Cincinnati Pharmacy College to faculty and students, Cincinnati, OH, 6/1/94.

h) Watson C, Roarke K, Simone K, Vella J, Mailloux P and Hoffer M. Angiotensin II to facilitate intermittent hemodialysis in a case of metformin toxicity. Clin Toxicol 2024;62(S2): 113 (abstract).

Wilkosz C, Yu M, Kennedy JM, Simone KE and Neavyn MJ. Should we wait to cannulate? The role of venoarterial extracorporeal membrane oxygenation (VA-ECMO) in venlafaxine overdoses resulting in cardiogenic shock. Clin Toxicol 2023;61(S2): 103 (abstract).

Finkelstein and Simone K. Empowering health care providers: preliminary evaluation of a toolkit for preventing intentional self-poisoning in youth. Clin Toxicol 2023;61(S2): 145 (abstract).

Yu M, Frankl V, Neavyn MJ, and Simone K. Stop and smell the onions: case report of delayed cardiotoxicity post ingestion of veratrum viride. Clin Toxicol 2022;60(S2): 51 (abstract).

Wilkosz C, Bonney, C, Neavyn MJ, Joshua Swenson, Ian Wells and Simone K. Fatal hyperammonemia in a pediatric patient taking deferasirox (Jadenu®): a case report. Clin Toxicol 2022;60(S2): 44 (abstract).

Wilkosz C, Bonney, C, Neavyn MJ, Simone K. All set without Chemet®: the challenge of treating a pediatric exposure to lead paint during a shortage of succimer. Clin Toxicol 2021;59(11): 1179 (abstract).

Wang GS, Simone KE, Palmer RB. Description of edible marijuana products, potency ranges, and similarities to mainstream foods. Clin Toxicol 2014;52:805 (abstract).

Schaeffer TH, Bond AG, Earnshaw ME, Simone KE. Methemogobinemia and Hemolysis in an Undiagnosed G6PD Patient After Receiving Pegloticase. Clin Toxicol 2015;53(7): 686 (abstract).

Wiegand TC, Simone KE. Suboxone Exposure; How Long is the Initially Symptomatic Child at risk for Sequallae after Naloxone Reversal? A Case Report and

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Literature Review. In press for Clin Toxicol, to be presented at the XXIX International Congress of the European Association of Poisons Centres and Clinical Toxicologists Meeting in Stockholm Sweden in May 2009(abstract).

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Simone, KE, Clement, C, Tomassoni AT. Financial Savings Associated with Videoconference Technology. Clin Toxicol 2004;4(5): 702(abstract).

Tomassoni AT, Simone KE. Development and Use of a Decentralized Antidote Stockpile in a Rural State. Clin Toxicol 2004;4(5): 710(abstract).

Smith HW, Simone KE, Aziz W, Lambert DA, Greene KA, Hayman M, The Role of Clinical Pharmacists in Mass Arsenic Poisoning, Pharmacotherapy 2003;23(10)(abstract).

Simone ,KE, Bond GR. Detection of Unusual Abuse Patterns Using Broad Searching of the Toxic Exposure Surveillance System. Clin Toxicol 2002;40(5):657-8(abstract).

Simone, KE, Bond GR. Dextromethorphan: A Successful Example of Monitoring for Emerging Abuse Using the Toxic Exposure Surveillance System. Clin Toxicol 2002;40(5):653-4(abstract).

Kemmerer D, Simone KE, Tomassoni A. Non-Anion Gap Metabolic Acidosis Associated with Acute on Chronic Topiramate Overdose. Clin Toxicol 2002;40(5):691(abstract).

Simone KE, Bottei EM, Siegel ES, Tsipis GB. "Coricidin Abuse in Ohio Teens and Young Adults," Journal of Toxicology Clinical Toxicology 2000; 38(5):532(abstract).

Finke D, Roll D, Sunshein M, Simone KE. The Internet: Sometimes Helpful, Sometimes Not. Clin Toxicol 2000;38(5):564(abstract).

Krummen KE, Tsipis G, Siegel E, Bottei E. Accuracy of Drug Abuse Call Patterns in Predicting Prescription Drug Abuse. Clin Toxicol 1999;37(5):643(abstract).

Krummen KE, Nelson E, Tsipis G, Siegel E, Bottei E. Tramadol Abuse in the Cincinnati Area. Clin Toxicol 1999;37(5):647(abstract).

Krummen KE, Bottei E, Whiteman P. Sex on the Streets of Cincinnati. Clin Toxicol 1999;37(5):647 (abstract).

Prybys K, Krummen KE. Airway Edema Resulting from Nonionic Laundry Soap Powder. Clin Toxicol 1996;34(5):567(abstract).

Krummen KE, Tsipis G, Siegel E, Sigell L. Description of Questions about Herbal Products and Other Nutritional Supplements Posed of a Consumer Information Service. Clin Toxicol 1996;34(5):596(abstract).

Tsipis G, Krummen KE, Sigell L. Telephone Medication Information Service for Older Adults. Clin Toxicol 1996;34(5):632(abstract).

Krummen KE, Tsipis G, Siegel E. Herbal Highs: Natural is Not Necessarily Nice, presented as a poster session at the National Parents' Resource Institute for Drug Education (PRIDE) World Drug Conference, Cincinnati, OH, March 28-30, 1996.

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Sigell L, Krummen KE. A Unique Drug Abuse Prevention, Intervention and Crisis Management Service, presented as a poster session at the National Parents'

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Resource Institute for Drug Education (PRIDE) World Drug Conference, Cincinnati, OH, March 28-30, 1996.

i) *April 4, 2025, Improving the detection and prosecution of cannabis impaired driving for law enforcement, prosecutors and laboratory personnel, Augusta, ME*

February 25, 2025, High-reliability principles in behavioral health: lessons for leaders and trustees for the American Hospital Association Rural Health Care Conference in San Antonio, TX.

