***In Re*: Combination by and among GraniteOne Health, Catholic Medical Center, Monadnock Community Hospital, Huggins Hospital, Alliance Ambulatory Services, Alliance Health Services and Catholic Medical Center Physician Practice Associates with Dartmouth-Hitchcock Health to be known as "Dartmouth-Hitchcock Health GraniteOne"**

JOINT NOTICE TO THE DIRECTOR OF CHARITABLE TRUSTS PURSUANT TO NEW HAMPSHIRE RSA 7:19-b

This Joint Notice and its Appendices (this "Notice") is submitted to the New Hampshire Attorney General, Director of Charitable Trusts (the "Charitable Trusts Director"), pursuant to New Hampshire Revised Statutes Annotated ("NHRSA") Section 7:19-b, III by the following, each a New Hampshire voluntary corporation: **GraniteOne Health**, the current sole corporate member of Huggins Hospital, Monadnock Community Hospital and co-member, along with CMC Healthcare System, of Catholic Medical Center ("GraniteOne"); **Catholic Medical Center** ("CMC"); **Monadnock Community Hospital** ("MCH"); **Huggins Hospital** ("HH"); **Alliance Ambulatory Services** ("AAS"); **Alliance Health Services** ("AHS"); and **Catholic Medical Center Physician Practice Associates** ("CMCPPA"). (AAS, AHS and CMCPPA are referred collectively as the "CMCHS Subsidiaries"). While not changing control as defined in NHRSA 7-19-b, I(c), **Dartmouth-Hitchcock Health**, a New Hampshire voluntary corporation and coordinating organization of the multi-member, integrated academic health system known as "Dartmouth-Hitchcock Health System" ("D-HH") and **CMC Healthcare System**, a New Hampshire voluntary corporation and the public juridic person of diocesan right to CMC and the CMCHS Subsidiaries ("CMCHS"), are signatories to the Combination Agreement described below. GraniteOne, CMC, MCH, HH, the CMCHS Subsidiaries, D-HH and CMCHS are referred to collectively as the "Parties."

I. INTRODUCTION

D-HH and GraniteOne propose to combine their respective systems to form a New Hampshire-based, integrated, and regionally distributed health care system that will better serve their patients and communities (the "Proposed Combination"). Caring for one of the nation's oldest populations with increasingly chronic and complex health conditions while combatting one of the nation's most acute opioid and substance use disorder crises has posed significant clinical, financial, and workforce challenges for the Parties, straining their capacity to respond to pressing patient needs. Having gained experience in coordinated care delivery through the development of their respective systems, the Parties believe that patients will benefit from the Proposed Combination by offering a more fully integrated health system that increases convenient access to care, reduces variability in outcomes, and incentivizes joint investment in clinical programming, workforce development, and the critical infrastructure to support the Proposed Combination's expanded breadth of services.

New Hampshire's health care landscape has transformed dramatically in the decade since D-HH and CMC sought to consummate a materially different transaction. The health care market in southern New Hampshire, in particular, has shifted as a consequence of increased in- and out-of-state competition. In-state, two major southern New Hampshire health systems recently combined to form SolutioNHealth and southern New Hampshire providers, like Concord Hospital, and ambulatory surgery centers have expanded. Out-of-state, Massachusetts providers are steadily increasing their market penetration through hospital acquisitions and clinical affiliations to draw New Hampshire patients out-of-state for more costly, less convenient care.

D-HH and CMC also have evolved. In the last ten years, D-HH has become a more mature coordinating organization for New Hampshire's only academic health system, which includes three rural critical access hospitals, while CMC has become the leader of the GraniteOne Health system that includes two rural, secular critical access hospitals. D-HH and GraniteOne have a demonstrated record of achieving many of the patient-centered clinical benefits and operational efficiencies of integrated care delivery and, together, they will draw upon this experience to achieve even greater benefits with the Proposed Combination.

Over the last year, the Parties have carefully evaluated the health care needs of the patients and communities they serve and how best to address those needs together through the benefits of the Proposed Combination. See Appendices I(1) and I(2) (*Confidential*). Among its many benefits, the Proposed Combination will offer expanded access to high quality specialty services, particularly in southern New Hampshire, greatly reducing the need for patients to seek complex care out-of-state, at a higher cost and greater distance from home. The Proposed Combination will not just lower costs by attracting patients currently going out-of-state to high-cost Massachusetts providers, but also by increasing services at lower cost locations in the System, such as by treating patients now traveling to D-HH's academic medical center in Lebanon at CMC in Manchester, and by treating CMC patients at more outpatient centers in the greater Manchester area. Patients in rural communities, where services have been contracting or closing, also will benefit by the Parties' combined efforts to deploy specialists or utilize telehealth capabilities to help ensure that those rural patients continue to enjoy local access to acuity-appropriate care as well as obtain access to enhanced care, a hallmark of the Proposed

Combination.[1] Additionally, as their respective system integration experience demonstrates and given the competition the post-Combination System will face, the Parties will achieve their targeted efficiencies without material price increases. Thus, despite the continuing structural problem of a growing public payer mix but steadily diminishing public payer reimbursement, including one of the lowest Medicaid reimbursement rates in the nation, by efficiently utilizing the Parties' rural hospitals, this regionally distributed care model will stabilize and strengthen the financial condition of the Parties' member hospitals. The Proposed Combination will not only deliver the right care, at the right time, at the right place, it will be New Hampshire-based care.

The Proposed Combination also will draw on the Parties' respective strengths to address New Hampshire's health care workforce shortage. With an academic medical center providing tertiary and quaternary care in a rural setting, a high performing acute care community hospital located in an urban setting, and multiple critical access hospitals throughout New Hampshire and Vermont, the Proposed Combination will offer opportunities for growth and diversity of experience that will attract and retain high-demand providers, nurses, and support staff.

For the foregoing reasons and as demonstrated in this Notice, the Proposed Combination furthers the charitable missions of the Parties, is designed to maintain and improve access to quality health care in New Hampshire in a cost-efficient manner, and is the result of extensive study, negotiation and due diligence in the exercise of the Parties' fiduciary responsibilities, all in fulfillment of the requirements of NHRSA 7:19-b.

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[1] See "Dartmouth-Hitchcock Health and GraniteOne Health: Together We Are Stronger," https://www.for a healthiernh.org/about-us/ ("The combined non-profit health care system, Dartmouth-Hitchcock Health GraniteOne, if approved, will offer Granite Staters access to a broad array of clinical services and state-of-the-art care closer to home.")

II. STRATEGIC IMPERATIVES FOR PROPOSED COMBINATION

The Parties negotiated and developed the Proposed Combination in response to significant changes in the health care environment that impact community needs, and to internally-identified strategic needs necessary to sustain and further the Parties' respective charitable missions.

A. NEW HAMPSHIRE HEALTH CARE ENVIRONMENT

1. Growing Community Needs

The New Hampshire population is aging rapidly. The number of New Hampshire residents age 65 or older is expected to increase by 91% between 2010 and 2040, at which point 25% of New Hampshire's population will be 65 or older (compared to 20% for the nation overall).[2] Because the elderly use nearly 2.5 times the inpatient hospital services as those in the next nearest age group, the aging of the New Hampshire population will increase demand for new, expanded and higher acuity services.[3] This need is compounded by pressing public health developments throughout the state, including the opioid and obesity epidemics which place additional strain on New Hampshire's health care infrastructure.

2. Weakening Rural Health Care Infrastructure

New Hampshire's rural health care infrastructure is weakening. 83% of New Hampshire's critical access hospitals ("CAHs") had at least two years with a negative operating margins between 2008 and 2016, and 62% of New Hampshire's CAHs have seen a decline in admissions over the past decade.[4,5] CAHs also experience difficulties recruiting and retaining

[2] US Census Bureau Data (Weldon Cooper Center Analysis, 2016).
[3] Healthcare Cost and Utilization Projection (Statistical Brief #235, 2018).
[4] New Hampshire Hospital Association (Comparison of Operating Margins, 2016).
[5] New Hampshire Hospital Association (Trend Reports, 2008-2017).

staff and providers, thus further challenging their long-term viability and ability to provide services needed in their communities.

3. Outmigration to Massachusetts Facilities

Partially due to insufficient access to tertiary services, each year over 10,000 inpatient cases from southern New Hampshire are treated in Massachusetts, where care is more expensive and less convenient for patients and their families or caregivers. This care can be delivered in New Hampshire at a lower cost.[6,7] For patients with employer-sponsored commercial insurance, the average price for an inpatient discharge in Massachusetts is 41% higher than New Hampshire hospitals and 67% higher than CMC.[8] A substantial portion of these patients could be treated at CMC with the appropriate investment in CMC's clinical capacity and capabilities.

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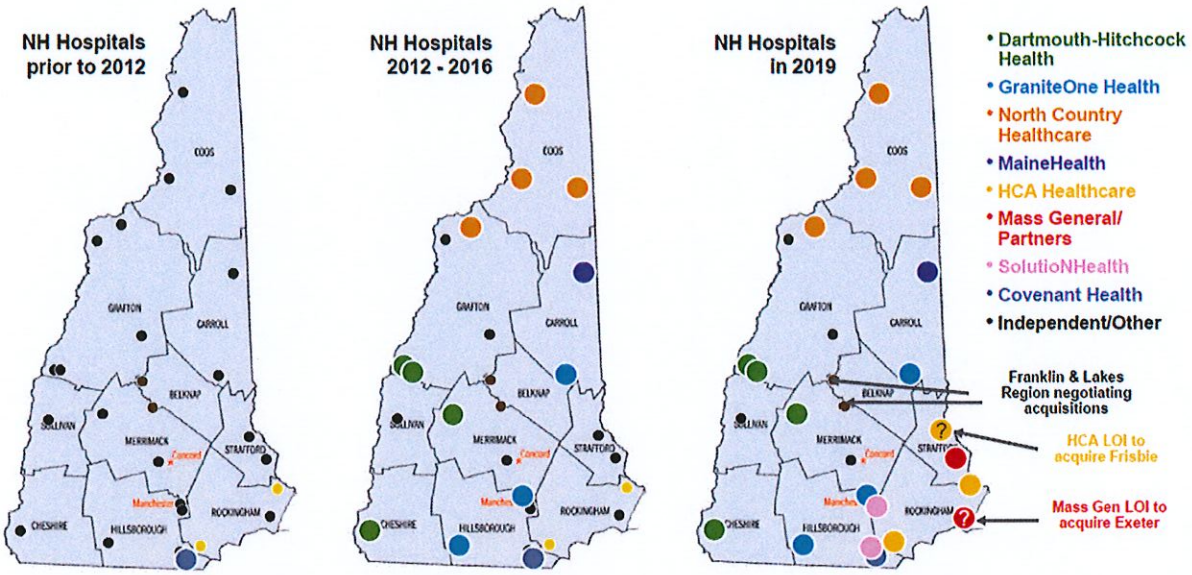
[6] In this document, southern New Hampshire is considered to include Hillsborough, Merrimack and Rockingham counties.

[7] Unless otherwise stated, all data on Massachusetts outmigration comes from data summarized and analyzed by NERA Consulting who was jointly retained by General Counsel to the Parties. The underlying source data used by NERA Consulting is the fiscal year 2017 data provided by the MA Center for Health Information Analysis ("CHIA").

[8] RAND Study ("Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely", 2019).

4. Changes in the Competitive Landscape

From 2010 to 2019, the New Hampshire provider landscape has evolved, as new health systems have formed and out-of-state systems have entered the state. The following charts illustrate this evolution and the decision by many independent hospitals to join a health system to deliver care to their communities:



Notably, Massachusetts based Partners Healthcare - recently renamed "Mass General Brigham" - has significantly expanded its presence in New Hampshire through clinical affiliations, hospital acquisitions, and other strategies designed to direct clinical referrals for New Hampshire patients to its flagship hospital, Massachusetts General Hospital. [9]

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[9] See, e.g.: https://southernnhandmgh.org/ (clinical affiliation with southern New Hampshire Medical Center); https://www.massgeneral.org/locations/Wentworth-Douglass-Hospital (MGH acquisition of Wentworth-Douglass Hospital) and https://www.doj.nh.gov/charitable-trusts/exeter-hospital.htm (proposed transaction with Exeter Hospital and Wentworth-Douglass Hospital)

B. DARTMOUTH-HITCHCOCK HEALTH STRATEGIC NEEDS

1. Academic Medicine and Research

D-HH operates the only academic medical center in New Hampshire, Dartmouth-Hitchcock Medical Center ("DHMC"), which also is the most rural academic medical center in the United States and one of the smallest.[10] To sustain its essential education and research programs, D-HH must preserve and grow its access to patients, which it can achieve by establishing a greater presence in southern New Hampshire, which is home to most of the state's population and is the only region in the state with a rising population. Due to the importance of southern New Hampshire for ongoing research, the increasing migration of southern New Hampshire patients to Boston-based academic medical centers is a competitive risk to the D-HH academic mission that can be mitigated by integrating with the GraniteOne system and investing in services and facilities at CMC. The expanding presence in New Hampshire of out-of-state academic medical centers also poses an existential threat to D-HH's New Hampshire-based academic mission. Without the ability to offer a full array of services, research, teaching and clinical trial opportunities to patients in southern New Hampshire, academic medicine in that market will be ceded to the likes of Mass General Brigham with cascading recessionary effects on D-HH's academic mission, i.e., an aging and shrinking patient mix, insufficient patient volume to support research and clinical trial opportunities, fewer graduate medical education programs, and the diminution of D-HH status as a major academic health system.

[10] Of the approximately 100 most-established medical centers in the country, over one-third of them are surrounded (within a 20-mile radius) by a population of four million people or more. Notably, there are only nine "rural" academic medical centers with a surrounding population of under 500,000. Of these, DHMC has the smallest surrounding populations (under 200,000). Also, DHMC is one of the smallest academic medical centers in the country with 383 inpatient beds, compared to the average bed count of 657. These population estimates are from Nielsen (2016), and bed counts are from the Medicare Cost Report (FY 2016).

2. Management of Clinical Care in Southern New Hampshire

In addition to advancing its academic mission, D-HH requires a more integrated delivery system in southern New Hampshire to enhance the quality and efficiency of clinical care for its southern New Hampshire patients. The Dartmouth-Hitchcock Clinic community group practice ("DHC") includes nearly 300 multi-specialty providers based in Manchester, Bedford, Nashua, Concord. DHC cares for nearly 140,000 southern New Hampshire patients through its primary care panel, manages 81,000 patients through various risk-based contracts, and directs the care of approximately 170 inpatients per day in non-D-HH hospitals, including 60 at CMC.[11] Each year over 2,000 inpatients from southern New Hampshire seek care at DHMC, which regularly operates at or above capacity and could operate more efficiently if more of these patients were cared for closer to home. Based on experiences in Lebanon and Keene where D-HH has both a multi-specialty physician group and a hospital presence, D-HH believes there are opportunities to enhance the quality, clinical management, and efficiency of care for its southern New Hampshire patients by integrating primary, specialty, and hospital care into a single delivery system with a dedicated hospital with expanded capabilities in southern New Hampshire (i.e., CMC). For example, the integrated delivery network ("IDN") that D-HH leads in the Lebanon and Keene areas experiences the lowest per member per month ("PMPM") Medicaid costs than any IDN in the state and has the second lowest PMPM costs for commercially insured patients in the state.[12] For these academic and clinical reasons, D-HH needs to expand its presence in southern New Hampshire.

[11] Estimates based on D-HH professional activity data for fiscal year 2017.
[12] New Hampshire Institute for Health Policy & Practice "Value-Based Public & Private Payment Landscape in New Hampshire" (presentation delivered June 2019).

C. GRANITEONE HEALTH STRATEGIC NEEDS

1. Expansion of Tertiary Services

To remain competitive in an increasingly competitive health care environment, GraniteOne and its member hospitals must continue to expand access to high-quality inpatient and outpatient services and specialty care. For example, CMC's current service mix is heavily weighted toward its center of excellence, the New England Heart and Vascular Institute ("NEHVI"), and CMC will continue to expand its heart and vascular services to meet rising demand. To better position itself as a strong community hospital with tertiary care capabilities, however, CMC will need to expand its capacity and capabilities in other high-acuity care service lines, particularly surgical services like oncology, orthopedics and more complex trauma and spine surgery. This diversification of services will better position CMC to meet growing community need, especially in more acute services, and will help it establish scale in the full complement of tertiary services to which the marketplace is demanding. Developing these capabilities also will help CMC treat thousands of the southern New Hampshire residents who currently obtain services from Massachusetts hospitals each year.