December 10, 2024, CHEMPACK training for state of New Hampshire healthcare providers and others involved in emergency preparedness (virtual)

December 4, 2024, CHEMPACK training for state of New Hampshire healthcare providers and others involved in emergency preparedness (virtual)

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August 10, 2023, New Guidance on Management of Acetaminophen Poisoning recorded continuing medical education for Medscape, online

December 4, 2023, Drug Testing Basics – Information You Can Use, Training for Maine Office of Child and Family Services, Augusta, ME (virtual)

November 16, 2023, Drug Testing Basics – Information You Can Use, Training for Maine Office of Child and Family Services, Augusta, ME (virtual)

November 13, 2023, Drug Testing Basics – Information You Can Use, Training for Maine Office of Child and Family Services, Augusta, ME (virtual)

November 3, 2023, The Poison Center Landscape During the Continuing Opioid Crisis – Problems You Might Not Consider, Maine Governor's Annual Opioid Response Summit & Seminars, Augusta, ME (virtual)

April 29, 2023, Cannabis and Driving – What is Known? What should Providers be doing?, New England Society of Addiction Medicine, Portland, ME

April 29, 2023, Pediatric Poisoning involving Liquid Methadone, Buprenorphine, Cannabis Edibles and Vaping Cartridges, New England Society of Addiction Medicine, Portland, ME

July 21, 2021, Marijuana Products & Urine Drug Screening, Microlearning Video for New England Preventon Technology Transfer Center, Augusta, ME (virtual)

March 13, 2021, Street Drugs and the Problematic Interactions with Prescribed Medications, Shalom House, Portland, ME (virtual)

March 9, 2021, Marijuana – THC, CBD, Medical, Recreational, Other . . ., Co-Occurring Collaborative Serving Maine, Portland, ME (virtual)

March 5, 2021, Mostly Substance Use – With Some Chemicals, Medications and Toys Thrown In, Maine Child Death & Serious Injury Review Panel, Augusta, ME (virtual)

January 19, 2021, Pediatric Fatalities – Concentration on Opioids, New Hampshire Child Fatality Review Committee, Concord, NH (virtual)

February 21, 2020, Today's Marijuana – Stronger, More Edibles and Confusing Information about Driving, Pen Bay Medical Centers Clinical Conference, Rockport, ME

September 25, 2019, AACT diversity and Inclusion in Toxicology/Women in Toxicology, North American Congress of Clinical Toxicology, Nashville, TN

February 7, 2016, Substance Abuse: Do we recognize what we are seeing in primary care?, 2016 Dartmouth CO-OP Project Annual Meeting, North Conway, NH

January 20, 2016, Substance Abuse Interventions – Responses from the Addicted, the Maine Medical Associations - Inside ME's Medicine Cabinet: What Prescription Monitoring Can Tell Us About Prescribers & Patients, Portland, ME

November 7, 2015, Substance Abuse Interventions – Responses of the Addicted; not always what we had planned, New Hampshire Medical Society Annual Scientific Conference, Portsmouth, NH

October 17, 2015, Synthetic Street Drugs and Sedation in the ICU, Exeter Hospital 3rd Annual Critical Care Conference, Exeter, NH

October 12, 2015, PEC: Drug Abuse Urinalysis Testing: Basic Introduction to Interpretation, North American Congress of Clinical Toxicology, San Francisco, CA

May 29, 2015, Debate: Should cannabis be legalized in terms of public health issues, XXXV International Congress of the European Association of Poisons Centres and Clinical Toxicologists, St. Julian's, Malta

April 3, 2014, Synthetic Street Drugs, Horizons 2014 Region 1 of the American Association of Critical Care Nurses, Portland, ME

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April 2, 2014, Opioid Poisoning and Poison Center Data, RX Drug Summit, The Killer Co-Pay: The REAL Cost of Rx Drug Misuse, Strafford County Rx Taskforce Annual Prescription Drug Summit, Wentworth Douglas Hospital, Dover, NH

March 19, 2014, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

March 3, 2014, Update on Drugs of Abuse in northern New England, New England Organ Bank, Waltham, MA (by webinar)

November 21, 2014, Commonly Misused Drugs – What they are and what they Do, presented at the Shalom House in Portland, ME.

October 18, 2012, Commonly Misused Drugs – What they are and what they Do, presented at the Shalom House in Saco, ME.

July 25, 2012, New Trends in Drug Abuse, presented at the School Nurse Summer Institute at Bates College in Lewiston, ME.

July 19, 2012, Substance Abuse Trends and Interpretation of Urine Drug Screen Results, presented to medical staff at Spring Harbor Hospital in Westbrook, ME.

June 6, 2012, Substance Abuse and Poisoning – Same or Different, presented for pharmacy continuing education on behalf of the New Hampshire Board of Pharmacy at Frisbie Memorial Hospital in Rochester, NH.

March 21, 2012, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

March 7, 2012, Education Standards – Why do we need them?, presented at the American Association of Poison Control Centers Mid Year Meeting in Saint Petersburg, FL.

May 15, 2011, Prescription Drug Abuse, presented at the American Academy of Pediatrics Adolescent Medicine Conference for the Maine Chapter, Vermont Chapter and District 1 in Bar Harbor, ME.

March 23, 2011, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

December 9, 2010, K2, Salvia, Jagerbombs, Subies, Monster and other driving hazards – enhance your knowledge and increase you chances of detection, presented at the Drug Recognition Expert Training in Boise, ID.

November 9, 2010, Northern New England Poison Center Teen Poisonings – from RX Drugs to K2, Salvia and Monster, presented at the 2010 Maine Association for Health, Physical Education, Recreation and Dance Conference in Rockland, ME.

October 12, 2010, AACT Articles You May Have Missed, panel speaker at the 2010 North American Congress of Clinical Toxicology in Denver, CO.

March 18, 2010, Drugs of Abuse and Resources of the Poison Center, presented at the 40-hour Basic Drug Enforcement Training Program in Vassalboro, ME.

October 10, 2009, Saturday's Dean's Lecture - Using Simulated Patient Learning to Recognize and Manage Drug-to-Drug Interactions, presented with colleagues to University of New England College of Osteopathic Medicine's 25th Continuing Medical Education/Reunion Weekend to Alumni in Portland, ME.

September 23, 2009, Maine Attempts to Treat Pain and Addiction – is treatment part of the problem? Presented at the 2009 North American Congress of Clinical Toxicology as part of the American Association of Poison Control Centers symposium on Emerging Opportunities for Poison Center Data in San Antonio, TX.

August 8, 2009, Herbal and Over-the-Counter Medications: Highs, Enhancements and Misadventures" Presented at the Fifteenth Annual International Association

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of Chiefs of Police Training Conference on Drugs, Alcohol & Impaired Driving "Dynamic, Revolutionary, Effective" in Little Rock, AR.

April 22, 2009, Maine Attempts to Treat Pain and Addiction – is treatment part of the problem? Presented at the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS®) Third Annual Scientific Meeting: Risk Management of Scheduled Drugs – Where Are We Now? Where Are We Headed? in Bethesda, MD.

March 25, 2009, Sports Supplements - Red Bull, 5-hour ENERGY, Yellow Jackets, Stacker, Mini Thins, Creatine and Amino Acids - what's the harm? on behalf of the Knox County Community Health Coalition for Rockland High School in Rockland, Maine.

March 11, 2009, Alcohol and Drug Abuse – Real Teen Risk for Chevrus High School in Portland, ME.

February 4, 2009, Drugs of Abuse and Resources of the Poison Center for the Maine Criminal Justice Academy ME Basic Law Enforcement Training Program in Vasselboro, ME.

January 26, 2009, Poisoning and Antidotes: Update on Toxicity and Managements (new antidotes and new ways to use old antidotes) for the University of Rhode Island College of Pharmacy and Maine Society of Health-System Pharmacists Continuing Pharmacy Education Program in Bethel, ME.

December 9, 2008, Pharmaceuticals in water: sources, impact, interventions for the Maine Rural Water Association's Pharmaceuticals in our water and wastewater conference in Freeport, ME.

December 7, 2008, Substance Abuse and the Pharmacy - Are you the Neighborhood Drug Supplier? for the Massachusetts College of Pharmacy & Health Sciences' New Hampshire Pharmacists Association Continuing Education Program in Manchester, NH.

December 4, 2008, Methamphetamine, other Drugs of Abuse and Resources of the Poison Center for the Maine Drug Enforcement Agency Laboratory Enforcement Team Refresher Course in Bangor, ME.

December 3, 2008, Inhalant Abuse for the Mercy Medical Center Department of EMS Refresher Training Education in Holyoke, MA.

November 21, 2008, Alcohol, Inhalants, Over-the-Counter and Prescription Drug Abuse for the Penobscot Job Corps Academy in Bangor, ME.

November 20, 2008, Energy Drinks on behalf of the Knox County Community Health Coalition for the Thomaston School District in Thomaston, ME.

November 19, 2008, Toxicology and Substance Abuse Laboratory Results for the Maine Medical Center Social Work Department in Portland, ME.

November 11, 2008, Facilitator for the Benzodiazepine and other Prescription Drugs Symposium on Prescription Drug Trends for the 2008 International Symposium on Pharmaceutical in the Home and Environment: Catalysts for Change – Sixth Annual Maine Benzodiazepine Study Group Conference in South Portland, ME.

October 22, 2008, A Career in Poison Control for the Maine Explorer Program at Maine Medical Center in Portland, ME.

October 13, 2008, Defining the Problem: What the Data Tell Us for the 2008 Symposium on preventing prescription and over the counter drug poisoning in South Burlington, VT.

September 24, 2008, Carbon monoxide exposure during house fire – pediatric patient with large anion gap acidosis – need to treat for cyanide? for physicians and pharmacists at the New England Regional Toxicology Meeting in Hartford, CT.

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October 11, 2008, Substance Abuse and Emergency Preparedness for the Maine Pharmaceutical Association 2008 Fall Conference in Rockport, ME.

September 18, 1008, Basic Disaster Life Support Program, classes on chemical, biological and psychological issues associated with mass casualties related to terror, pandemic or industrial release on behalf of the National Center for Emergency Medical Preparedness & Response at Texas A & M Health Science Center for the New England Pharmacists Convention in Uncasville, CT.

September 14, 2008, Moderator for Platform Session 1:Poison Center at the North American Congress of Clinical Toxicology in Toronto, Canada.

July 5, 2008, SASRS, a home-grown toxicological surveillance system for the Maine Medical Center Information Systems Department in Portland, ME.

June 19, 2008, Herbal Highs for the 2008 Arkansas Drug Recognition Expert Conference for the Criminal Justice Institute in Little Rock, AR.

June 4, 2008, Substance Abuse and the Laboratory, for counselors and a physician at the Spring Harbor Access Program in Portland, ME.