2. Improved Support of Local Care in Rural Communities

GraniteOne needs to ensure the stability of its rural members, MCH and HH. Specifically, GraniteOne needs to help these facilities care for more patients closer to their homes to provide the right care in the right place as economically as possible through additional integration and clinical support in key service lines, including: behavioral health, oncology and other medical surgical specialties (e.g., ophthalmology, orthopedics, general surgery, endocrinology, ear-nose-throat, rheumatology and urology).

The ability of GraniteOne to address these strategic imperatives alone is limited; therefore, GraniteOne has determined that partnering with another health care system will enhance its ability to fully achieve its charitable objectives and address increasing community health care needs more expeditiously.

III. DESCRIPTION OF THE TRANSACTION

The terms of the Proposed Combination are detailed in the Combination Agreement among the Parties effective as of September 30, 2019 and attached as Appendix I(1) (the "Combination Agreement"). The following is a summary of the Proposed Combination's material terms:

A. PARTIES TO THE TRANSACTION (NHRSA 7:19-b, III)

1. GraniteOne Health

GraniteOne is a non-profit, community-based network of New Hampshire hospitals that combines its members' experience, resources, and expertise to provide high quality health care.[13] MCH and HH formed GraniteOne in January 2017, and CMC joined the system shortly thereafter. GraniteOne is the sole corporate member of MCH and HH, and the co-member, along with CMCHS, of CMC. CMCHS is the entity through which the Roman Catholic Bishop of the Diocese of Manchester oversees CMC and ensures its Catholic mission. GraniteOne is responsible for establishing and overseeing system-wide strategy and integrating activities of the GraniteOne system. GraniteOne offers more than 30 medical and surgical subspecialties within the Lakes region and southern New Hampshire.[14] A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and consolidated financial statements for the year ended September 30, 2018 along with the most

[13] See "The GraniteOne Health Story," https://graniteonehealth.org/about/.
[14] Id.

recently closed financial quarterly reports for the quarter ending September 30, 2019[15] are attached as Appendices III(1)-(5), respectively.

2. Catholic Medical Center

CMC is the anchor member of the GraniteOne Health system. CMC is a not-for-profit, 330-bed acute care hospital devoted to providing services and care in accordance with its Catholic mission and identity.[16] CMC provides medical and surgical care to Manchester and surrounding communities, including more than 25 subspecialties, inpatient and outpatient rehabilitation services, a 24-hour emergency department, outpatient behavioral services, and diagnostic imaging.[17] CMC manages the Poisson Dental Facility, the Pregnancy Care Center, the Healthcare for the Homeless Project, and the Parish Nurse Program. In addition, CMC provides support to Amoskeag Health-McGregor, a primary care clinic that provides care to under and uninsured residents and specializes in caring for refugees.[18] CMC also operates both the CMC Special Care Nursery, a state-of-the-art neonatal facility,[19] the Women's Wellness & Fertility Center, a mission driven, regional center for excellence in obstetrical, gynecological and surgical care[20], and the nationally recognized NEHVI, which provides advanced cardiology and vascular care.[21] A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and consolidated financial statements for the year ended September 30, 2018 are attached as Appendices III(6)-(8), respectively.

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[15] Note: the GraniteOne Financial Quarterly Report for Quarter Ending September 30, 2019 at Appendix III(5) includes quarterly financial reports for the CMCHS system which is inclusive of CMC and the CMCHS Subsidiaries, MCH and HH.
[16] Id. at 1-2; *see also* "History and Mission," https://www.catholicmedicalcenter.org/about-cmc/history-and-mission.
[17] "About CMC," https://www.catholicmedicalcenter.org/about-cmc; "Care & Treatment," https://www.catholicmedicalcenter.org/care-and-treatment.
[18] "Amoskeag Health," https://www.catholicmedicalcenter.org/care-and-treatment/community-health/amoskeag-health-mcgregor.
[19] "Special Care Nursery," https://www.catholicmedicalcenter.org/locations/special-care-nursery.
[20] https://www.catholicmedicalcenter.org/locations/womens-wellness-fertility-center.
[21] "Heart & Vascular," https://www.catholicmedicalcenter.org/care-and-treatment/heart-care.

3. The CMCHS Subsidiaries

AAS owns and operates interests in various ambulatory and urgent care facilities, AHS manages the professional services relationship between CMC and D-HC Manchester, and CMCPPA employs the physicians who provide health care services to patients of CMC and other facilities within CMCHS. A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and consolidated financial statements for the year ended September 30, 2018 are attached as Appendices III(9)-(17), respectively.

4. CMC Healthcare System

Being part of a Catholic affiliated healthcare system, CMC and the CMCHS Subsidiaries are subsidiaries of CMCHS. CMCHS was established to be the public juridic person of diocesan right of the Roman Catholic Bishop of the Diocese of Manchester (the "Bishop"), meaning CMCHS is the corporate mechanism by which the Bishop oversees CMC to ensure its implementation of, and compliance with, the Ethical and Religious Directives for Catholic Health Care Services of the United States Conference of Catholic Bishops (the "ERDs"). Following the completion of the Proposed Combination, CMCHS will remain a co-member of CMC and the CMCHS Subsidiaries. A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and consolidated financial statements for the year ended September 30, 2018 are attached as Appendices III(18)-(21), respectively.

5. Monadnock Community Hospital

MCH is a not-for-profit, 25-bed CAH located in Peterborough, New Hampshire. MCH focuses on primary care and secondary acute care services, which are limited by federal

regulations applicable to CAHs.[22] MCH's services include inpatient and outpatient medical and surgical services, emergency care, ambulatory care, and primary and specialty care, such as cardiology, noninvasive respiratory care, general surgery, orthopedic surgery, pediatrics, behavioral health outpatient care, and obstetrics and gynecological services including labor and delivery.[23] MCH also is home to The Bond Wellness Center, a medically-based fitness and rehabilitation facility that includes an oncology and infusion therapy center.[24] Within the GraniteOne system, CMC collaborates with MCH to provide that hospital with cardiology and vascular care, and shared hospitalists, as well as shared laboratory services.[25] A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and consolidated financial statements for the year ended September 30, 2018 are attached as Appendices III(23)-(26), respectively.

6. Huggins Hospital

HH is a not-for-profit, 25-bed CAH located in Wolfeboro, New Hampshire. It focuses on primary care and secondary acute care services, as limited by federal regulations, and provides inpatient and outpatient medical services, emergency care, ambulatory care, primary care, and certain specialty care services.[26] HH manages various family and internal medicine offices.[27] GraniteOne built on CMC's long-standing clinical relationship with HH to provide HH with cardiology and vascular care and, more recently, hospitalists.[28] A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and

[22] See "Overview – Primary Care," https://monadnockcommunityhospital.com/services/primary-care/.
[23] "Services," https://monadnockcommunityhospital.com/services/.
[24] "Welcome to the Bond Wellness Center," https://monadnockcommunityhospital.com/wellness/.
[25] See "The GraniteOne Health Story," https://graniteonehealth.org/about/.
[26] "About HH," https://www.hugginshospital.org/about/main; "Services," https://www.hugginshospital.org/services.
[27] "Locations," https://www.hugginshospital.org/locations.
[28] See "The GraniteOne Health Story," https://graniteonehealth.org/about/.

consolidated financial statements for the year ended September 30, 2018 are attached as Appendices III(28)-(31), respectively.

7. Dartmouth-Hitchcock Health

D-HH is the coordinating organization of the Dartmouth-Hitchcock Health System (the "D-HH System"), which is an integrated, academic medical and health care system that predominantly serves patients in its primary and secondary service areas in New Hampshire and Vermont. The D-HH System is New Hampshire's only academic health system and provides patients with access to acute care hospital services, multispecialty ambulatory clinical services, and more than 1,500 primary and specialty care physicians.[29] It is a national leader in promoting patient-centered health care, with a focus on a sustainable health system that improves health care quality while also reducing the cost of care.[30] The D-HH System is anchored by DHMC in Lebanon, New Hampshire. DHMC is an academic medical center and includes (1) the Mary Hitchcock Memorial Hospital ("MHMH"), (2) Dartmouth-Hitchcock Clinic ("DHC"), a multi-specialty physician group practice with locations throughout New Hampshire, including Manchester, Concord, Bedford, Nashua, and Bennington, Vermont, (3) the Children's Hospital at Dartmouth-Hitchcock ("ChaD"), and (4) the Norris Cotton Cancer Center ("NCCC"). Other members of the D-HH System include Cheshire Medical Center ("Cheshire"); Alice Peck Day Memorial Hospital ("APD"); New London Hospital ("New London"); Mt. Ascutney Hospital and Health Center ("Mt. Ascutney"); and the Visiting Nurse and Hospice for Vermont and New Hampshire ("VNH"). A New Hampshire Certificate of Good Standing, Certified Articles of Agreement, current Amended and Restated Bylaws and consolidated financial statements for the

[29] See "About Dartmouth-Hitchcock," https://www.dartmouth-hitchcock.org/about_dh/dn-facts.html.
[30] See "Creating a Sustainable Health System," https://www.dartmouth-hitchcock.org/2012_progress_report /creating_sustainable_health_system.html. Bed figures in this Section II for D-HH and GraniteOne hospitals are for licensed beds.

year ended September 30, 2018 along with the most recently closed financial quarterly reports for the quarter ending June 30, 2019 are attached as Appendices III(33)-(37), respectively.

B. PURPOSE, MUTUAL VISION AND GUIDING PRINCIPLES (NHRSA 7:19-b, III)

Article 1 of the Combination Agreement describes the Parties' purposes for the Proposed Combination and their shared vision of its benefits. See Appendix I(1). It begins by recognizing the compatibility of the missions and cultures of the Parties as demonstrated by the success of their numerous and varied clinical collaborations, and by acknowledging that each Party seeks to advance its charitable mission of enhancing the health of individuals in the communities it serves and advancing health care through education, research and the improvement of clinical practice while preserving its unique local identity and traditions. Section 1.3 of the Combination Agreement describes the Parties' mutual goal of establishing a more fully-integrated health system that will maximize clinical integration through a bi-regionally distributed care delivery model (the "Combined System"). The remaining sections of Article 1 describe the anticipated benefits of the Proposed Combination: improved access to cost-effective services; continuous quality improvement; enhanced ability to address workforce needs; the reinforcement of health care delivery in rural areas; population health management; and financial sustainability.

Article 2 of the Combination Agreement sets forth the principles which the Parties agree will guide the evolution of their relationship and the Combined System as they encounter unforeseen circumstances and changes in the future. The Parties agree that the health care needs of the communities they serve are paramount, and that a more integrated delivery model will ensure that patients receive the highest quality, acuity-appropriate care at the most convenient, cost-effective site of service across the continuum of care. In addition to commitments to

patient-centered care, Article 2 of the Combination Agreement contains the Parties' commitment to supporting and enhancing the quality and accessibility of health care in rural areas and reinforcing the viability of CAHs in the Combined System as appropriate. Article 2 also confirms that the Catholic identity and mission of CMC and the CMCHS Subsidiaries and the academic medical mission of D-HH will be continued and respected in the Combined System, and that neither will impinge upon the other. See Combination Agreement, Sections 2.6 and 2.7.

C. CORPORATE AND GOVERNANCE STRUCTURE OF PROPOSED COMBINATION (NHRSA 7:19-b, III)

As set forth in the Combination Agreement, the corporate and governance structure of the Proposed Combination will be as follows:

1. Corporate Membership

Upon consummation of the Proposed Combination of the D-HH System and the GraniteOne System (the "Combination Date"), D-HH will be reconstituted as described below, re-named "Dartmouth-Hitchcock Health GraniteOne" ("D-HH GO"), and substituted for GraniteOne as the sole corporate member of MCH and HH and as a co-member, with CMCHS, of CMC and the CMCHS Subsidiaries. D-HH GO will remain the sole corporate member of the existing D-HH System members described in Section III(A)(7) above. D-HH GO will be the coordinating entity of the Combined System and will hold certain reserved powers over CMC, the CMCHS Subsidiaries, MCH and HH as described in Section III(C)(3) below. The foregoing will be accomplished by the recording of amended governance documents of the Parties with the office of the New Hampshire Secretary of State and the clerks of the municipalities in which each Party is located. Following the substitution of D-HH GO for GraniteOne as a corporate

member of CMC, the CMCHS Subsidiaries, MCH and HH, GraniteOne will wind down its affairs and dissolve.

2. Boards of Trustees

(a) The Combined System Board of Trustees

On the Combination Date, the D-HH GO Board of Trustees (the "System Board") will be comprised of fifteen (15) trustees determined as follows:

(i) The System Chief Executive Officer will serve *ex officio* with full voting rights;

(ii) The President of Region I (described in Section III(D) below) will serve *ex officio* with full voting rights;

(iii) The President of Region II (described in Section III(D) below) will serve *ex officio* with full voting rights;

(iv) Seven (7) initial System Board Trustees will be nominated by the D-HH Board of Trustees prior to the Combination Date and elected by the D-HH GO Board as of the Combination Date (together with any successors during the transitional period described in paragraph (c) below, the "D-HH Nominees"); and

(v) Five (5) initial System Board Trustees will be nominated by the Board of Trustees of GraniteOne prior to the Combination Date and elected by the D-HH GO Board as of the Combination Date (together with any successors during the transitional period described in paragraph (c) below, the "GOH Nominees").

D-HH and GraniteOne will identify their respective nominees before the Combination Date, and their terms will be staggered between one and three years. If a D-HH Nominee is subject to re-election or vacates his or her position on the System Board during a transitional period equal to the individual's first term and one successive three-year term, then the D-HH Nominee will be re-elected or replaced by a majority vote only of the remaining D-HH Nominees on the System Board. If a GraniteOne Nominee is subject to re-election or vacates his or her position on the System Board during a transitional period equal to the individual's first term and one successive three-year term, then the GraniteOne Nominee will be re-elected or replaced by a majority vote only of the remaining GraniteOne Nominees on the System Board. See the System Board term chart attached to the Combination Agreement as Schedule 3.3.2(c). After the end of the 6-year transitional period, the System Board will become self-perpetuating.

(b) CMC, MCH, HH and CMCHS Subsidiaries Boards of Trustees

The Boards of Trustees of CMC, each of the CMCHS Subsidiaries, HH and MCH, respectively (collectively the "Member Boards"), will determine the total number of individuals who will comprise their respective Member Boards. Up to one-third (1/3) of the trustees serving on the Member Boards of HH and MCH will be appointed by the System Board, and the remaining two-thirds (2/3) will be nominated by the HH and MCH Member Boards and upon approval, will be elected by the System Board. Up to one-third (1/3) of the trustees serving on the Member Boards of CMC and the CMCHS Subsidiaries will be nominated by the System Board, and the remaining two-thirds (2/3) will be nominated by the Member Boards of CMC and the CMCHS Subsidiaries, respectively. All nominees to the Member Boards of CMC and the CMCHS Subsidiaries will be appointed by CMCHS and the Bishop.

(c) Member Leadership Council and Rural Hospital Group

To ensure an integrated and cohesive approach to management issues throughout the Combined System, and to be responsive to the needs of Combined System members, the System Board will establish a Member Leadership Council comprised of one or more senior management executives employed by each Combined System member and/or a representative from the boards of trustees of each Combined System member. The Council will meet at least quarterly and the meetings will be led by the System Chief Executive Officer ("System CEO") or his or her designee. In support of the Parties' commitment to rural health care, the Member Leadership Council will form a subgroup of one or more senior executives of the rural hospitals (including CAHs) which are members of the Combined System (the "Rural Hospital Group"). The Rural Hospital Group will convene a breakout session at each meeting of the Council to review and discuss strategic, clinical, financial and/or operational issues or challenges unique to rural community hospitals and CAHs in the Combined System. The Rural Hospital Group will report matters raised by the Rural Hospital Group to the System CEO or his or her designee, who in turn will communicate such matters to the System Board together with matters raised by the Member Leadership Council.

3. Reserved and Retained Powers

The Parties acknowledge that the Combined System must be well-integrated to accomplish their mutual goals for the effective and efficient delivery of quality health care. The Parties also acknowledge that the member hospitals and other provider organizations in the Combined System are responsible for identifying the health needs in their communities and overseeing their organization's delivery of care. To balance the needs of the Combined System and the responsibilities of its members within an effective and dynamic structure for the

integrated delivery of care, the Parties agree that (i) the System Board will hold certain powers reserved to it as the corporate member of each of HH and MCH and will share certain powers reserved to it with the co-member, CMCHS, with respect to CMC and the CMCHS Subsidiaries only, so that the System Board can serve as the coordinator and steward of the Combined System, and (ii) the Board of Trustees of each of CMC, the CMCHS Subsidiaries, HH and MCH will retain certain powers and responsibilities for health care in their respective communities.