June 1, 2008, Substance Abuse in Northern New England – Poison Center Perspective" for the 10th Annual Pharmacy Services Collaborative CE Program by Lahey Clinic supported by the Hitchcock Foundation in Fairlee, VT.

May 21, 2008, Substance Abuse and the Laboratory" for counselors and a physician at the Spring Harbor Access Program in Portland, ME.

April 24, 2008, Adolescent Drug Use Trends for the 23rd Maine Schoolsite Health Promotion in Carrabassett Valley, ME.

March 19, 2008, Social Hosting – It's more than taking the keys discussion of alcohol and caffeine on behalf of the Knox County Community Health Coalition for the Camden Hills Regional High School in Camden, ME.

February 29, 2008, Dangerous Drugs in Teens for physicians, nurses and counselors at Goodall Hospital in Sanford, ME.

February 25, 2008, Buprenorphine - Discussion between treatment providers and national experts for the University of Vermont Substance Abuse Treatment Center in Burlington, VT.

October 31, 2007, Current Trends and Concerns Surrounding Benzodiazepine Poisoning for the Fifth Annual Benzodiazepine Study Group Conference in Portland, ME.

October 17, 2007, Chronic Pain, Addiction, and the Law teleconference series for New Mexico Pharmacists' continuing education sponsored by the New Mexico Pharmacists Association and SynerMed® Communications supported by an educational grant from PriCara, Unit of Ortho McNeil, Inc.

October 14, 2007, Substance Abuse and Emergency Preparedness - Just Another Day at the Poison Center for the Annual Meeting of the Maine Pharmacy Association.

October 12, 2007, Chronic Pain, Addiction, and the Law teleconference series for New Mexico Pharmacists' continuing education sponsored by the New Mexico Pharmacists Association and SynerMed® Communications supported by an educational grant from PriCara, Unit of Ortho McNeil, Inc.

September 25, 2007, New Substance Abuse Trends in Teens and Early 20s for physicians, nurses, counselors and others working in the University of Southern Maine Health Clinic in Portland, ME.

July 30, 2007, Poisonings, Scope of the Problem for health care professionals and lay people at the Prescription Drug Misuse – A Community Challenge Conference for the Maine Injury Prevention Group in Hallowell, ME.

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July 11, 2007, Current Trends in Substance Abuse" for Spring Harbor Hospital for nurses, physicians, social workers and other care-givers in Westbrook, ME.

June 25, 2007, Facilitated Sexual Assault for a sexual assault training course for detectives and counselors in Ellsworth, ME.

May 17, 2006, Interpretation of Substance of Abuse Laboratory Results for the Family Support Program of the Social Work Department of Maine Medical Center in Portland, ME.

May 5, 2006, Medication Administration on behalf of Youth Alternatives to care givers of institutionalized youth in Portland, ME.

April 2, 2006, Adverse Effects – Concentration on Older Adults for the Annual Maine Pharmacy Association Spring Conference in South Portland, ME.

March 24, 2006, Drugs Commonly Diverted for the New England Chapter of the National Association of Drug Diversion Investigators Conference in Newport, RI.

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TUFTS UNIVERSITY SCHOOL OF MEDICINE
CURRICULUM VITAE AND BIBLIOGRAPHY FORMAT
FOR CLINICAL FACULTY

DATE PREPARED:	September 29, 2025
FULL NAME AND DEGREES:	Mark John Neavyn, M.D.
CURRENT ADMINISTRATIVE TITLE:	Medical Director, Northern New England Poison Center
OFFICE MAILING ADDRESS:	Maine Medical Center, Emergency Department 22 Bramhall Street, Portland, ME 04102
OFFICE PHONE NUMBER:	(207) 662-7222
OFFICE FAX NUMBER:	(207) 662-5941
E-MAIL ADDRESS:	Mark.Neavyn@mainehealth.org

EDUCATION AND TRAINING

Undergraduate

Year of Degree	*Degree*	*Institution, City, State or Country*	*Discipline*
2000	BA	Augustana College, Rock Island, IL	Biology

Graduate School and/or Medical School

Year of Degree	*Degree*	*Institution, City, State or Country*	*Discipline*
2006	MD	Jefferson Medical College (now Sidney Kimmel Medical College), Philadelphia, PA	

Postdoctoral Training

Internship and Residencies:

Years	*Institution, City, State or Country*	*Specialty*
2009	Drexel University, Philadelphia, PA	Emergency Medicine Residency

Fellowships:

Years	*Institution, City, State or Country*	*Specialty*
2012-2014	University of Massachusetts Medical School, Worcester, MA	Toxicology Fellowship

Other Professional Training

Years	*Institution, City, State or Country*	*Discipline*
2016-2017	University of Massachusetts Medical School, Worcester, MA	Peers for Promotion

Licensure and Certification

Medical Licensure:

Dates	*Location*	*Certificate Number*
2009-2012	Michigan	4301093671
2014-2016	Connecticut	52572

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2012-2020	Massachusetts	250461
2020-Present	Maine	MD23807

Board Certification:

Dates	*Organization*	*Certificate Number*	*Specialty*
2010-present	American Board of Emergency Medicine	48855	Emergency Medicine
2014-present	American Board of Emergency Medicine Medical Toxicology	48855	Medical Toxicology

ACADEMIC APPOINTMENTS

Dates	*Titles/Primary or Secondary*	*Department*	*Institution, City, State or Country*
2010-2012	Assistant Professor	Emergency Medicine	Wayne State University, Detroit, MI
2012-2014	Clinical Instructor	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2014-2016	Assistant Professor	Emergency Medicine	University of Connecticut Medical School, Farmington, CT
2016-2020	Assistant Professor	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2020-9/30/2021	Associate Professor	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2020-11/30/2023	Visiting Associate Professor	Emergency Medicine	Tufts University School of Medicine, Boston, MA
12/1/2023-Present	Associate Professor	Emergency Medicine	Tufts University School of Medicine, Boston, MA

EMPLOYMENT

Dates	*Titles/Position*	*Department*	*Institution, City, State or Country*
2009-2012	Emergency Medicine Practice	Emergency Medicine	St. John Hospital & Medical Center, Detroit, MI
2012-2014	Emergency Medicine Practice	Emergency Medicine	University of Massachusetts Memorial Medical Group, Worcester, MA
2014-2016	Emergency Medicine Practice	Emergency Medicine	Hartford Hospital, Hartford, CT
2016-2020	Emergency Medicine Practice	Emergency Medicine	University of Massachusetts Memorial Medical Group, Worcester, MA
2020-Present	Medical Director, Northern New England Poison Center	Emergency Medicine	MaineHealth, Portland, ME

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ADMINISTRATIVE APPOINTMENTS

Dates	*Titles/Position*	*Department/Program*	*Institution, City, State or Country*
2014-2015	Director	Medical Toxicology	Hartford Hospital, Hartford, CT
2020-Present	Medical Director	Northern New England Poison Center	Maine Medical Center, Portland, ME

AWARDS AND HONORS

Dates	*Award/Honor*	*Organization, City, State or Country*
2000	Cum Laude	Augustana College, Rock Island, IL
2003	Foerderer Scholarship	Jefferson Medical College
2014	McNeill Travel Award	American College of Medical Toxicology

INSTITUTIONAL COMMITTEE SERVICE

Dates	*Role/Committee*	*Department/Program*	*Institution, City, State or Country*
2010-2012	Physician Member, Medication Safety Committee	Hospital Committee	St. John Hospital and Medical Center, Detroit, MI
2012-2014	Physician Member, Sedation Committee	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2012-Present	Physician Member, Alcohol Withdrawal Task Force	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2014-2015	Physician Leader, Cytotoxic and Hazardous Medications Policy Committee	Hospital Committee	Hartford Hospital, Hartford, CT
2014-2015	Physician Member, P&T Committee	Hospital Committee	Hartford Hospital, Hartford, CT
2014-2015	Physician Member, Ethics Committee	Hospital Committee	Hartford Hospital, Hartford, CT
2016-2020	Physician Member, Medication Safety Committee	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	Physician Member and Peer Supporter, Peer Support Network	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	Physician Appointee, Ethics and Treatment Issues Committee	Hospital Committee	University of Massachusetts Memorial Medical Center, Worcester, MA

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2016-2020	Lead, Clinical Competency Committee	Medical Toxicology Fellowship	University of Massachusetts Medical Toxicology, Worcester, MA
2016-2020	Lead, Program Evaluation Committee	Medical Toxicology Fellowship	University of Massachusetts Medical Toxicology, Worcester, MA
2016-2020	Member, Clinical Competency Committee	Emergency Medicine Residency	University of Massachusetts Emergency Medicine, Worcester, MA
2018-2020	Member, Program Evaluation Committee	Emergency Medicine Residency	University of Massachusetts Emergency Medicine, Worcester, MA
2020-present	Pharmacy & Therapeutics Committee	Hospital Committee	Maine Medical Center, Portland, ME
2020-Present	P&T Formulary Subcommittee	Hospital Committee	Maine Medical Center, Portland, ME
2020-Present	Member, Program Evaluation Committee	Emergency Medicine Residency	Maine Medical Center, Portland, ME
2025-Present	Member, Faculty Senate	Tufts University School of Medicine Faculty Affairs	Tufts University School of Medicine, Boston, MA

EXTERNAL COMMITTEE SERVICE

Local/Regional:

Dates	*Role/Committee Assignment*	*Organization/Membership*
2023-Present	Governor Appointed Board member	Maine Board of Pesticide Control
2021-Present	Physician, Medical Advisory Committee	Maine Board of Pesticide Control
2022-Present	Member, Technical Advisory Committee	BiomonitoringNH, New Hampshire Department of Health and Human Services

National:

Dates	*Role/Committee Assignment*	*Organization/Membership*
2012-Present	Physician Member, Research Committee	American College of Medical Toxicology
2012-Present	Physician Member, Education Committee	American College of Medical Toxicology
2014-Present	Co-Chair, Position Statement on Brian Death	American College of Medical Toxicology
2015-2016	Physician Member, Ethics Committee	Society for Academic Emergency Medicine
2015-2018	Appointee, National Fatality Review Team	American Association of Poison Control Centers

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2016-2020	Physician Member, Fellowship Director Committee	American College of Medical Toxicology
2018-2019	Co-Chair, Planning Subcommittee, Education Committee	American College of Medical Toxicology

International:

Dates	*Role/Committee Assignment*	*Organization/Membership*
N/A		

PROFESSIONAL SOCIETIES

Dates	*Role/Committee Assignment*	*Organization/Membership*
2005-Present	Member	American College of Emergency Medicine
2012-Present	Member	European Association of Poison Centers and Clinical Toxicology
2012-Present	Member	American Academy of Clinical Toxicology
2012-Present	Member, Education Committee	American College of Medical Toxicology
2012-Present	Member	Society of Academic Emergency Medicine
2015	Member, Ethics Committee	Society of Academic Emergency Medicine
2016-2020	Member, Fellowship Directors Committee	American College of Medical Toxicology
2023-2024	Member, Faculty Development Committee	Society of Academic Emergency Medicine
2023-2024	Member, Program Committee	Society of Academic Emergency Medicine