(a) System Board Approval Rights Over Certain Actions of the Member Boards

To become effective, each of the following actions by CMC, the CMCHS Subsidiaries, HH and MCH (subject to certain qualifications as described in Sections 3.4.1(a) and 3.4.2(a) of the Combination Agreement) must be approved by the System Board (and, in the case of certain actions by CMC and the CMCHS Subsidiaries, by CMCHS and the Bishop):

(i) The determination of the size of the Member Board and any nominations of trustees to serve on the Member Board after the Combination Date, provided that the System Board's objection to a Member Board nominee must be based on the nominee's failure to meet the criteria described in Schedule 3.3.3 of the Combination Agreement;

(ii) Amendments to their respective Articles of Agreement or Bylaws which would (a) impact the powers reserved to the System Board, or (b) reasonably be expected to have any material strategic, competitive or financial impact on the Combined System;

(iii) The adoption and approval of annual operating and capital budgets, and approval of unbudgeted expenses over a specified amount;

(iv) The incurrence of unbudgeted indebtedness over a specified amount;

(v) The unbudgeted disposition of assets over a specified amount;

(vi) The appointment of an independent auditing firm;

(vii) The elimination or addition of any health care program, a change in any license, or a change to the operating character of the Combined System member;

(viii) The adoption or material revision of policies relating to academic and research programs, and the decision by a Combined System member to enter into or terminate an academic affiliation;

(ix) The proposed exercise of reserved powers over any subsidiary or other organization that it controls;

(x) The adoption or material revision of any strategic initiative or plan;

(xi) A decision to enter into a key strategic relationship;

(xii) A decision to merge, consolidate, acquire substantially all of the assets of another entity, or sell or lease substantially all of the assets of the Combined System member; and

(xiii) A decision to commence bankruptcy or insolvency proceedings, and/or to liquidate and dissolve the Combined System member.

(b) System Board Rights to Initiate or Enforce Actions of Member Boards

In addition to the approval rights described above and the right to appoint representatives to the Member Boards, the System Board will have the right to initiate the following actions to be taken or directed by CMC, the CMCHS Subsidiaries, HH and MCH, subject to limitations set forth in Sections 3.4.1(b) and 3.4.2(b) of the Combination Agreement and, with respect to CMC

and the CMCHS Subsidiaries, subject to Section 2.6 of the Combination Agreement and the rights of CMCHS and the Bishop to assure compliance with Catholic moral teaching, the ERDs and Canon Law:

(i) Following consultation with the Member Board chair, the removal (or in the case of CMC and the CMCHS Subsidiaries, the request for removal by CMCHS) of a Member Board trustee if the System Board determines that the removal is in the best interests of the System;

(ii) Following consultation with the Member Board chair and the applicable Regional President (and the System Board Chair in the event of a contrary recommendation from the Member Board), the System Board acting through the System CEO or his or her designee will retain the sole authority to hire (or in the case of CMC or a CMCHS Subsidiary, to recommend to CMCHS the hiring of), evaluate, compensate and terminate (or in the case of CMC or a CMCHS Subsidiary, to recommend to CMCHS the termination of) the President and Chief Executive Officer of the Combined System member;

(iii) To the extent applicable and determined by the System Board to be in the best interest of the Combined System, the participation of the Combined System member in System-wide strategies, delivery networks, products (including risk-based reimbursement arrangements) and other similar initiatives consistent with the Combined System strategic plan(s) and designed to further the establishment of an integrated and sustainable health delivery system;

(iv) As determined and directed by the System Board, the participation of the Combined System member in, and the fulfillment of the requirements of, System-wide programs and initiatives designed to improve access, quality and/or costs of services to patients,

such as group purchasing, information system integration, quality improvement measures, shared finance functions and shared corporate services; and

(v) The initiation of changes in clinical services of the Combined System member if necessary to implement the Combined System strategic plan and System-wide objectives, to further the clinical program development contemplated by Section 5.3 of the Combination Agreement, or to improve the financial position of the Combined System member. Prior to implementing the clinical changes, the System Board must follow the process and conduct the evaluation described in Sections 3.4.1(b)(v) and 3.4.2(b)(v) of the Combination Agreement.

The Parties also acknowledge that the System Board will have authority and powers under other sections of the Combination Agreement, including without limitation the right to appoint representatives to Member Boards, the establishment of a Combined System strategic plan, the development and negotiation of joint ventures, affiliations or reorganizations with prospective Combined System members or other parties, financial management of the Combined System, and the consolidation of administrative functions. See Combination Agreement Sections 3.4.1(b)(vi) and 3.4.2(b)(vi).

(c) Retained Powers of CMC, the CMCHS Subsidiaries, HH and MCH

Each of CMC, the CMCHS Subsidiaries, HH and MCH will retain the following powers:

(i) The determination of *ex officio* positions on the Member Boards and the nomination of individuals who, with *ex officio* trustees, will comprise at least two-thirds (2/3) of the trustees on the respective Member Board, subject to the System Board's reserved powers;

(ii) The selection of the Chair of the Member Board from among the trustees nominated by CMC, the CMCHS Subsidiaries, HH and MCH, respectively;

(iii) The provision of an evaluation of its President and CEO, and a recommendation prior to any decision to hire or terminate the President and CEO of a Combined System member;

(iv) Primary responsibility for identifying the health needs of the communities it serves, developing a strategic plan (consistent with the Combined System Strategic Plan described in Section 5.1 of the Combination Agreement) for meeting those needs, and overseeing the delivery and safety of health care services at its respective hospital and any related facilities;

(v) Subject to applicable reserved powers of the System Board and donor intent, the determination of whether and how much to appropriate from its donor-restricted funds for qualifying expenditures;

(vi) The authority to determine and implement fundraising activities conducted by the Combined System member in its respective service area, and to approve any fundraising efforts proposed by the System Board in the Combined System member's respective service area; and

(vii) Retention of exclusive rights with respect to the ownership and use of its corporate names and any trade names it has registered or put into use in the marketplace, including without limitation CMC's name "Catholic Medical Center" for its main hospital campus in Manchester, New Hampshire and "New England Heart and Vascular Institute" and "NEHVI" for its heart center.

4. Coordination with CMCHS

The Parties acknowledge that in addition to the power to approve certain actions of CMC and the CMCHS Subsidiaries as described in Section 3.4.2(a) of the Combination Agreement, CMCHS will continue to have the sole authority to approve any proposed change to the philosophy, objectives or purposes of CMC and its subsidiaries or of the CMCHS Subsidiaries and their subsidiaries, and any change to its ethical religious standards. No action that could impact CMC's name, or the Catholic identity of, or compliance with Catholic moral teaching, the ERDs and Canon Law by, CMC and the CMCHS Subsidiaries may be taken without the prior approval of CMCHS. See Combination Agreement Section 3.4.3. If there is a conflict in the exercise of reserved powers by the System Board and the Bishop or CMCHS with respect to a proposed action of CMC or one of the CMCHS Subsidiaries, then the Bishop's decision will govern unless the System Board objects, in which case the proposed action will be modified by CMC or the CMCHS Subsidiaries until it receives the approval of both the Bishop or CMCHS and the System Board. Notwithstanding the foregoing, the Parties agree that if a proposed action conflicts with Catholic moral teaching, the ERDs or Canon Law, or if there is a question related to the interpretation of Catholic moral teaching, the ERDs or Canon Law, as applied to CMC and the CMCHS Subsidiaries, then the decision and interpretation of the Bishop will govern.

D. MANAGEMENT STRUCTURE OF PROPOSED COMBINATION (NHRSA 7:19-b, III)

1. Clinical Structure

The Combined System will develop a pluralistic medical staff model for community practice physicians, community hospital and CAH medical staff, academic medical center physicians, and independent physicians, which model accommodates and respects the existing

medical staff structures of the Parties while seeking to achieve the clinical integration goals of the Combination. Following the Combination Date, each of the Parties will continue to maintain its medical staff structures and be responsible for granting clinical privileges, subject to System-wide initiatives such as credentialing which may be implemented by the System Board as described in Sections 3.4.1(b)(iii) and (iv) and Sections 3.4.2(b)(iii) and (iv) of the Combination Agreement. The Combined System's pluralistic medical staff model will be designed to support the critical access and rural hospital characteristics of HH and MCH (and other existing Members of the D-HH System), the acute care community hospital and Catholic characteristics of CMC, and the academic medical center characteristics of DHMC.

2. Administrative Structure

(a) Combined System Chief Executive Officer

The Combined System will have a chief executive officer (the System CEO) and such other individual management officers as are determined by the System Board to be necessary or appropriate. The System CEO will report to the System Board and be responsible for, among other things, providing leadership, strategic guidance and operational oversight to the Combined System. The System CEO will appoint (subject to the approval of the System Board) and oversee the Regional Presidents (described in paragraph (b) below) in the performance of their responsibilities. The initial System CEO will be Joanne M. Conroy, MD.

(b) Regional Structure

As of the Combination Date, the Combined System will consist of two Regions (each a "Region"). Region I generally will include the following: MHMH, DHC Keene, Lebanon and Putnam, New London, Mt. Ascutney, Cheshire, APD, VNA and any other current northern New Hampshire and Vermont facilities and practices that are part of the D-HH System on the

Combination Date. Region II generally will include the following: CMC, the CMCHS Subsidiaries, HH, MCH, DHC Concord, Manchester, Bedford and Nashua and any other current southern New Hampshire facilities and practices that are part of the D-HH System or the GraniteOne System on the Combination Date, and any southern New Hampshire facilities and practices that become part of the Combined System after the Combination Date. The System Board will retain the power and authority to establish new regions and to add to the component entities and facilities of each Region from time to time as it deems appropriate.

Region I will be managed by the President of Region I, who initially will be Joanne Conroy, MD, the current President and CEO of D-HH and D-H. Region II will be managed by the President of Region II, who initially will be Joseph Pepe, MD, the current President and CEO of GraniteOne and CMC ("Dr. Pepe"). The Regional Presidents will report to the System CEO. Subject to certain restrictions on Region II described in paragraph (c) below, the Regional Presidents will be responsible for overseeing and coordinating the implementation, management and evaluation of the Combined System strategies, clinical initiatives and operational programs at the Combined System member hospitals and outpatient facilities, including, but not limited to, Dartmouth-Hitchcock Clinic facilities and ambulatory surgical centers (the "D-HC Facilities"), within each Regional President's respective Region. The Regional Presidents also will foster and guide collaboration among the Combined System members in the assigned Region, recognizing that Combined System members may cooperate and collaborate with each other outside their assigned Region consistent with the Combined System strategic plan. See Combination Agreement Section 4.2.2(c).

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(c) Region II Adherence to Catholic Moral Teaching, ERDs and Canon Law

For so long as the CMC President and CEO also serves as the President of Region II, the President of Region II will be responsible and accountable for, and oversee, only those strategic initiatives and clinical and operational programs of System Members in Region II that are consistent with Catholic moral teaching, the ERDs and Canon Law. Procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law will be overseen by the President of Region I. After the Combination Date, D-HC will bifurcate those operations and procedures in Region II that are consistent with Catholic moral teaching, the ERDs and Canon law from those that are not, and along with secular hospitals in Region II, will report to the D-HH Chief Operating Officer and Chief Clinical Officer with respect to operations and procedures that are not consistent with Catholic moral teaching, the ERDs and Canon Law. Regardless of whether the CMC President and Chief Executive Officer also is serving as the Region II President, D-HC will take certain administrative steps with respect to its clinical operations in Region II to ensure respect for the ERDs and CMC's Catholic identity and the avoidance of confusion among CMC patients who may be referred to a D-HC specialist. See Combination Agreement Section 4.2.2(e).

(d) Member Leadership and Reporting Relationship

Each of the Combined System members will be served by a chief executive officer (each a "Member CEO"), who may be employed by the Combined System and may serve as the chief executive officer for more than one Combined System member. Unless a subsequent change to the System's regional structure is approved by the System Board, each Member CEO will report directly to the Regional President for the Region in which the Member is located or, in the case of Region I if the System CEO and the Region I President are the same person, to his or her

designee. Each Member CEO also will be responsible to his or her Member Board, and will consult regularly with and inform his or her Member Board acting through its Chair or the Chair's designee. The Member CEO will perform such duties as are typical of an executive of a community hospital in an integrated health care system, including but not limited to the execution of the Combined System strategic plan and Member strategic plan, oversight of hospital administration, operations, and finances, and supervision of Member personnel reporting to the Member CEO.

3. Integration Period

The Parties entered into the Combination Agreement with a commitment to the regional structure described above. The Parties also recognize that they may discover challenges with the regional structure or encounter unforeseen circumstances that may dictate a revision to the Combined System's delivery model. Therefore, the System Board may revisit the regional structure after the 2nd anniversary of the Combination Date, provided that any change to the structure before the 6th anniversary of the Combination Date receives the approval of a majority of each of the D-HH Nominees and the GraniteOne Nominees. If HH or MCH requests transition to a different region, the System Board will approve the request unless the request is inconsistent with the Combined System's interests. The identity of the Region II President is similarly important to the Parties and consideration for their execution of the Combination Agreement. Therefore, the appointment of any successor to Dr. Pepe as the Region II President during the six consecutive years following the Combination Date will be subject to the approval of a majority of the GraniteOne Nominees.

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E. FINANCIAL MATTERS (NHRSA 7:19-b, II(d); NHRSA 7:19-b, III)

1. No Change in Asset Ownership

Upon the completion of the Proposed Combination, each of the Parties will retain its separate legal identity and ownership and responsibility for its assets and liabilities, subject to certain reserved powers of the System Board and the potential for each of CMC, HH and MCH to participate in the Dartmouth-Hitchcock Obligated Group described below. See Combination Agreement Sections 3.3.1 and 5.5.3.

2. Financial Principles/Reallocation of Resources

One of the primary responsibilities of D-HH GO is to ensure that the collective resources of the Combined System are used to address as effectively as possible the health care needs of all of the communities served by the Combined System. Therefore, subject to the provisions of Section 2.6 with respect to CMC and the CMCHS Subsidiaries, the System Board will have the responsibility and power to ensure that the Combined System and its Members observe sound financial principles described in Schedule 5.5.2(a) to the Combination Agreement (the "System Financial Principles"). D-HH GO will monitor the financial performance of members of the Combined System, and it may require members who are unable to meet the System Financial Principles or have a material deviation from its approved operating budget to meet with the D-HH GO Chief Financial Officer to develop a financial performance improvement plan.

To achieve the Parties' mutual objectives of utilizing their collective resources in the most effective and efficient manner in support of the Combined System and its delivery of quality and accessible care, the System Board also will have the power to require a reallocation of the Combined System's assets (other than Endowment Funds, defined below) or resources for one or more Combined System purposes. The System Board first must determine that a

reallocation of assets or resources from one or more Combined System members to D-HH GO for use elsewhere within the Combined System (i) will further the System Strategic Plan, (ii) is the most appropriate way in which to fund the Combined System need or program or initiative, (iii) will not materially impair the ability of the Combined System member from which the assets or resources are re-allocated to continue to serve the health needs of the communities in its service area and meet its debt obligations, and (iv) is consistent with the member's compliance with the Financial Principles. The System Board must notify the Member Board, and the Member Board and the Member CEO then will have the opportunity to discuss the proposal with the System Board Chair, the System CEO and the Regional President, and to provide additional information or alternative recommendations. The input of the Member Board, the Member CEO and the Regional President then will be considered by the System Board before it approves the proposed reallocation. No reallocation may be made if: (i) it would cause a default under any indebtedness obligation or a reduction or other materially adverse effect on the rating of the member's outstanding bonds; (ii) with respect to CMC or the CMC Subsidiaries, the reallocated funds would be used to fund or implement any procedure that is inconsistent with Catholic moral teaching, the ERDs or Canon Law; or (iii) the funds would be reallocated from HH and/or MCH to fund the CMC expansion project (described below) or the D-HH patient tower project.

3. Obligated Group and Expansion Project Commitment

Following the Combination Date, when the Combined System Chief Financial Officer and the respective member Chief Financial Officer determine that it is advantageous, then each of CMC, HH and MCH will be offered an opportunity to join the Dartmouth-Hitchcock Obligated Group (the "DHOG") and become subject to its covenants and obligations. Such joinder must be approved by the DHOG and the Member's Board, and is designed to reduce the

cost of the member's indebtedness and make more member funds available for the delivery of quality health care.