GRANT REVIEW ACTIVITES

Dates	*Role*	*Organization*
N/A		

HEALTH-RELATED ADVOCACY & COMMUNITY SERVICE

Dates	*Organization, City, State or Country*	*Role*
2003	Helping Hands Health Education, Kathmandu, Nepal	Health Clinic Volunteer
2002-2006	JeffHOPE Philadelphia, PA	Free Health Clinic Volunteer
2012-2014	Massachusetts/Rhode Island Poison Information Center	Providing On-Call Toxicology Consult
2014-2016	Connecticut Poison Control Center	Providing On-Call Toxicology Consult
2016-Present	University of Massachusetts Overdose Prevention Fund	Physician Member
2024-Present	Tribhuvan University Teaching Hospital, Nepal Poison Information Center, Kathmandu, Nepal	Volunteer Faculty Consultant

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TRAINING OF STUDENTS/TRAINEES

Students/Mentees:

Dates	*Name of Student/Advisee*	*Level of Training*	*Role and Sponsor (if applicable)*	*Current Position of Advisee*
2017-2019	Keaton Cameron-Burr	MS1	Research supervisor, UMass Medical School	Resident in Emergency Medicine, Brown University
2017-2020	Graham Powell, M.D.	Resident	Emergency Medicine Residency Program, UMass Medical School	Faculty in Medical Toxicology, UMass Medical School
2024-present	Riley Ochs, D.O.	Resident	Emergency Medicine Residency Program, Maine Medical Center	PGY1, Maine Medical Center

Postdoctoral Trainees:

Past/Current Trainee	*Trainee Name (Where Training Occurred)*	*Postdoc Research Training Period*	*Prior Academic Degree(s)*	*Prior Academic Degree Year(s)*	*Prior Academic Degree Institution(s)*	*Title of Research Project*	*Current Position of Past Trainees/Source of Support of Current Trainees*
2012-2017	Matt Griswold, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Connecticut School of Medicine		Assistant Professor of Emergency Medicine and Medical Toxicology
2012-2017	Alicia Lydecker, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	Albany Medical School		Assistant Professor of Emergency Medicine and Medical Toxicology
2016-2018	Jeff Lai, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine		Assistant Professor of Emergency Medicine and

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2016-2018	Katharine Devin-Holcomb, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Medical Toxicology Assistant Professor of Emergency Medicine and Medical Toxicology
2016-2020	Amelia Curtis, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2017-2021	Albert Conicella, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2017-2021	Eric Kaczor, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology
2018-2020	Charlotte Goldfine, M.D.	Medical Toxicology Fellowship Program	Fellow	MD	University of Massachusetts School of Medicine	Assistant Professor of Emergency Medicine and Medical Toxicology

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EDUCATIONAL ACTIVITES

Dates	*Role/Course or Program Title*	*Department*	*Institution, City, State or Country*
2009-2012	Clinical Teaching and Supervision	Emergency Medicine	St. John Hospital & Medical Center, Detroit, MI
2012-2014	Clinical Teaching and Supervision	Emergency Medicine	University of Massachusetts Memorial Medical Center, Worcester, MA
2014-2016	Clinical Teaching and Supervision	Medical Toxicology	Hartford Hospital, Hartford, CT
2014-2016	Clinical Teaching and Supervision	Emergency Medicine	Hartford Hospital, Hartford, CT
2014-2016	Medical Toxicology Board Review	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016	Development of Curricula and Educational Materials, Medical Toxicology Board Review	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-Present	Clinical Teaching and Supervision	Medical Toxicology	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-Present	Clinical Teaching and Supervision	Emergency Medicine	University of Massachusetts Memorial Medical Center, Worcester, MA
2016-2020	EM_4004 (Emergency Clinical Problem Solver)	Emergency Medicine	University of Massachusetts Medical School, Worcester, MA
2016-2020	Lead, EM_4448 (Medical Toxicology Sub-Internship)	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-2020	Lead, FCE_3007 (Flexible Clinical Elective)	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-2020	Program Director, Fellowship in Medical Toxicology	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2016-2020	Director, Medical Toxicology Clinical Course	Medical Toxicology	University of Massachusetts Medical School, Worcester, MA
2020-present	Director, EMR415-MM, Medical Toxicology Course	Medical Toxicology	Tufts University School of Medicine, Portland, ME

PRACTICE ACTIVITIES & INNOVATIONS

Dates	*Activity*	*Sponsor/Institution*
2012-2020	Alcohol Withdrawal Task Force to monitor and keep up-to-date safe protocols for the management of alcohol withdrawal	University of Massachusetts Memorial Medical Center, Worcester, MA
2009-2012	Providing Emergency Medical Care in a Tertiary Referral Center	Emergency Medicine Specialists, Detroit, MI
2012-2014	Providing Emergency Medical Care in a Tertiary Referral Center	University of Massachusetts Memorial Medical Group, Worcester, MA

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2014-2015	Medical Toxicology Clinic created to support statewide referrals from the Connecticut Regional Poison Control Center for outpatient management of chronic toxic exposures, including heavy metals, pesticides, hydrocarbons, and other environmental and occupational hazards	Hartford Hospital, Hartford, CT
2014-2015	Medication Safety Trigger Tool analysis used to monitor the incidence of medication safety events not reported by a centralized self-reporting system-randomized charts were reviewed monthly and analyzed for established medication safety triggers	Hartford Hospital, Hartford, CT
2014-2015	Hazardous Medications Task Force to monitor and keep up-to-date safe protocols for the management of cytotoxic and hazardous drugs used in cancer treatment	Hartford Hospital, Hartford, CT
2014-2016	Providing Emergency Medical Care in a Tertiary Referral Center	Hartford Healthcare Medical Group, Hartford, CT
2016-2020	Providing Emergency Medical Care in a Tertiary Referral Center	University of Massachusetts Memorial Medical Group, Worcester, MA
2020-Present	Emergency Medical Care in a Tertiary Referral Center	Maine Medical Center, Portland, ME
2020-Present	Medical Toxicology Practice Protocols and Guideline Development	Northern New England Poison Center, Portland, ME
2023-Present	Subject Matter Expert, Engagement Team	System-Wide BioEmergency Response Team, MaineHealth

VISITING PROFESSORSHIPS & INVITED ACADEMIC PRESENATTIONS

Visiting Professorships

Dates	*Department*	*Institution*	*City, State or Country*
N/A			

Invited Academic Presentations

Local/Regional:

Dates	*Presentation Title*	*Presentation Type*	*Institution*	*City, State or Country*

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2010-2011	Anemia in the Emergency Department	Emergency Medicine Residency	St. John Hospital	Detroit, MI
2010-2011	Board Review of Hematology Oncology	Emergency Medicine Residency	St. John Hospital	Detroit, MI
2014	Drug Interactions in Psychiatry	Psychosomatic Medicine Fellowship	Hartford Hospital	Hartford, CT
2014	Common Psychiatric Medications in Overdose	Psychosomatic Medicine Fellowship	Hartford Hospital	Hartford, CT
2014	Circling the Drain – Toxicology Resuscitation	Emergency Medicine Residency	University of Connecticut	Hartford, CT
2014	Review of Emergency Management of Toxic Alcohols	Emergency Medicine Residency	University of Massachusetts	Worcester, MA
2014	Brain Death in Medical Toxicology	New England Regional Toxicology Conference	University of Massachusetts	Worcester, MA
2014	Ethical Considerations in Medical Toxicology	Grand Rounds	Hartford Hospital	Hartford, CT
2017	Ethical Considerations in the Poisoned Patient	Grand Rounds	Institute of Living	Hartford, CT
2017	The Problem with Marijuana and Driving	7th Annual Research Retreat	University of Massachusetts Center for Clinical and Translational Science	Hartford, CT
2018	Medication Safety is No Accident: Extravasation Injuries	One-Day Conference	University of Massachusetts Memorial Medical Center	Worcester, MA
2018	Public Health Implications for Deregulating Marijuana	Keynote Speaker, Annual Medical Education Conference Cottle Lecture	Worcester District Medical Society	Worcester, MA

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2020	Introduction to Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2020	Toxicity of Antithrombotics	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2021	In-Service Toxicology Review	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2021	Maritime Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2021	Pediatric Toxicology 101	Pediatric Grand Rounds	Maine Medical Center	Portland, ME
2021	Oktoberfest Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2021	Antidepressant Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	In-service Toxicology Review	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	Colors In Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	Relaxation Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	Toxicology Fundamentals	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	Snakes, Spiders, and Scorpions	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	Ophthalmic Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2022	Antidiabetic Medications	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2023	In-service Toxicology Review	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2023	Weight-Loss Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME

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2023	Toxicity of Antipsychotics	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2024	Hepatotoxic Principles in Medical Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2024	Neurologic Principles in Medical Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2024	Colors in Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2024	Baclofen and Brain Death	Critical Care Morbidity and Mortality Rounds	Maine Medical Center	Portland, ME
2024	Fentanyl drug screening	Pediatric critical care Morbidity and Mortality Rounds	Maine Medical Center	Portland, ME
2024	Xylazine associated Leukencephalopathy	Pediatric Clinicopathologic Case Conference	Maine Medical Center	Portland, ME
2025	Federal Agencies in Toxicology	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2025	Pre-Hospital Care of Poisoned Patients	Maine EMS Webinar	Maine EMS	Portland, ME
2025	Poisonous Plants of North America	Emergency Medicine Didactics	Maine Medical Center	Portland, ME
2025	Maine Prosecutor Program and Cannabis Impairment	Maine Prosecutors Association	University of Maine	Augusta, ME

National:

Dates	*Presentation Title*	*Presentation Type*	*Institution*	*City, State or Country*
2014	Brian Death in the ToXIC Registry	Research Symposium	American College of Medical Toxicology Scientific Meeting	Phoenix, AZ
2018	Clinical Pathophysiologic Case	Clinical Case Presentation	North American Congress of	Chicago, IL

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2022	Marijuana Toxicity	Total Tox Course	Clinical Toxicology American College of Medical Toxicology	Virtual Webinar
2024	Marijuana Toxicity	Total Tox Course	American College of Medical Toxicology	Virtual Webinar

International:

Dates	*Presentation Title*	*Presentation Type*	*Institution*	*City, State or Country*
2017	Twitter and Facebook groups: How we can maximize our toxicology education and engage learners	Medical Education	European Association of Poison Centres and Clinical Toxicologists	Basel, Switzerland
2018	Public Health Challenges and Impacts of NPS	Clinical Case Presentation	Novel Psychoactive Substances Symposium	Philadelphia, PA

MAJOR RESEARCH INTERESTS

My academic pursuits have been in the area of drug abuse, particularly with novel psychoactive substances and cannabis products. In addition, I have worked closely with the National Highway Traffic Safety Administration (NHTSA) to improve the Fatality Analysis Reporting System (FARS), which is the national data repository of all roadside fatalities. I have a keen interest in the effects of drugs on psychomotor performance. As well, as the medical director for the Northern New England Poison Center serving the state of Maine, New Hampshire and Vermont, I work to enhance medical education and outreach throughout the region regarding poisoning and access to uncommon antidotes.