CMC currently has insufficient inpatient capacity to meet the health care needs of its service area. It recently acquired a commercial parcel of land adjacent to the CMC campus in Manchester, New Hampshire upon which it plans to construct an addition to its hospital facility containing inpatient beds, clinical service areas and related amenities (the "CMC Expansion Project"). The project details have not yet been finalized, but the Parties acknowledge that the scope and/or phasing of construction of the CMC Expansion Project will be materially impacted without access to additional capital given the current borrowing capacity of CMC and uncommitted financial resources available to it. To further the objectives of the Combination, D-HH and CMC agree to work collaboratively before (to the extent legally permissible), and D-HH GO will work collaboratively with CMC after, the Combination Date to finalize the CMC Expansion Project plan at a project cost not to exceed $200 Million and to access up to $200 Million for the construction and equipping of the CMC Expansion Project, subject to the satisfaction of certain conditions set forth in Section 5.5.5 of the Combination Agreement. After the Combination Date and as part of the Combined System's strategic planning process, D-HH GO will solicit input from members and will identify and prioritize any new capital projects to which the System Board may decide to contribute Combined System resources consistent with the System Strategic Plan and the Financial Principles.

4. Restricted Funds Honored

Each Party will retain ownership and control over all donor-restricted assets and unrestricted assets received in connection with its fundraising efforts (the "Endowment Funds"). See Combination Agreement Sections 5.5.1 and 5.5.6. The Endowment Funds will continue to

be invested and expended in accordance with the donors' restrictions and applicable law, subject to the System Board's approval rights regarding expenditures. See Combination Agreement Section 3.4.1 (with respect to HH and MCH) and Section 3.4.2 (with respect to CMC and the CMCHS Subsidiaries).

5. No Consideration Paid (NHRSA 7:19-b, II(d))

The Proposed Combination does not involve the payment of any proceeds or exchange of consideration among the Parties, except for the commitment to future financial support as described in Section III(E)(3) above. See Combination Agreement Section 7.1.13. The primary consideration being exchange by the Parties is the commitment to integrating and further developing their clinical programming as described in Section F below, the benefits of which will be measured by improvements in quality, improved access and more cost-effective care. See Combination Agreement Articles 1 and 2 and Section 5.3.

F. CLINICAL INTEGRATION (NHRSA 7:19-B, III)

The Parties recognize that they cannot address the Strategic Imperatives discussed in Section II above or meet the objectives of the Proposed Combination without integrating and enhancing their clinical programming. Therefore, the Parties have committed to evaluating and developing clinical services and delivery methods designed, among other objectives, to: enhance population health and wellness and prevention services; expand primary care practice development; enhance existing clinical collaborations and addition of new specialty services in southern New Hampshire; support services appropriately provided in rural locations to promote access to care in the most efficient and economical setting; achieve high quality clinical outcomes; reduce risk and assure corporate compliance; improve physician recruitment and retention; achieve efficiencies; and implement best practices. Section 5.3 of the Combination

Agreement describes the specific clinical programming and processes to which the Parties are committing, including inpatient services, and specialty services such as behavioral health, pediatrics, oncology, orthopedics, spine care and pain management, obesity and bariatrics, and heart and vascular. Section 5.3.4 of the Combination Agreement describes specific Combined System commitments to HH and MCH. The Parties also will align and enhance their telehealth services, disseminate throughout the Combined System their quality improvement infrastructure and resources, and seek new opportunities for new academic synergies and expanded access to clinical trials.

In addition to identifying those areas of clinical collaboration under the Proposed Combination that have the greatest potential for immediate benefit to patients, the Parties engaged a reputable national health care consulting firm, The Chartis Group ("Chartis"), to assist the Parties in developing a Clinical Integration Strategy report (the "Chartis Integration Report"). A confidential copy of the Chartis Integration Report is attached as Appendix I(2).[31] In addition to articulating the opportunities of the Combined System for clinical service enhancement, the Report also details the initiatives necessary to realize those enhancements and quantifies the expected benefits of each initiative, as discussed in more detail in Section IV below.

G. CONDITIONS TO CLOSING

The consummation of the Proposed Combination is conditioned upon: (1) the continued truth and accuracy of the Parties' respective representations and warranties; (2) the performance of pre-Closing covenants described in Article 8 of the Combination Agreement; (3) the receipt of all necessary governmental and third party approvals; (4) the completion of due diligence and the

[31] The Dartmouth-Hitchcock Health GraniteOne ("D-HH GO") Clinical Integration Strategy dated December 27, 2019 is confidential and considered competitively sensitive and for this reason is not subject to the New Hampshire Right-to-Know Law, RSA 91-A and is being provided to the Director under separate cover as "CONFIDENTIAL, EXCLUDED FROM RSA 91-A".

receipt of satisfactory results; (5) corporate approvals of any future due diligence findings or proposed modifications to the Proposed Combination as a result of the regulatory review process; and (6) the absence of a Material Adverse Event defined in Section 6.3.6 of the Combination Agreement. See Combination Agreement Section 6.3.

H. NO OUT-OF-STATE ACQUIRER (NHRSA 7:19-b, II(f))

As a New Hampshire-based, New Hampshire patient focused system, the proposed member of HH and MCH and co-member of CMC and the CMCHS Subsidiaries, D-HH GO, is and will continue to be a New Hampshire health care charitable trust. See Appendix III(33) (D-HH Certificate of Good Standing; See also proposed Affidavit of Amendment to be filed at closing at Appendix I(1).

I. DISTINCTION FROM AFFILIATION PROPOSED IN 2009-10

In July 2009, D-HH and CMCHS filed with the Charitable Trusts Director Notice of a proposed change of control transaction under an Affiliation Agreement between them dated July 22, 2009. GraniteOne did not exist at that time, and neither HH nor MCH were involved in any way. In January, 2010 D-HH and CMCHS executed a First Amendment to their Affiliation Agreement in response to public commentary, and filed a Supplemental and Restated Notice with the Charitable Trusts Director on January 21, 2010 (as amended, the "2010 Proposed Affiliation"). On May 21, 2010, the Director of Charitable Trusts issued his report objecting to certain components of the 2010 Proposed Affiliation. For various reasons, D-HH and CMCHS elected not to pursue the 2010 Proposed Affiliation and instead modified the nature and scope of their existing professional services agreement.

The Proposed Combination differs significantly from the 2010 Proposed Affiliation. As noted in Sections I and II of this Notice, the health care industry and the competitive landscape in which the Parties must operate has changed dramatically in the last decade. The paradigm shift in reimbursement from fee-for-service to value-based that was just underway in 2010 has become prevalent and more robust under both commercial health insurance and governmental health programs. Over the last several years the Parties have experienced the need for, and value of, the provision of integrated health services to a broad segment of patients across the continuum of care in order to better manage population health, respond to critical needs such as behavioral health services, and improve access to quality care. As a result of their participation in Accountable Care Organizations and other integrated delivery networks and joint ventures, the Parties have endeavored to reduce costs, improve outcomes, and predict and quantify the results of their efforts in fulfilling their charitable missions. The Proposed Combination is the embodiment of the Parties' shared experiences and learning, and the vehicle most likely to address the needs of New Hampshire's citizens to obtain better access to more economical quality care as close to home as possible.

In response to changes in health care reimbursement and to increasing industry consolidation and competition from out-of-state providers since the 2010 Proposed Affiliation, D-HH expanded its regional health system and MCH and HH formed, and CMC joined, GraniteOne. Although each health system is in a different stage of its evolution, all of the Parties recognize the need to develop a more integrated and comprehensive health care delivery system in order to achieve the vision and objectives outlined in Article 1 of the Combination Agreement. As described in Section II of this Notice, D-HH recognizes the shortcomings of a health system without tertiary services in southern New Hampshire, and GraniteOne recognizes the need to

diversify its services and provide more robust support to the delivery of health care in rural areas. The Parties' experience with the challenges of a less-integrated, less-comprehensive health system has informed their decision to further their charitable missions through the Proposed Combination.

In addition to significant changes in the health care environment over the last decade, the Proposed Combination is structured much differently than the 2010 Proposed Affiliation. The Proposed Combination preserves the existing mechanism for ensuring that CMC and the CMCHS Subsidiaries continue to operate in compliance with Catholic moral teaching, the ERDs and Canon Law[32]. As described in Section III(A)(4) above, CMCHS was established as the public juridic person and corporate mechanism by which the Bishop oversees CMC to ensure its implementation of, and compliance with, the ERDs and Canon Law. Under the 2010 Proposed Affiliation, D-HH would have become the sole corporate member of CMCHS (not CMC) with certain reserved powers over CMCHS reserved exclusively to D-HH, and other reserved powers to be exercised in parallel with the powers over CMCHS reserved to the Bishop. The 2010 Proposed Affiliation also contemplated that AHS would be the organizing entity for a "Manchester System" operating within the D-HH regional system, and that D-HH would select a majority (65%) of the AHS Board of Trustees.

Under the Proposed Combination D-HH GO will become, together with CMCHS, a co-member of CMC and the CMCHS Subsidiaries, and CMCHS will retain its authority and independence with the Bishop as its sole member. The System Board will have the power to nominate no more than one-third (1/3) of the trustees of CMC and the CMCHS Subsidiaries, and

[32] This is the singular feature which distinguishes CMC and the CMCHS Subsidiaries from other charitable members of the D-HH or GraniteOne health systems, and the trustees of those entities will retain unmitigated fiduciary power and authority to ensure that CMC and the CMCHS Subsidiaries continue to operate in full compliance with Catholic moral teaching, the ERDs and Canon Law.

the System Board nominees must be approved and appointed by CMCHS. The Combination Agreement mandates that all of the approval powers reserved to the System Board over certain actions proposed by the CMC or the CMCHS Subsidiaries boards of trustees also are reserved concurrently to CMCHS[33]. See Combination Agreement Section 3.4.2(a). Rather than utilizing a dispute resolution mechanism like the 2010 Proposed Affiliation, Section 3.4.4 of the Combination Agreement states that the Bishop's interpretation of Catholic moral teaching, the ERDs or Canon Law will be final and binding upon the System Board, and that if a proposed action subject to reserved powers does not receive the approval of both the System Board and the Bishop, then CMC and the CMCHS Subsidiaries must revise their proposed actions until they receive unanimous approval. Finally, pursuant to the opinion issued by the Charitable Trusts Director on February 13, 2017, the revised D-HH GO Bylaws expressly require the System Board to honor a limited fiduciary duty to every member of the Combined System when exercising the powers reserved to it by members (including CMC and the CMCHS Subsidiaries). See Amended D-HH GO Bylaws Section 3.17 at Appendix I(1).

Unlike the 2010 Proposed Affiliation, the Proposed Combination provides GraniteOne with significant representation on the System Board and more control over the management of the Combined System operations in Region II. GraniteOne will appoint one of three *ex officio* positions and five of twelve elected positions on the System Board, or forty percent (40%) of the total System Board voting positions[34]. After an integration period of six (6) years following the Combination Date, the System Board will become self-perpetuating. The CMC President and

[33] Certain actions of the CMC and CMCHS Subsidiaries Boards of Trustees, such as governance amendments and changes to clinical services, are subject to CMCHS approval only if they implicate the Bishop's reserved powers or could impact compliance with Catholic moral teaching, the ERDs and Canon Law.

[34] D-HH would have had similar representation on the CMCHS Board under the 2010 Proposed Affiliation, which the 2010 Charitable Trust Director Report found to be significant and impactful on governance decisions of that entity.

CEO also will be appointed as the President of Region II, which includes most of the southern New Hampshire providers in the Combined System. This regional structure will be preserved for at least six (6) years unless a majority of the GraniteOne Nominees votes otherwise after the 2nd anniversary of the Combination Date. As described above, the chief executive officer of each Combined System member in Region II will be responsible for the administration and operation of the member hospital and report to the Region II President, giving that position authority and influence over the Combined System operations in Region II.

A final significant difference between the Proposed Combination and the 2010 Proposed Affiliation is that the Proposed Combination already has received the approval of the Bishop based on the moral analysis conducted by his ethicist. See discussion in Section V(B) below. The moral analysis contains the following conclusion:

> The proposed combination whereby CMC will become part of a larger, non-Catholic System is complex yet permeated with attention to the importance of CMC's Catholic identity. The protections for CMC, through its co-member CMCHS, are explicit and extensive. They ensure that CMC will be able to follow the ERDs and give vibrant witness, and they enable the Bishop of Manchester to continue exercising his proper moral authority over CMC.

Section 2.6 of the Combination Agreement imposes a blanket restriction on the System Board's exercise of its reserved powers over CMC and the CMCHS Subsidiaries, including the rights to initiate action by CMC or the CMCHS Subsidiaries described in Section 3.4.2(b) of the Combination Agreement. This principle is expressed throughout the Combination Agreement. As noted above, the Combination Agreement also establishes an administrative mechanism to ensure that the Region II President will not manage or supervise programs which may not be consistent with Catholic moral teaching, the ERDs or Canon Law, and that CMC patients will understand the secular members of Region II are not bound by Catholic moral teaching, the

ERDs or Canon Law. See Combination Agreement Sections 4.2.2(d) and (e). It should be noted that CMC and the CMCHS Subsidiaries currently are members in a secular health system which received the approval of the Bishop and the Charitable Trusts Director, and that the Proposed Combination is a transaction that combines the two secular systems while leaving intact the Catholic identity of CMC and the CMCHS Subsidiaries and the Bishop's mechanism for ensuring their adherence to Catholic moral teaching, the ERDs and Canon Law.

IV. FULFILLING FIDUCIARY DUTIES

The essence of NHRSA 7:19-b(II) is to ensure that the governing body of a health care charitable trust does not approve an "acquisition transaction" unless it has fully exercised its fiduciary obligations. Trustees of a New Hampshire health care charitable trust have two primary fiduciary roles: (1) to ensure that the activities of the organization and decisions of the board are designed to further its charitable mission (i.e. "obedience to the mission"); and (2) to ensure that the assets and other resources of the organization are invested and used prudently to support the organization's charitable mission in a sustainable manner (i.e. "stewardship"). When fulfilling the roles of obedience to the mission and stewardship, trustees must exercise their fiduciary duties of due care and loyalty to the organization. In the context of an acquisition transaction, these fiduciary obligations are captured by the following provisions of NHRSA 7:19-b:

> due diligence has been exercised in seeking the acquirer, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the transaction, and in determining that the transaction is in the best interest of the health care charitable trust and the community which it serves (NHRSA 7:19-b(II)(b)); and

> [t]he assets of the health care charitable trust and any proceeds to be received on account of the transaction shall continue to be devoted to charitable purposes consistent with the charitable objects of the health care charitable trust and the needs of the community which it serves (NHRSA 7:19-b(II)(e)).

The following outlines how the Boards of Trustees of GraniteOne, CMC, the CMCHS Subsidiaries, MCH and HH determined that participation in a larger, more fully-integrated health care delivery system with D-HH will address the strategic imperatives described in Section II above and meet the identified health needs of the communities they serve, thus furthering their charitable missions in a more sustainable manner.

A. COMPATIBILITY OF CHARITABLE MISSIONS AND PRESERVATION OF CHARITABLE PURPOSES

The Trustees of each of the Parties have ensured that their charitable assets will remain devoted to their charitable purposes under the Proposed Combination. The Parties first determined and expressly confirmed that their charitable missions were aligned and compatible. All of the Parties are tax-exempt, charitable health care providers devoted to meeting the health needs of New Hampshire citizens in their communities. The Combination expressly mandates that "no Party will be required to take any action that is materially inconsistent with, or in contravention of, its respective charitable mission." See Combination Agreement Section 2.3. The Parties' participation in the Proposed Combination will not result in the alteration of the purposes for which their charitable assets have been, and must continue to be, used.

The Parties then negotiated components of the Combination Agreement to preserve unique features of their charitable health care trusts. As described in Sections III(I) and V(B) of this Notice, CMC and the CMCHS Subsidiaries will retain their Catholic identity and adherence to Catholic moral teaching, the ERDs and Canon Law. See, e.g., Combination Agreement

Section 2.6; see also Appendix V(2). Furthermore, CMC and the CMCHS Subsidiaries have negotiated operational requirements for the Proposed Combination to ensure adherence to the principles imposed by Section 2.6 of the Combination Agreement, including the two region structure with the CMC CEO serving as the President of Region II and the operational restrictions described in Sections 4.4.2(d) and (e) of the Combination Agreement.

Likewise, D-HH negotiated components of the Combination Agreement to preserve the academic medicine component of its charitable mission. See, e.g., Combination Agreement Section 2.7. The Parties also identified opportunities to integrate D-HH's research expertise into the clinical activities of the Parties following the Combination Date, and the D-HH CEO or her designee will serve as the President of Region I. See, e.g., Combination Agreement Section 5.3.7.