RESEARCH SUPPORT

Dates	*Grant Title*	*PI Name*	*Funding Source*	*Grant Number*	*Amount*	*Role*
2016-2017	Changing Culture: A Medication Safety Initiative	Kavita Babu, M.D. and Mark Neavyn, M.D. (Co-PI)	University of Massachusetts Memorial Medical Center Risk Management		$25,000	Co-Principal Investigator

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2019-2020	Medical Toxicology Consultant Service	Mark Neavyn, M.D.	National Highway Traffic Safety Administration, U.S. Department of Transportation	GS10F0211M, NHTSA Task Order No: 693JJ918F000240	$178,722.75	Project Manager
2019-2020	Crash Risk Associated with Drug and Alcohol Use by Drivers in Fatal and Serious Injury Crashes	Mark Neavyn, M.D.	National Highway Traffic Safety Administration, U.S. Department of Transportation	DTNH2211D00225L, NHTSA Task Order No: 6	$454,771	Site Director
2020-2025	Medical Toxicology Consultant Service	Dereece Smither, Ph.D.	National Highway Traffic Safety Administration	Contract Numbers: GS10F0211M 693JJ920F000159	$1,030,562	Consultant

EDITORIAL BOARDS

Dates	*Role*	*Board/Publication Name*
2013-2014	Editorial Board member	Journal of Medical Toxicology

AD HOC JOURNAL REVIEWER

Publication Name

American Journal of Emergency Medicine
Drug and Alcohol Dependence
European Journal of Pediatrics

PATENTS

Year Awarded	*Patent Number*	*Description*
N/A		

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a) *Refereed Publications:*

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b) *Books Authored/Books Edited:*

1. Irwin and Rippe's Textbook of Intensive Care Medicine, 9th Edition,
Section 10: Pharmacology, Overdoses and Poisonings
Co-Section Editors: **Mark J. Neavyn** & Luke Yip
Chapters 97-126

c) *Book Chapters/Invited Reviewers:*

1. Vohra V, Aaron C, **Neavyn MJ** Chapter 103: Antidepressant Poisoning, in Irwin & Rippe's Intensive Care Medicine, 9th Edition, 2024
2. Curtis A, **Neavyn MJ** Chapter 319: Antidysrhythmics, in Harwood-Nuss Clinical Practice of Emergency Medicine, 7th Edition, 2020
3. Carey JL, **Neavyn MJ** Chapter 79: Hallucinogens, in Goldfrank's Toxicologic Emergencies, 11th Edition, *2019.*
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d) *Monographs, Proceedings, and White Papers:*

1. Development of a predictive algorithm for patient survival after traumatic injury using a five analyte blood panel. Parinaz Fathi, Maria Karkanitsa, Adam Rupert, Aaron Lin, Jenna Darrah, F. Dennis Thomas, Jeffrey Lai, Kavita Babu, **Mark Neavyn**, Rosemary Kozar, Christopher Griggs, Kyle W. Cunningham, Carl I. Schulman, Marie Crandall, Irini Sereti, Emily Ricotta, Kaitlyn Sadtler. medRxiv 2024.04.22.24306188; doi: https://doi.org/10.1101/2024.04.22.24306188
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3. **Neavyn MJ**, JMT Update: Plagiarism. American College of Medical Toxicology Newsletter, August 2013.
4. **Neavyn MJ**, JMT Update: Chelation. American College of Medical Toxicology Newsletter, October 2013.
5. **Neavyn MJ**, *Suicide and the Surrogate*. Journal of Medical Toxicology, 2013 Oct, 10:3–6 DOI 10.1007/s13181-013-0335-6.

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N/A

g) *Case Reports:*
N/A

h) *Theses/Dissertation:*
N/A

i) *Published Abstracts*:

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5. **Mark Neavyn**, C. James Watson, Jennifer Mabey, Karen Olson, Tania D. Strout *NEED: Naltrexone education in the emergency department. (2024),* SAEM24 Abstracts. Acad Emerg Med, 31: 8-401. https://doi.org/10.1111/acem.14906
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7. Christopher Wilkosz, Michael Yu, Joseph M.Kennedy, Karen E. Simone and **Mark J. Neavyn.** *Should we wait to cannulate? The role of venoarterial extracorporeal membrane oxygenation (VA-ECMO) in venlafaxine overdoses*

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16. Salinger L, McKay C, Laskey D, **Neavyn M**, Sangalli B, Bayer M. *Lessons Learned from a Brodifacoum Case Exhibiting Prolonged Morbidity,* Abstracts of the 2015 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT) - October 10-12, 2015
17. Laskey D, **Neavyn M**. *APAPxAT as a Hepatotoxicity Predictor in Patients with Acetaminophen Ingestions of Chronic, Subacute, or Unknown Time,* Abstracts of the 2015 Annual Meeting of the North American Congress of Clinical Toxicology (NACCT)- October 10-12, 2015
18. Felton D, Carey JL, Boyer EW, **Neavyn MJ.** *Brain Death and Overdose*, Abstracts of the XXXIV International Congress of the European Association of

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20. **Neavyn MJ**, Yen M, Williams M, Weibrecht KW. *A Case Report of Early Levothyroxine Toxicity in a Young Child*, Abstracts of the XXXIII International Congress of the European Association of Poisons Centres and Clinical Toxicologists, 28 to 31 May 2013, Copenhagen, Denmark
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24. Zuckerman MD, **Neavyn MJ**, Boyer EW, Babu KM.The *Fall of OxyContin® and the rise of Opana®: Use of Google Trends to Monitor Drug Diversion*, Abstracts of the 2013 ACMT Annual Scientific Meeting - March 15–17, 2013 San Juan, Puerto Rico, US
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j) *Non-print Scholarship:*

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