HH and MCH also negotiated components of the Combination Agreement to support their charitable missions of serving the health needs of each of their rural communities. To reinforce the demonstrated long-term commitment of both D-HH and CMC to supporting rural healthcare, Section 2.8 of the Combination Agreement expressly states the commitment of the Parties after the Combination Date to support and enhance the quality and accessibility of health care in rural areas and the viability of CAHs. See also, Combination Agreement Section 3.4.1(b)(v) and 5.3.3(a). Finally, HH and MCH negotiated specific commitments of the Combined System to support needed clinical and specialty services in their rural communities. See Combination Agreement Section 5.3.4.

B. ADDRESSING COMMUNITY NEEDS (NHRSA 7:19-b, III)

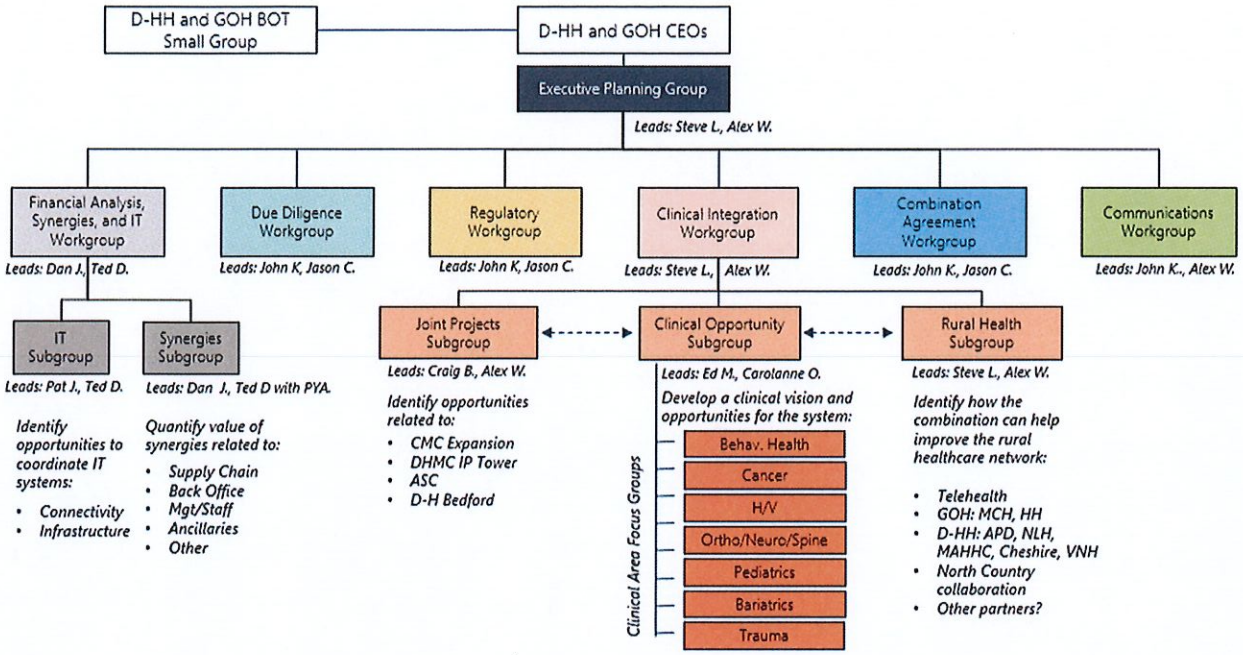
1. Assessing Community Needs

The Proposed Combination's organizing principle is the identification of those pressing community needs on which the Parties' combined expertise, resources and coordinated care delivery will have the greatest impact. After confirming that their missions are compatible and will be preserved and furthered by the Proposed Combination, the Parties then focused on the specific initiatives made possible by the Proposed Combination to address their strategic imperatives (see Notice Section II above) and meet the health care needs of the communities they serve. The Parties' most recent board-approved community needs assessments are included at Appendices IV(4) – (8) as required by NHRSA 7:19-b, (III). Although each assessment has unique features, they all reveal the following primary needs that the Proposed Combination will address: (i) greater access and availability of behavioral health and addiction treatment and prevention services; (ii) improved access to more affordable care in their communities; (iii) preparation for the needs of an aging population including greater availability of high quality, more affordable specialty and more complex care; and (iv) initiatives to improve the overall general health of their communities through greater primary care access, population health management and addressing social determinants of health. See Appendix IV(4).

2. Combination Evaluation and Planning Process

To assist with the evaluation and structuring of the Proposed Combination, D-HH and GraniteOne jointly engaged the national health care consulting firm, Chartis, as described in Section III(F) of this Notice. Chartis worked intensively with an Executive Planning Group consisting of D-HH and GraniteOne senior management officials to develop and oversee the

evaluation process. The Executive Planning Group commissioned the following work groups, assisted by Chartis, to address all elements of the Proposed Combination:



The Clinical Integration Workgroup performed the most extensive work over an eight month period and engaged internal and external stakeholders, culminating in the Chartis Integration Report referenced in Section III(F) above. See Appendices I(2) and IV(20) (*Confidential*). The Clinical Integration Workgroup was divided into three subgroups, each responsible for identifying opportunities related to capital projects, clinical opportunities, or rural health, respectively. The Clinical Opportunity Subgroup was further divided into groups focused on certain clinical services which met from April through July, 2019 and involved subject matter experts when appropriate.

To ensure that the evaluation and integration planning was thorough and identified synergies beyond clinical services, the Financial Analysis, Synergies, and IT Workgroup, which was comprised of two subgroups (one responsible for identifying opportunities to coordinate information technology systems and the other for identifying potential synergies that the

Proposed Combination could achieve), provided additional analysis. The Synergies subgroup met through April, 2019 and commissioned a study by PYA, P.C., an independent consultant (described further below), to estimate the dollar value of potential synergies.[35] See Appendix IV(3) (*Confidential*). The IT Subgroup also met through April, 2019, and conducted an initial assessment of D-HH and GraniteOne's information systems infrastructure and developed the information systems vision for the Combined System.

An initial working version of the Chartis Integration Report was distributed to D-HH and GraniteOne clinical and administrative leaders for comment in July, 2019. Chartis then summarized the Report for the Boards to inform their understanding and approval of the Proposed Combination in September, 2019 with further refinements to its analysis made in December, 2019. As noted in Section 6 of the Chartis Integration Report, D-HH and GraniteOne will continue to refine and update the business plans, including timelines, resources and tactics, necessary to implement each initiative. The final work plans will be submitted to the System Board for approval following the Combination Date.

3. Meeting Community Needs and Addressing Strategic Imperatives

The Chartis Integration Report identifies a number of initiatives that address the Parties' strategic imperatives and the health needs of their communities. Informed by the Report, the Parties documented their commitment to these initiatives in Section 5.3 of the Combination Agreement. These commitments include the enhancement of clinical programs in behavioral health; pediatric emergency, urgent care and neonatology; spine services and pain management; heart and vascular; orthopedics; trauma; oncology; and obesity management and bariatrics. The

[35] The Dartmouth-Hitchcock Health and GraniteOne Health Executive Summary Report of Efficiency Opportunities prepared by PYA, P.C. dated June 13, 2019 is confidential and considered competitively sensitive and for this reason is not subject to the New Hampshire Right-to-Know Law, RSA 91-A and is being provided to the Director under separate cover as "CONFIDENTIAL, EXCLUDED FROM RSA 91-A".

Parties also plan to expand their capacity and care coordination through rural hospital support, capacity expansion, integration of IT systems and additional telehealth services. Finally, the Parties plan to expand and improve their service infrastructure by aligning quality processes and metrics, developing new residency programs and extending access to clinical trials, continuing to improve the delivery of value-based care, and emphasizing workforce development strategies and initiatives. The Chartis Integration Report provides a detailed preliminary work plan for each initiative and estimates the cost and benefits of their implementation. The Parties continue to refine these work plans which will support and guide the Parties' collective effort to improve access to quality care and needed services in New Hampshire following the Combination Date.

4. Improving Access to Quality Behavioral Health Services

The Parties have identified myriad health care and health care-related community needs but none greater than in the area of behavioral health. While D-HH and GraniteOne members separately lead efforts to address the mental health and substance use disorder ("SUD") crises afflicting many of our citizens and affecting all New Hampshire communities, their efficacy is limited by a scarcity of resources, a paucity of providers, and a fragmented behavioral health care delivery system. The problem is most acute in southern New Hampshire, where overdose-related deaths, emergency department visits, and hospital admissions have stretched mental health and SUD treatment resources beyond their limits. Accordingly, the Parties are committed to behavioral health care as a top priority, and to sharing their expertise, jointly investing resources, integrating physical and behavioral health care, and optimizing telehealth capabilities to expand access to high quality mental health and addiction treatment services throughout the communities they serve and beyond.

Guided by the New Hampshire Department of Health and Human Services "10-Year Mental Health Plan," and with the assistance of expert consultants and stakeholder input, the Parties have prioritized several strategic areas in which their combined efforts can offer the most immediate benefit to the greatest number of patients. Through a coordinated and regionally distributed care delivery model the Parties will expand access to addiction treatment services, make integrated behavioral health and primary care more widely available, enhance behavioral health crisis services in emergency departments, and improve support for hospital inpatients with behavioral health comorbidities. Additionally, the Parties are committed to building strong foundational initiatives that grow the behavioral health care workforce and expand tele-psychiatry services, both of which are integral to sustaining their strategic priorities.

(a) Addiction Treatment Services (Strategic Priority #1).

The demand for addiction treatment and recovery services continues to outpace existing resources and programs, particularly in southern New Hampshire. While the "Doorway-NH" program has improved *access* to services through its regional points of entry and the 211 help line, there has been no commensurate expansion of treatment and recovery services themselves. (D-HH provides access to addiction treatment services through its "Doorways" at DHMC in Lebanon and Cheshire Medical Center in Keene, and supports the 24/7 operation of the program's 211 help line). Together after the Combination Date, D-HH and GraniteOne members will integrate and broaden their respective outpatient addiction treatment, medication assisted treatment ("MAT"), and specialized addiction treatment programs, e.g., "Moms in Recovery" at DHMC and "Roots for Recovery" at CMC for pregnant and parenting women, to expand the availability of addiction treatment and recovery services.

D-HH's intensive outpatient addiction treatment program offers individual and group therapy through a multidisciplinary team of psychiatrists, social workers, addiction counselors, recovery coaches, and resource specialists to facilitate ongoing support. The Proposed Combination will enable CMC to replicate this multidisciplinary approach to addiction treatment, including its standardized training materials and operating procedures, in southern New Hampshire, where it is most needed.

(b) Integrated Behavioral Health and Primary Care (Strategic Priority #2)

Given the relative dearth of intensive outpatient addiction treatment and recovery services, the Parties recognize that early behavioral health intervention is critically important. A "collaborative care model" that integrates behavioral health and primary care is a well-studied best practice that improves care quality, patient experience, treatment compliance, and clinical outcomes, avoiding unnecessary and costly emergency department visits and hospitalizations. The Parties will expand D-HH's well-established collaborative care model and their respective MAT programs to primary care sites throughout the D-HH GO System, integrating mental and physical health care services and SUD screening in order to assess and address the totality of patient needs at the first visit.

D-HH and GraniteOne members are leaders in the effort to build regionally integrated delivery networks ("IDNs") through New Hampshire's Delivery System Reform Incentive Program ("DSRIP") waiver, the federal funding for which will expire in December 2020. While the DSRIP has focused on the coordinated behavioral health and primary care of Medicaid beneficiaries, mental illness and SUDs cross all patient cohorts. The D-HH GO System will draw on its Members' combined resources, collective experience, and expanded collaborative care model to build upon the foundation laid by the DSRIP and sustain its objective

to establish a statewide integrated behavioral health network serving patients long after the program expires.

(c) Crisis Emergency Department Services (Strategic Priority #3)

The problem of access to behavioral health services in New Hampshire is felt most profoundly by hospital emergency departments ("EDs"), which have become the primary site of service for patients in behavioral health crisis. Most patients who seek behavioral health care in the ED, particularly those awaiting placement to an inpatient facility, do not receive adequate and timely care due to a lack of behavioral health providers in the ED. This delay and/or denial of treatment often exacerbates the patient's condition and leads to a longer length of stay either in the ED or in the hospital inpatient setting. The Parties are committed to using their combined resources and expertise to support the management, timely treatment, and early discharge of behavioral health patients in the ED.

CMC has developed a model program for identifying eligible patients and implementing MAT in its ED, with associated benefits in improved patient experience and engagement in treatment, reduced recidivism, and reduced reliance on overburdened inpatient addiction treatment services. D-HH oversees a tele-psychiatry service that provides on-demand psychiatric assessment and care management consultation to ten hospital EDs in New Hampshire. The D-HH Center for Telehealth provides equipment and technological support to the EDs and contracts with an out-of-state vendor for the psychiatric services.

A combined D-HH GO behavioral health program will expand access to tele-psychiatry services in the CMC ED, complementing its MAT capabilities. Providing timely and appropriate behavioral health care in the ED will bring a cascade of benefits to both patients and providers. Patients will receive the specialized care they need, which will improve their experience and

outcome, which will expedite their disposition or discharge, which will expand ED capacity for patients presenting with emergency medical or surgical needs, and which will reduce disruptive patient conduct that places ED staff in harm's way.

(d) Behavioral Intervention for Hospital Inpatients (Strategic Priority #4)

Many hospital inpatients receiving acute medical or surgical care also suffer from one or more behavioral health comorbidities. A recent assessment at CMC revealed that approximately 60% of inpatients had at least one behavioral health secondary diagnosis.[36] Without early intervention, these patients experience worse clinical outcomes, longer lengths of stay, greater costs, and the need for more health care resources than patients without behavioral health comorbidities.[37] The Parties are committed to identifying these patients early in their hospital stays and providing necessary treatment and support through a proactive, team-based "consult-liaison" psychiatry program.

D-HH has developed a model consult-liaison program known as the "Behavioral Intervention Team" or "BIT" to care for inpatients with co-occurring behavioral health conditions. The BIT is a multidisciplinary team comprised of psychiatrists, advance practice registered nurses ("APRN"), licensed clinical social workers ("LCSW"), and recovery coaches who work collaboratively with hospital-based medical and surgical providers to proactively screen patients for mental health and SUD comorbidities. BIT members participate in complex care rounds and diagnostic evaluation, making care management recommendations to the hospital-based team. They provide therapeutic support for patients and their families, as well as peer-to-peer guidance to staff for the duration of the patient's stay.

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[36] Data from iVantage iPM Clinical Report (8/1/19). MC FY19 Oct-May (annualized).
[37] Melek, Norris, Paulus, Matthews, Weaver, and Davenport, "*Potential Economic Impact of Integrated Medical-Behavioral Healthcare*," Milliman (January 2018).

While CMC employs teams of behavioral health providers, including psychiatrists, psychiatric nurse practitioners, psychologists, and LCSWs, and supports those inpatient behavioral health teams with a tele-psychiatry service provided by a third-party vendor, its ability to meet the behavioral health care needs of its patients is limited by the sheer volume of demand and difficulty in recruiting and retaining sufficient numbers of clinicians. The combination of D-HH and GOH will enable the Parties to share clinical resources and expertise to expand the BIT to CMC and other Combined System member hospitals, resulting in improved patient experience, reduced length of stay, better clinical outcomes, reduced care burden on medical and surgical providers, lower overall costs, and expanded inpatient capacity to meet rising demand.

(e) Workforce and Tele-Psychiatry Services (Foundational Initiatives)

The Parties have identified growth of the behavioral health care workforce and expanded tele-psychiatry services as foundational initiatives, on which the success of their strategic priorities largely depends. New Hampshire faces a behavioral health care workforce shortage no less alarming than the behavioral health crisis itself, particularly in rural communities. Psychiatrists, APRNs, psychiatric nurse practitioners, LCSWs, licensed nursing assistants ("LNAs"), and licensed clinical mental health counselors ("LCMHCs") are all in high demand and short supply.

One of the "Guiding Principles" set forth in the Parties' Combination Agreement is a commitment to "draw on [their] respective strengths to educate, recruit, develop, and retain the workforce required to meet the complex medical needs of the communities they serve." See Combination Agreement Section 1.6. D-HH is anchored by an academic medical center with a national reputation for innovative behavioral health care, offering psychiatric residency and

fellowship programs, including at New Hampshire Hospital where D-H provides the clinical staff. GraniteOne is anchored by an acute care, urban community hospital at the epicenter of the behavioral health crisis. The combined D-HH GO System will offer opportunities for professional development and diversity of experience to attract those high demand behavioral health providers and clinicians.

D-HH and GraniteOne members have led their respective IDN workforce development initiatives and, through the combination, they will be better-positioned to sustain a behavioral health workforce pipeline after federal funding for the DSRIP expires. Building on affiliations with Colby-Sawyer College, Manchester Community College, Granite State College and the University of New Hampshire, the Parties will target their combined resources to fulfill the workforce requirements of their expanded addiction medicine, collaborative care, MAT, and BIT programs.

One antidote to the statewide shortage of behavioral health care providers is the provision of tele-psychiatry services in primary care practice sites, the ED, and the hospital inpatient setting. As mentioned above, CMC utilizes a third-party vendor to provide tele-psychiatry services to support its inpatient behavioral health teams. D-HH oversees a tele-psychiatry service that uses an out-of-state vendor to provide on-demand psychiatric assessment and care management consultation to ten hospital EDs and two hospital inpatient units. A combined D-HH GO System will enable the Parties over time to integrate and strengthen their internal tele-psychiatry capabilities, reduce their reliance on third-party vendors who lack integration with the System's quality and cost initiatives, avoid costly duplication of services, and achieve economies of scale to defray the high cost of human resources and technological infrastructure necessary to support a robust tele-psychiatry service. Patients will benefit by

receiving behavioral health care close to home, delivered by New Hampshire-based psychiatrists whose local knowledge of the care network and community-based resources will promote more coordinated and higher quality patient care.

(f) Other Strategic Priorities

In addition to the four strategic priorities and two foundational initiatives above, the Parties have identified outpatient specialty psychiatric services, complex outpatient behavioral health services, and community-based crisis services as strategic priorities to be developed over a longer time horizon. These services are more complicated to deliver, they require the participation of multiple community-based partners, and the Parties believe they will not bring the most immediate benefit to the greatest number of patients.

C. DUE DILIGENCE (NHRSA 7:19-b, II (b))

NHRSA 7:19-b, II(b) requires that "[d]ue diligence has been exercised in selecting the acquirer, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed transaction, and in determining that the transaction is in the best interest of the healthcare charitable trust and the community which it serves..." The Parties' due diligence regarding each other and the structure and benefits of the Proposed Combination, as detailed below, was preceded by CMC's years-long ongoing assessment about the need and opportunities to partner with an academic medical center. Similar to the clinical relationships between CMC, MCH and HH which gave rise to the formation of GraniteOne, the clinical relationship between CMC and D-HH has developed over a decade of collaboration. These clinical collaborations provide the Parties with valuable experiential and cultural information

with which to determine whether D-HH is the best partner to accomplish the desired benefits of the Proposed Combination.

1. Requests and Document Review

D-HH and GraniteOne each formed both internal and external (independent) teams to perform due diligence and report their assessments to the Executive Planning Group, the Parties' senior management and their respective Boards. See Appendix IV(9). In an effort to be efficient and effective, one general report was produced and shared with the GraniteOne, CMC, MCH and HH Boards. Initial due diligence request lists were produced, reviewed and negotiated between the legal counsel of D-HH and GraniteOne, with input from counsel to CMC, MCH and HH. Independent consultants were engaged (listed and described below), and in many cases, these firms made additional information requests. All of the more significant information request lists shared among the Parties are provided at Appendices IV(10) – (15) to provide a basis for what was reviewed and considered to inform the Boards about the Parties, their assessment of the ability of the System to execute on the intended initiatives and goals of the Proposed Combination, including enhancement of the Parties' respective missions, and the Boards' decisions to participate in the Proposed Combination.

While GraniteOne took the lead in reviewing and summarizing due diligence for its member hospitals, CMC, MCH and HH each provided its own information in response to the D-HH requests and in some cases made individual information requests of D-HH for matters not covered by GraniteOne. The Parties exchanged diligence information on a secure online data sharing room administered by the law firm Hinckley Allen, to which room access was restricted to individuals authorized by the respective legal counsel and Chief Financial Officers of each of the Systems.

D-HH appointed its Director of Strategic Integration to coordinate and manage the efforts of its 25-member internal due diligence team, each of whom was provided access to the secure online data sharing room. The GraniteOne 20-member internal due diligence team was managed by the GraniteOne General Counsel office with coordination efforts led by the CMC Director of Project Management. External expert advisors identified in subparagraph (c)(ii) below assisted the D-HH and GraniteOne internal team's document requests and review, which covered an exhaustive list of topics.

Preliminary assessments were made and shared with senior management throughout the process beginning in May 2019. A more thorough reporting to each of the Parties' Boards was made in September. For GraniteOne, CMC, MCH and HH, a draft written report inclusive of the independent consultant reports was posted and shared with the respective board portals for all board members to review or discussed at board meetings. For D-HH, due diligence presentations were made by the D-HH Chief Legal Officer and the Chief Financial Officer to the D-HH finance committee in June, August and September and to the full D-HH Board on September 13, 2019.

While due diligence was performed at various stages of the negotiation and discussion process and draft reports were made to the Boards to help inform their decisions to proceed with the Proposed Combination, like all transactions, due diligence remains an on-going process and will continue until consummation of the Proposed Combination. The Parties' Boards expect an update on due diligence prior to consummation of the Proposed Combination.

(a) Engagement of Expert Advisors

The Parties individually or jointly engaged a number of legal, industry, financial and management consultants and advisors each with expertise to help the Parties' Boards identify

and articulate the need to combine systems, the decision to combine systems, the selection of the Parties as partners and the strategic, clinical and integration plans for the Combined System. The following summarizes the engaged expert advisors:

The Parties are each represented by legal counsel. GraniteOne, CMC and the CMC Subsidiaries are represented by the GraniteOne and CMC offices of General Counsel. MCH and HH are jointly represented by the law firm of Orr & Reno, P.A.[38] GraniteOne, CMC, MCH, HH and the CMC Subsidiaries are represented before the New Hampshire Antitrust Bureau and the Federal Trade Commission by the law firm Winston & Strawn, LLP.[39] D-HH is represented by the D-HH office of General Counsel and the law firm of Hinckley, Allen & Snyder, LLP. The law firm of Mayer Brown LLP represents D-HH before the New Hampshire Antitrust Bureau and the Federal Trade Commission.[40,41]

Unrelated to this Notice but pertinent to the antitrust regulatory review, the D-HH and CMC's General Counsel jointly retained the firm NERA Economic Consulting on behalf of their respective clients to assist with market analysis.[42]

In early August 2018, the D-HH's and CMC's General Counsel jointly engaged the national healthcare consulting firm, Chartis[43]. Chartis is a comprehensive advisory and analytics services firm that focuses on the healthcare industry. Chartis has played and continues to serve a pivotal role in assisting, guiding and facilitating the Parties' respective executive leadership teams and their Boards as follows:

- Confirming each Party's strategic imperatives to partner;

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[38] See: https://orr-reno.com/
[39] See: https://www.winston.com/en/
[40] See: https://www.hinckleyallen.com/
[41] See: https://www.mayerbrown.com/en
[42] See: https://www.nera.com/
[43] See: https://www.chartis.com/

- Assisting with the evaluation of how each party could help each other better meet community needs as a more integrated system;
- Identifying, confirming and articulating opportunities for beneficial integration and operational efficiencies that could be achieved as a more integrated proposed combined system (informed by Chartis' expertise and knowledge of the New England and National healthcare markets);
- Developing, agreeing and articulating the vision of the Combined System;
- Developing a high-level business plan for the Combined System;
- At the direction of and in assistance of legal counsel, serving as discussion facilitators in developing a system corporate, governance and management structure;
- Assisting with due diligence;
- Performing financial modeling and facilitating discussions around capital needs of the Parties (individually) and the Combined System;
- Assisting legal counsel with financial and market assessments to prepare regulatory filings;
- Facilitating and assisting with the development and articulationn of the Parties' Clinical Integration Strategy (as defined hereinbefore, the Chartis Integration Report); and
- Supplementing each of the Parties project management departments for certain workgroups.

The process for facilitation and negotiations followed a well-defined work plan overseen by the two system CEOs and led by the Executive Planning Group comprised of members of the Parties' senior leadership and legal counsel. The Chartis work flow and work group process was discussed above at Section IV(B)(2). See also Appendices I(2) and IV(20) (*Confidential*).

As previously noted in Section IV(B)(2), the firm PYA was retained jointly by General Counsel to aid in the quantification of some of the potential combination specific efficiency opportunities identified by the Parties' Financial Analysis and Synergies workgroup.[44] PYA's work was limited in scope to investigate a few of the potential synergies identified in a "black box" setting to quantify the financial benefit of certain combination specific opportunities identified. From the eight (8) opportunities identified, the largest one being a move to a more

[44] See: https://www.pyapc.com/

consolidated and uniform supply chain, PYA estimated that the three (3) year cumulative savings to the proposed system could range from $12.5 million to almost $32 million. While more investigation is needed and other initiatives require assessment, PYA informed the Boards that efficiency opportunities exist only if the integration anticipated by the Proposed Combination is put into effect and that the potential savings are material, particularly in light of the Parties' razor thin operating margins. See Appendix IV(3) (*Confidential*).

CMC also retained the firm Echo Financial Products, LLC ("Echo") to assess and quantify the potential and preliminary financial savings (based upon then existing market conditions) that could be attained by CMC, MCH and HH joining the Dartmouth-Hitchcock Obligated Group.[45] In a detailed comparison of the Parties' various existing debt structures and terms and extrapolating what the terms would be if the GraniteOne members were to join the D-HH Obligated Group, Echo estimated an annual savings to GraniteOne of approximately $470,000 per year (based on market conditions in May 2019). The difference in cost and timing of capital for the funds necessary for the CMC Expansion Project, estimated a savings of almost $188,000 thousand per year by funding the project through the D-HH Obligated Group. See Appendix IV(16) (*Confidential*).[46]

The efforts of Chartis, PYA and Echo, each acting independently, helped inform the Parties' Boards that there are opportunities to achieve savings through greater integration as a combined system and that joining the D-HH Obligated Group, both in terms of refinancing their existing debt and for planned capital projects in the future, could result in a lower cost of capital

[45] See: http://www.echo-fp.com/

[46] The Acquisition Funding Refinancing Opportunities report prepared by Echo Financial Products, LLC dated May 7, 2019 is confidential and considered competitively sensitive and for this reason is not subject to the New Hampshire Right-to-Know Law, RSA 91-A and is being provided to the Director under separate cover as "CONFIDENTIAL, EXCLUDED FROM RSA 91-A".

and a quicker deployment of those investment resources. If achieved, these cost savings are a clear and quantifiable benefit to the Parties and their abilities to serve their communities' needs.

Several other subject matter experts were retained by the Parties to inform their respective legal and financial due diligence which were incorporated in draft reports to the Parties' Boards. General Counsel to GraniteOne and CMC retained:

- the law firm of Devine, Millimet & Branch, Professional Association to assist the General Counsel office with legal due diligence for GraniteOne and its member hospitals[47];
- the accounting firm of Baker Newman Noyes, LLC to perform financial due diligence and supplement internal assessments[48];
- Sibson Consulting to perform a financial review of the D-HH pension plan[49];
- the actuarial firm Milliman[50] to perform an actuarial review of the D-HH captive liabilities and reserves.

To assist with internal and external communications – including a communications plan to keep the public informed during this process – each of the Parties used its internal public relations teams and engaged the firms Granite Edge Consulting, The Spradling Group and public and government relations individuals employed by the Diocese of Manchester.

Finally, as discussed in greater detail in Section V(B) below, CMC retained the National Catholic Bioethics Center ("NCBC") and Canonist, Rev. Francis Morrisey to perform an ethical analysis of CMC's ability to participate in the proposed Combination and ensure its ongoing adherence to the moral Catholic teaching, the ERDs and Canon Law.[51] See Section IV(B) of this Notice and Appendices V(1) – (2).

General Counsel to D-HH retained:

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[47] See: https://www.devinemillimet.com/
[48] See: https://www.bnncpa.com/
[49] See: https://www.sibson.com/
[50] See: http://us.milliman.com/
[51] See: https://www.ncbcenter.org/

- the accounting firm of PricewaterhouseCoopers, LLP to perform financial due diligence of CMC, MCH and HH[52];
- Willis Towers Watson to perform a financial review of the CMC pension plan[53];
- Kaufman Hall to assist with a review of the CMC, MCH and HH debt and respective obligated groups[54]; and
- Hinckley Allen to assist with due diligence review, and which is in the process of completing a controlled group assessment for purposes of determining whether the Proposed Combination will result in a controlled group (this assessment will be shared with GraniteOne and its members).

In addition to the D-HH internal public relations team, the firm Montagne Communications was retained to assist D-HH with internal and external communications.

MCH and HH also retained independent consultants to assess their GraniteOne participation to date and partnership opportunities, including alternative partners to the Proposed Combination. MCH retained the consulting firm BKD Advisors[55] which assisted the Board of MCH with its past partnership assessments including its decision to form and participate in GraniteOne. HH retained the consulting firm Stroudwater Associates[56] which also had advised the HH Board in the past.

2. GraniteOne, CMC, MCH and HH Board Review Process

The following is a narrative of the review processes that the GraniteOne Board and its members' Boards – CMC, MCH and HH – engaged upon to exercise their due diligence:

Partnering with a larger system and academic medical center has been a long-standing strategic goal of CMC for its urban, high acuity community hospital which serves a large, aging and diverse population in a highly competitive market. By 2017, CMC had executed a

[52] See: https://www.pwc.com/
[53] See: https://www.willistowerswatson.com/en-US
[54] See: https://www.kaufmanhall.com/
[55] See: https://www.bkd.com/industries/health-care
[56] See: http://www.stroudwater.com/

successful five-year strategic plan to address its strategic needs including a reinvigoration of its Catholic identity, the development of its transfer center, expansion of NEHVI and participation and formation of strategic partnerships culminated by its participation and leadership in GraniteOne. CMC's next phase of its strategic plan beginning in 2017 has been to lead and develop GraniteOne and system initiatives; build and execute upon a comprehensive and innovative workforce development plan; expand CMC's capacity through new construction, facilities planning and achieve operational excellence; advance its support of rural healthcare; expand specialty services; implement an electronic medical record system; and balance and expand upon CMC's tertiary care relationships with both Massachusetts General Hospital ("MGH") and D-HH.

CMC has a long history of collaborating with D-HH to deliver clinical services dating back to CMC's opening of "The Mom's Place" in 2005. Through contractual arrangements D-HH and CMC have been working to ensure some availability to the greater Manchester area of services in endrocrinology, internal medicine, pediatrics, primary care and family medicine, pulmonary, rheumatology, surgical services and support of the CMC Women's Wellness & Fertility Center. CMC also began a clinical affiliation with MGH in 2015 and considered a mutual project of some type with MGB in NH in 2018.[57, 58]

By working with these two academic medical centers, CMC gained experiences that helped inform the CMC Board about how the two potential partners operated. It was able to

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[57] Cardiac and vascular care, neurosurgery, substance use disorder, surgical services, trauma support and telepsychiatry.

[58] See: https://www.catholicmedicalcenter.org/about-cmc/newsroom/news/2018/april/cmc-explores-medical-facility-at-tuscan-village-in (Note: Negotiations, planning efforts and the executed letter of intent were terminated by mutual consent on March 31, 2019, in part because negotiations and discussions of a plan for Salem were unsuccessful from CMC's perspective and in part because of the announcement of the Proposed Combination. MGB just recently announced that plans have been agreed to with the developer, see: https://www.unionleader.com/news/health/partners-healthcare-announces-plans-for-outpatient-center-in-tuscan-village/article_4015ad0f-8135-578f-a161-67dcef46b972.html

assess their cultures and determine which could best work with CMC and its GraniteOne partners to meet their community needs in New Hampshire. These experiences were shared with the GraniteOne Board. At almost every Board meeting beginning in 2017, a status report on how the two relationships were going was made to the CMC and GraniteOne Boards and discussions ensued during more substantive updates around culture, negotiations regarding a joint project with MGH in Salem and opportunities for service collaborations. Service collaborations – particularly through limited contractual relationships – were expensive and of limited success.

By the Fall of 2017, D-HH approached CMC to discuss opportunities to expand outpatient services in Manchester and look for ways to work together to better meet community needs. Discussions were focused on specialty services in the Manchester area and outpatient services. D-HH and CMC were represented by their respective in-house General Counsel offices during these discussions. The discussions revealed the limitations imposed on a more expansive and effective collaboration between D-HH and CMC imposed by the lack of integration and alignment on the full continuum of care. Without being financially, clinically and operationally integrated, the opportunities to expand services were both expensive and accompanied by a disproportionate return on any necessary investment. Moreover, CMC was beginning to experience more significant capacity challenges than it had in the past, which challenges impaired its ability to assist D-HH patients on a consistent basis. The ability to expand clinical services to meet community needs became extremely challenging and limited under the non-integrated transactional "one-off" structure of hiring D-HH for clinical services through professional services agreements. Because CMC and D-HH had been working together for so long, they each understood very clearly and quickly the strategic and community benefits of working together in a more integrated manner. CMC and D-HH also had a good understanding

of the other's respective cultures and culture compatibility. Discussions evolved to exploring the benefits and the impact to community needs and patient care that a larger, more integrated system could have for southern New Hampshire. During the on-going CMC Board updates about these discussions and in acknowledgement that one academic health system was Boston-based and the other New Hampshire-based, the CMC Board began to recognize the need to more fully integrate with one of the systems in the future.

By the Spring of 2018, D-HH approached CMC to discuss D-HH's need for a southern inpatient presence and proposed discussions to explore how combining systems would enable the Parties to establish the care delivery models that were being discussed with CMC. CMC was receptive and discussed GraniteOne's strategic challenges and its need for an academic medical partner. With their good understanding of each other informed by their history, CMC and D-HH decided to tackle the challenging questions to combining systems early on by investigating options and potential key terms of what a more integrated delivery model would look like accounting for identity, community needs, capital needs, a desire for a two region distribution and management of clinical services, governance and structure. During its June 2018 meeting, the CMC Board, endorsed the recommendation by CMC President and CEO, Dr. Pepe and D-HH Chief Executive Officer ("D-HH CEO"), Joanne M. Conroy, MD ("Dr. Conroy"), that the parties conduct a preliminary level of due diligence over the summer and explore the potential for an agreement on a preliminary system structure and proposed key terms for a Board discussion in the Fall. The expectation in the Fall being that the Board would be asked for a "go/no-go" endorsement to proceed with negotiating a more formal letter of intent or look to explore alternatives.

The Summer 2018 exploration efforts were led by a joint Executive Planning Group which included the CMC Chief Operating Officer, Chief Financial Officer and General Counsel and the D-HH Chief Strategy Officer, Chief Financial Officer and Chief Legal Officer. CMC and D-HH engaged their respective antitrust legal counsel and the consulting firm NERA Economics was jointly retained by General Counsel to preliminarily assess the markets. The Parties also jointly retained Chartis to facilitate discussions on "pressure point" matters, help identify and articulate clinical and community need opportunities and assist with analytic modeling on what a combined system would look like and what analytical information would need to be assessed if the Boards decided to proceed with discussions in October. As part of the "go/no-go" preliminary due diligence and proposal process, it is worth noting that during the summer, CMC continued to negotiate the possible acquisition of property north of its main campus to build an expansion. With the likelihood of reaching agreement on a letter of intent to acquire the property increasing, the Parties began to discuss the capacity constraints of CMC and what the needs would be to carry out the proposed two region care model that the Parties were exploring. The inclusion of a plan and ability to increase CMC's capacity to meet the needs of the community and two region distribution model became an important component of the Board's deliberations.

To inform their "go/no-go" decision, the Boards also required a sense that their specific identities would be preserved within a combined system. For CMC, the Proposed Combination would need to preserve CMC's Catholic identity and ensure it will continue to follow moral Catholic teaching, the ERDs and Canon Law. Through regular meetings with Dr. Pepe, the Bishop had been informed of clinical relationships with MGH and D-HH and was made aware of the discussions of the Proposed Combination and discussed a process for his review and

consideration of the Proposed Combination. Additionally, to inform the CMC Board and subsequently the GraniteOne Board, CMC engaged the NCBC and the Bishop in early September 2018 to summarize the preliminary contemplated governance and clinical structure and shared their preliminary assessments and answers to potential moral and ethical matters.

In September 2018, the Boards of CMC and D-HH met separately, with each discussing and deliberating the question as to whether there was consensus to proceed with the process including a move to draft a letter of intent. The discussions included a presentation by Chartis on the current healthcare landscape in New England, the challenges to all hospitals and those that the GraniteOne members and D-HH members are facing, the community and clinical opportunities of the Proposed Combination, preliminary analytics, capacity needs and a defined process and timeline for moving to next steps in the process. See Appendix IV(17) (*Confidential*). Board discussions were led by the Board chairs and members of the Executive Planning Group which in the case of CMC, included a discussion of its Catholic identity and the process for assessing any issues and informing the Bishop. The CMC Board concluded a desire to communicate to GraniteOne its desire that GraniteOne "go" towards next steps in the process in furtherance of its strategic imperatives. Pursuant to the GraniteOne structure, GraniteOne is unable to initiate a transaction like the Proposed Combination – it needs to ratify an action by the Member Boards. See Article V, Section 5.3 at Appendix III(3).

The GraniteOne Board met on October 4, 2018, had the same presentation by Chartis and held its own deliberations from the GraniteOne system perspective. See Appendix IV(18) (*Confidential*). There was a consensus in the GraniteOne Board to "go" towards next steps in the process. A small group of CMC and GraniteOne Board members began to interact directly to meet each other and begin to discuss community needs and a vision for how the Proposed

Combination can better meet those needs and improve the efficiency and effectiveness of the stewardship of their respective hospitals.

The discussions to combine GraniteOne with D-HH were initially driven by CMC but the Proposed Combination continues the GraniteOne commitment to support rural healthcare in New Hampshire. D-HH is the only potential partner to GraniteOne with a proven record of supporting and benefiting rural healthcare. Up to this point, MCH and HH, like CMC, also had executed on a successful strategic plan with their formation of and participation in, GraniteOne. The decision to participate in GraniteOne was made as a result of lengthy negotiations between CMC and HH and CMC's responses to an RFP process by MCH. Both identified GraniteOne as a system that was designed to grow, to move towards integration gradually but offered a level of independence. Although the GraniteOne "affiliation" was relatively new, MCH and HH and the patients they serve had seen modest progress towards some of the intended goals of the system. Physician recruitment and staffing have improved, reducing staffing gaps; services have been expanded to increase access for patients of MCH and HH; capital investments have been made in telehealth services technology to improve quality of care, and the member hospitals have achieved modest cost savings to secure the services of locum tenens physicians. At the same time, GraniteOne's ability to fully realize many of the goals of the affiliation have been hampered by the system's lack of financial integration, limited capital, and the short time GraniteOne existed before discussions with D-HH became more serious.

With GraniteOne representation on the Boards of MCH and HH, general discussions about the need to grow GraniteOne and potentially become or join a larger system had been ongoing since GraniteOne's formation. As noted above, at the October GraniteOne Board meeting, the possibility of a combination with D-HH was discussed. Dr. Pepe and GraniteOne

Chief Operating Officer, Alexander Walker made presentations and led discussions about a potential D-HH combination in October, November and December. MCH and HH began the process of seeking stakeholder engagement, including engaging their employees in discussions about the idea of joining a larger system beginning on October 30, 2018 (discussed in greater detail below).

By December of 2018, an extensive and detailed non-binding letter of intent by and between D-HH and GraniteOne was circulated to the Boards. The Board meetings included an updated presentation by Chartis, presentation of the letter of intent by members of the Executive Planning Group and presentation of a preliminary public communications plan and next steps in the process, including due diligence, negotiations of definitive terms, and further exploration of the desired integration efforts and benefits. See Appendix IV(19) (*Confidential*). The purpose of the letter of intent – which is between the two systems but contemplates a member substitution of CMC, MCH and HH which would require the member hospitals to be a direct party to any resulting binding definitive agreement – was to set out the vision and proposed structure to serve as a guideline for negotiations of the definitive agreement. The D-HH and GraniteOne legal counsel and members of the Executive Planning Group met with members of the Attorney General's office including the Director of Charitable Trust Unit on December 18, 2018 to inform the office of the discussions and potential execution of the letter of intent. By the end of December, the draft letter of intent was circulated to the Boards of CMC, MCH and HH. The Boards of MCH and HH jointly retained the law firm of Orr & Reno, P.A. to review, negotiate and advise their boards of the terms, satisfaction of their duties and represent their interests in the process.

The Boards of CMC, MCH and HH called special meetings on January 8, 2019, January 9, 2019 and January 11, 2019 to discuss and deliberate the letter of intent. Since the individual hospitals were not direct parties of the letter of intent, no votes were taken to approve the letter of intent, however, in order to initiate the approval of GraniteOne within the GraniteOne governance structure, the CMC Board resolved to affirm its intent and desire to participate in the more integrated and combined system and recommended that the GraniteOne Board approve the letter of intent to continue through that process. The MCH and HH Boards informally discussed the desire to move forward in the process and GraniteOne appointees to the MCH and HH Boards offered opportunities in those discussions for any Board member to raise an objection to moving forward.

On January 14, 2019 the GraniteOne Board approved the Letter of Intent and authorized its execution. On January 23, 2019 the D-HH Board approved the Letter of Intent and authorized is execution. The Boards announced the Letter of Intent publically on January 24, 2019 and requested that it be posted on the newly created website designed to inform the public about the Proposed Combination.[59] On January 25, 2019, the Parties began to engage the Antitrust Bureau of the New Hampshire Department of Justice to begin discussions of a plan of engagement and information sharing. A call occurred with the FTC on February 1, 2019 to discuss the same.

In February 2019, the Executive Planning Group approved the work plan approved by Chartis that was proposed to the Boards in January. This work plan is discussed in detail in Section IV(B)(2) of this Notice and in Appendix IV(20) (*Confidential*); see also Appendix I(2) (*Confidential*). The Parties began execution of the work plan, including the commencement of the more formal and rigorous due diligence process and retention of financial due diligence

[59] See: https://www.forahealthiernh.org/letter-of-intent/

consultants. See Section IV(B)(2) above and Appendices IV(9) – (15). The Executive Planning Group continued to meet in person on a bi-weekly basis to oversee the work plan and negotiate terms. This group was expanded to include the CEOs of MCH and HH and legal counsel to MCH and HH. Status reports and updates to the Board were standing agenda items at all Board meetings.

In April 2019, the MCH and HH Boards began the process of a more detailed discussion and evaluation of how the Proposed Combination would advance their community needs and evaluate their alternatives. In addition to working with their counsel, the Boards engaged independent expert advisors. The MCH Board retained BKD, LLP, a finance and healthcare consulting firm which was used by MCH in the past to assist with the evaluation of its joining GraniteOne. HH Board engaged Stroudwater Associates to provide the same assessment for HH. To assist with an assessment of how D-HH has supported rural hospitals in the past and to understand the need for the level of integration being proposed, Chartis worked with D-HH Executives to prepare and lead discussions with the HH and MCH Boards. On April 24, 2019 and May 2, 2019, D-HH Chief Strategy Officer, Steve LeBlanc and Chief Financial Officer, Daniel Jantzen attended meetings with the MCH and HH Boards respectfully, to engage in that discussion and share their experiences of the existing D-HH system. See Appendix IV(22) (*Confidential*).

On May 9, 2019, the Boards of GraniteOne, CMC, MCH and HH had their annual Board fiduciary training meeting. At this meeting, Director Thomas Donovan provided a presentation on the Charitable Trust Unit and fiduciary duties at the request of the Boards. Chartis then provided its perspective, as a national health care advisor and subject matter expert, on the

reasons for the Proposed Combination and the strategic needs and imperatives it addressed. See Appendix IV(21) (*Confidential*).

During the months of May through August, the Parties' consultants and members of the Executive Planning Group continued work on due diligence, negotiations and drafting of the Combination Agreement, and development of the Clinical Integration Strategy. A summary of key terms of the Combination Agreement draft were circulated to the Boards of GraniteOne, CMC, MCH and HH for review at the June 2019 Board meetings with some preliminary presentation and discussion led by the Parties' respective legal counsel.

On August 28, 2019, the draft Combination Agreement was posted on the GraniteOne Board portal for review. On September 5, 2019, the GraniteOne Board discussed the terms of the Combination Agreement. A presentation was made summarizing the terms and the Board discussed the agreement. Towards the end of the discussion, the Parties' CEO's voiced their support for the Proposed Combination.

By early September, all of the Parties circulated to their respective Boards, a more formal due diligence report inclusive of the reports done by independent third parties (see Section IV(C)(1)(a) above), the draft Combination Agreement and an executive summary of the Clinical Integration Strategy for the Boards' review.

In addition to being informed with respect to due diligence, the benefits, strategy and implementation plan of the community and clinical initiatives and the fully negotiated terms of the Combination Agreement, the CMC Board and the Board of Governors of CMCHS needed to know whether the structure sufficiently preserved CMC's Catholic identity. On September 19, 2019, the Bishop, the Chancellor of the Diocese, the Bishop's Delegate and the Vicar of Canonical Affairs were given copies of the draft Combination Agreement, a draft letter of

assessment by Fr. Morrisey assessing Canon Law and a thorough moral analysis by the NCBC. On September 19, 2019, CMC Vice President and General Counsel met with the Chancellor and the Bishop's Delegate to review the Combination Agreement and answer questions and address any suggested revisions. On September 19, 2019, Dr. John Di Camillo of the NCBC met at the Diocese with the Bishop, Dr. Pepe, the Chancellor, the Bishop's Delegate, the CMC Director of Catholic Identity and the Director of Governmental Affairs. They discussed the Combination Agreement, the NCBC moral analysis and discussed continued education efforts going forward. By letter, on September 23, 2019, the Bishop informed the Bishop's delegate that they had reviewed the Combination Agreement and related moral and canonists' assessment and that he supported the Proposed Combination and instructed the Bishop's Delegate to approve the Proposed Combination and the Combination Agreement on his behalf. At the CMC Annual Retreat, the CMC Board deliberated the Proposed Combination and the Combination Agreement. General Counsel to CMC discussed the standards of NHRSA 7:19-b and how they have been addressed by the Board through the process. After further discussion, the CMC Board approved unanimously the Combination and the Combination Agreement, including the Clinical Integration Strategy contemplated therein. See Appendix IV(24). The CMCHS Board of Governors approved the same by unanimous written consent and requested the Bishop's nihil obstat. The Bishop issued his *nihil obstat* that afternoon. See Appendices IV(28) and V(1). On September 25, 2019, the MCH Board met, discussed and unanimously approved the Proposed Combination and the Combination Agreement. See Appendix IV(25). On September 24, 2019, the HH Board met, discussed and approved the Proposed Combination and the Combination Agreement. See Appendix IV(26). The Boards of the CMC Subsidiaries approved the

Combination and the Proposed Combination by unanimous consent resolutions. See Appendices IV(29) – (32).

On September 30, 2019, after CMC, CMCHS, the Bishop, MCH and HH approved the Proposed Combination and the Combination Agreement and after a Board discussion of the requirements of NHRSA 7:19-b, the GraniteOne Board approved the same unanimously and ratified the approval acts of CMC, MCH and HH pursuant to its reserved powers and in so doing, approved the clinical integration strategy. See Appendix IV(23). The Parties informed the public on October 2, 2019 that the Combination Agreement was approved and executed and that the Parties would begin the regulatory process.[60] The Combination Agreement was posted on the Parties' websites to begin affording the public an opportunity to review and become informed of the terms of the Proposed Combination including the Parties' mission, vision, principles and clinical services integration plans.[61]

3. D-HH Board Review Process

In order to advance the mission of New Hampshire's only academic health system, D-HH has long sought a deeper presence in southern New Hampshire, the state's most densely populated region. Despite having three well-established, multi-specialty physician group practices in Concord, Manchester and Nashua, D-HH's ability to provide efficient, coordinated services across the ambulatory, outpatient, and inpatient continuum of care is limited by the lack of a D-HH controlled hospital in the region. In addition to offering patients expanded clinical services that can be delivered more efficiently and cost-effectively closer to home, a D-HH controlled hospital would offer greater research, teaching, and clinical trial opportunities in the

[60] See: https://www.forahealthiernh.org/news/
[61] See: https://www.forahealthiernh.org/news/combination-agreement/

region, lest academic medicine in southern New Hampshire be surrendered to out-of-state providers like Mass General Brigham or Beth Israel Lahey.

In 2008, with the assistance of Chartis, MHMH and DHC operating jointly as "Dartmouth-Hitchcock" ("D-H") undertook a comprehensive strategic planning process that identified growth in southern New Hampshire, among other things, as a strategic imperative to achieve the healthiest population possible and to support its clinical, education and research programs. The formation of D-HH and the unconsummated but distinguishable transaction with CMC in 2009-10, (*see* Section 3(H) above), was an attempt to achieve that strategic imperative. In 2015, the D-HH Board of Trustees (the "D-HH Board") reaffirmed the importance of growth in southern New Hampshire as a strategic area of focus and crucial to D-HH's long-term sustainability. Shortly thereafter, D-HH and Elliot Health System engaged in serious affiliation discussions, which were terminated by mutual agreement of the parties in early 2017.

Following the arrival of new D-HH CEO, Dr. Conroy, in August 2017, and some foundational work through the fall of 2017, D-HH senior leadership, supported by Chartis and guided by an "Ad Hoc Strategic Planning Committee" of the D-HH Board, developed a comprehensive and inclusive process for reframing the D-HH strategic plan. Launched in February 2018, the process was informed by surveys of more than 100 key stakeholders from across the D-HH System, data analysis, and demographic and health care market dynamics across the region. A day-long "Strategic Planning Session" attended by more than 100 senior leaders from across the D-HH System, community representatives and partner organizations followed on April 26, 2018. In its presentation at that session, Chartis observed that the nature of D-HH's presence in southern New Hampshire was the most pressing strategic question for most survey respondents. Based on robust discussion and feedback from the planning session, senior

leadership developed an emerging strategic agenda of issues for review by the D-HH Board, e.g., workforce, rural health care, system integration, and at the center of which was the southern New Hampshire question.

On May 21 and 22, 2018, the D-HH Board held a two-day retreat to review and refine the emerging strategic agenda. Following presentations and discussion led by Chartis, the D-HH Board unanimously endorsed the strategic agenda and authorized senior leadership to establish work groups to further refine the issues and recommend short- and long-term initiatives to achieve each element of the plan. The recommendations of these work groups comprise the Dartmouth-Hitchcock Health Strategic Plan (the "D-HH Strategic Plan"), which was formally approved by the Board at its quarterly meeting on September 21, 2018. Implementation of the southern New Hampshire component of the Plan entails a two-pronged approach that expands D-HH's ambulatory services and establishes an inpatient presence.

As the Strategic Plan was being developed throughout 2017 and 2018, senior management kept the D-HH Board updated about opportunities for growth in southern New Hampshire. Initial discussions, informed by health care consultant Kaufman Hall, revolved around the most cost-effective manner of executing the ambulatory prong of the southern New Hampshire strategy. As the D-HH Board considered its options, it took account of D-HH's continued relationship with CMC, with whom D-H physicians in Manchester had enjoyed long-standing professional service agreements. That relationship was buttressed by strong cultural alignment and the parties' mutual interest in cost-efficient, value-based contracting and high quality, coordinated care. Given the synergies between D-H's large physician network and its broad array of outpatient specialty services and CMC's inpatient capacity and hospital-based services, the value of a joint ambulatory care strategy was plain. At its meetings in September

and December 2017, the D-HH Board authorized senior leadership to further explore the contours of a potential outpatient and specialty care partnership with CMC.

As D-HH's strategic planning process evolved through the first half of 2018, so too did the discussions with CMC. The initial, limited vision for a joint outpatient strategy grew into a broader discussion of the benefits that a combined D-HH GraniteOne System could offer, taking full advantage of the systems' synergies to form a New Hampshire-based, integrated and regionally distributed health care delivery system. At its meeting on June 22, 2018, the D-HH Board received a comprehensive overview of D-HH's strategic options in southern New Hampshire, presented by senior leadership and Chartis. The relative merits of partnership and cultural alignment with several organizations were reviewed, including Partners Healthcare (now Mass General Brigham), Healthcare Corporation of America ("HCA"), SolutionHealth, Concord Hospital, St. Joseph Hospital, and GraniteOne. The relative merits and risks of a "go-it-alone" strategy were also reviewed. Following a thorough discussion, the D-HH Board accepted senior leadership's recommendation to seek a combination with GraniteOne and authorized work toward a letter of intent.

Throughout the summer, management teams from D-HH and GraniteOne met regularly to discuss the benefits that a D-HH GraniteOne combination could bring to patients, both rural and in southern New Hampshire. At its meeting on September 21, 2018, at which the D-HH Board approved the Strategic Plan and the construction of an ambulatory surgery center on the grounds of the DHC in Manchester, the D-HH Board received a status update on those discussions and authorized senior leadership to continue working toward a letter of intent. Throughout the fall, management teams continued to meet regularly to reach agreement on key terms, including the clinical, academic, and financial benefits of combination and an appropriate

corporate, governance, and management structure. The parties agreed to separately conduct cultural assessments and share results. Meetings involving the CEOs and select trustees of D-HH and GraniteOne also were held. Senior leadership made presentations to D-HH Member CEOs and provided a detailed update on all these efforts to the D-HH Board at its meeting on December 7, 2018. Following discussion and input from D-HH Board members, the D-HH Board expressed its full support for finalizing the letter of intent. At a special meeting held on January 23, 2019, the D-HH Board unanimously approved the letter of intent, authorized its execution by the D-HH CEO, and authorized management to conduct due diligence and negotiate the terms of a combination agreement with GraniteOne and its members. As noted above, the letter of intent was posted to the parties' public website at www.forahealthiernh.org.

The D-HH Board received comprehensive and detailed updates on the progress toward a combination agreement at its quarterly meetings in March, June, and September 2019. At a special meeting held on September 30, 2019, the Board unanimously approved the Combination Agreement, authorized its execution by the D-HH CEO, and authorized management to complete due diligence and seek the necessary regulatory approvals in order to close the transaction. See Appendix IV(27). As the resolution approving the Combination Agreement declares, "after thorough consideration of various options for achieving its strategic goals, the D-HH Board determined that combining [D-HH] with [GraniteOne] … offers the most effective and efficient means for D-HH to meet the growing demand for services, develop necessary clinical infrastructure and inpatient capacity, better serve patients and communities of southern New Hampshire, and further its charitable purposes and mission as an academic health system." Id.

4. Stakeholder Meetings (including Medical Staff and Employees)

The Parties' Boards and senior executives have been highly engaged in discussions with stakeholders throughout the process to ensure that their decisions and process included the consideration of feedback from stakeholders. Appendices IV(33) – (35) list the events and publications that CMC, MCH and HH undertook to inform and take comments from their stakeholders which include patients, medical staff, employees, donors and supporters, community business and political leaders, collaborative partners and in the case of CMC, the Catholic community. Appendix IV(36) includes example notices for employee forums and written communications. There were similar presentations and discussion opportunities with each GraniteOne member's Medical Executive Committees, physician leadership councils and general medical staffs.

CMC, MCH and HH took significant and on-going actions to engage employees and medical staff. Each of the Parties have held a significant number of employee town halls and meet and greet events at various stages of the due diligence and negotiation process. MCH and HH were particularly engaged with employees having the first employee discussion about the idea of GraniteOne becoming a part of a larger system as early as October 2018 at HH. At these meetings employees were given status reports and asked to offer feedback, pose questions or raise points of concern or support for the Proposed Combination. Dr. Pepe and Dr. Conroy also did a number of meet and greet forums offering opportunities for employees within the D-HH system or the GraniteOne system to meet and hear the perspective of the other system's leadership.

As discussed throughout this Notice, CMC engaged the Bishop, the Diocese and the NCBC and members of the Catholic community early in the process. That included individual meetings with parish leaders, individual parishioners and members of the Catholic community who expressed both support or raised questions about the Proposed Combination. For example, on February 8, 2019, Dr. Pepe led a presentation and discussion about the Proposed Combination with Catholic community leaders. On February 19, 2019, Dr. Pepe and other CMC leadership met with the Amoskeag Deanery which includes the pastors of Saint Peter Parish in Auburn, Saint Elizabeth Seton Parish in Bedford, Saint Lawrence Parish in Goffstown, Saint Francis of Assisi Parish in Litchfield, Blessed Sacrament Parish, Parish of the Transfiguration, Sacred Heart Parish, Saint Anne – Saint Augustin Parish, Saint Anthony of Padua Parish, Saint Catherine of Siena Parish, Saint Hedwig Parish, Saint Joseph Cathedral Parish, Saint Pius X Parish, Saint Raphael Parish and Sainte Marie Parish – all in Manchester. Dr. Pepe or other CMC leadership also met with individuals the leadership of the Knights of Columbus and the Catholic Lawyers Guild. Overall, there has been a wave of support for the Proposed Combination. An open letter in support of the Proposed Combination was signed by over 150 individuals identifying as Catholic very early in the process.[62] Stakeholder engagement included discussions with those who have expressed concerns or objection to the Proposed Combination, primarily the leadership and individual members of New Hampshire Right to Life.

5. Devotion of Assets to Charitable Purposes (NHRSA 7:19-b, II(e))

NHRSA 7:19-b, II(e) requires that the governing body assess and determine that the assets of the health care charitable trust and any proceeds to be received on account of the transaction shall continue to be devoted to charitable purposes consistent with the charitable

[62] https://www.catholicmedicalcenter.org/about-cmc/newsroom/news/2019/september/show-your-support-of-the-future-of-catholic-health

objects of the health care charitable trust and the needs of the community which it serves. As discussed in detail in Section IV(A) above, the Combination Agreement sets forth in detail the Parties commitment to the devotion of their assets to their Charitable Purposes. See Appendix I(1) (Article 1, Article 2 and Article 5). While the reserved powers applicable to CMC, the CMC Subsidiaries, HH and MCH do provide for significant System Board initiation or approval rights over asset allocation, budgets, debts and changes in clinical programming, these powers have restraints, the System Board must exercise them in a manner consistent with Articles I and II of the Combination Agreement which are clear commitments to the Parties' missions and purposes. There are agreed upon parameters for any change in clinical service, as the System Board is required to evaluate the impact of any proposed change on: (i) the ability of the member hospital (such as CMC, MCH and HH) to meet the health needs of the communities in its service area; (ii) the ability of the member hospital to continue to qualify as a CAH after the proposed change (as to MCH and HH) or in the case of CMC, its keeping with the moral Catholic teaching and adherence to the ERDs and Canon Law; (iii) the quality and efficiency with which the member hospital can deliver its health services; and (iv) the charitable purpose of the member hospital. See Sections 3.4.1, 3.4.2, 3.4.5 and 5.5.2(c) of the Combination Agreement at Appendix I(1). No core service may be terminated for the sole reason that it is unprofitable. Id. at Section 5.3.3(a). The System Board may not reallocate any assets of HH or MCH to fund the building projects of D-HH and CMC identified in the Combination Agreement. Id. at Section 5.5.2(c). In addition, in the case of CMC and the CMC Subsidiaries, most of the reserved powers require a similar approval from CMCHS or the Bishop to ensure its continued Catholic identity which is a significant protection that its assets remain for its charitable purposes which include their use is consistent with the moral Catholic teaching, the ERDs and Canon Law. See Sections 3.4.3,

3.4.4 and 2.6 of the Combination Agreement at Appendix I(1); see also Section V(B) below. In addition to the contractual obligations of the Parties, the D-HH GO Board will act as a fiduciary in their exercise of its reserved powers. See, e.g., Opinion of the Charitable Trusts Director Re: Fiduciary Duty of Corporate Members of Charitable Organizations dated February 13, 2017. These duties are acknowledged in the draft proposed D-HH GO Bylaws at Appendix 6.2.1(b) of the Combination Agreement at Appendix I(1). See also Appendices VI(8) – VI(9).

6. Sufficient Public Notice and Engagement (NHRSA 7:19-b, II(g))

NHRSA 7:19-b, II(g) requires that reasonable public notice of the proposed transaction and its terms be provided to the community served by the health care charitable trust, along with reasonable and timely opportunity for such community, through public hearing or other similar methods, to inform the deliberations of the governing body of the health care charitable trust regarding the proposed transaction. The Parties made significant efforts to engage the public, patients and the communities served by the Parties.

(a) Public Meetings

The Letter of Intent was robust and more detailed than typical letters of intent. The Parties focused on a detailed Letter of Intent not only for their benefit but to begin to inform the public. The Letter of Intent was provided to the public via the Parties' website beginning on January 23, 2019. After having been available for public review for a few months during the negotiations of the Combination Agreement, the Parties began holding community listening sessions or public forums in each of the four communities in May 2019 (See Appendix IV(37)):

May 13, 2019 Manchester	See Public Notice at Appendix IV(38) Published May 2, 2019 and May 9, 2019 Online April 29, 2019 – May 13, 2019 See Presentation Slides at Appendix IV(42)

May 14, 2019 Wolfeboro	See Public Notice at Appendix IV(39) Published May 2, 2019 and May 9, 2019 See Presentation Slides at Appendix IV(43)
May 15, 2019 Lebanon	See Public Notice at Appendix IV(41) Published May 2, 2019, May 5, 2019, May 9, 2019 and May 12, 2019 Online April 29, 2019 – May 15, 2019 See Presentation Slides at Appendix IV(45)
June 6, 2019 Peterborough	See Public Notice at Appendix IV(40) Published May 28, 2019, May 30, 2019, June 4, 2019 and June 6, 2019 Online May 27, 2019 – June 6, 2019 See Presentation Slides at Appendix IV(44)

(b) Website

On January 24, 2019 (within twenty-four (24) hours of the Board's approval of the Letter of Intent - the Parties launched the website: https://www.forahealthiernh.org. The website includes information about the Parties, information about the Proposed Combination and the reasons for pursuing the Proposed Combination and lists the benefits that patients and the community should expect to see from the Proposed Combination. The News & Updates section includes summaries and links to articles. While the articles and support has been overwhelmingly supportive, it should be noted that even the few articles that raised questions about the Proposed Combination were posted to ensure the public has had an opportunity to see those opinions as well. The FAQ page includes anticipated questions and answers to those questions. The Contact Us page provides an opportunity for the public to provide feedback.

On September 30, 2019, the Parties executed the Combination Agreement, and on October 2, 2019, issued a press release to notify the public that the respective Boards had approved the Proposed Combination and were proceeding to the next steps of the approval process. This announcement on the webpage and as highlighted in the press release, included a

link to the Combination Agreement providing the public an opportunity to review the agreement to better understand the anticipated governance, management, and financial structure of the Proposed Combination. The Combination Agreement includes details of what the Boards have prioritized as combination specific clinical integration opportunities.[63] The public disclosure of the Combination Agreement also provided the public the opportunity to see the detailed language and structure pertaining to the preservation of CMC's Catholic identity and continued adherence to the moral Catholic teachings, the ERDs and Canon Law. To assist with this review and to better inform the public, the Bishop's nihil obstat and an educational summary prepared by the NCBC summarizing their moral analysis of the Combination Agreement was posted as well.

V. THE TRANSACTION IS PERMITTED BY LAW (NHRSA 7:19-b, II(a); VI(a)-(b))

The Proposed Combination is permitted by applicable New Hampshire and federal law. As to CMC and the CMCHS Subsidiaries, the Proposed Combination as structured is permitted by moral Catholic teachings, the ERDs and Canon Law.

A. CHARITABLE TRUST LAW

1. RSA 292, Voluntary Corporations and Associations

The Proposed Combination is permitted pursuant to NHRSA 292. Each of the Parties is a New Hampshire voluntary corporation in good standing with the principal purpose of promoting health in the State of New Hampshire. NHRSA 292:1; NHRSA 292:4; See Appendices III(1)-(2); III(6)-(7); III(9)-(10); III(12)-(13); III(15)-(16); III(18)-(19); III(23)-(24); III(28)-(29) and III(33)-(34). Pursuant to RSA 292:7, the general authority to perform a transaction like the Proposed Combination is granted to the Board of Trustees by majority vote at a duly called meeting for that purpose. NHRSA 292:7. Each of the Parties that have one or more members

[63] See: https://www.forahealthiernh.org/news/combination-agreement/

has their respective rights set forth in their respective Articles of Agreement and Bylaws. NHRSA 292:6-b; See Appendices III(2)-(3); III(7)-(8); III(10)-(11); III(13)-(14); III(16)-(17); III(19)-(20); III(24)-(25); III(29)-(30) and III(34)-(35). The Articles of Agreement and Bylaws of each of the Parties further sets forth the authority to approve and consummate the Proposed Combination, subject to the rights of their respective members. NHRSA 292:6-a; NHRSA 292:6; NHRSA 4; Id. In this case, duly authorized meetings of the respective Boards were held on September 23, 25, 26 and 30th, respectively. The Parties obtained all necessary Board approvals, member approvals and, in the case of CMC, the Bishop's approval, of the Proposed Combination by September 30, 2019. See Appendices IV(23)-(32).

2. Compliance with Common Law

The Proposed Combination also is permitted by New Hampshire statutory and common law pertaining to charitable trusts. As noted above, each of the Parties will retain its charitable mission of the promotion of health, as permitted by NHRSA 564-B:4-405(a), unmodified by the Proposed Combination. See Combination Agreement Section 2.3. Therefore, the doctrine of *cy pres* is inapplicable to the Proposed Combination and no probate court approval is required under NHRSA 564-B:4-413.

Any modification to the manner in which each Party administers its charitable trust as a result of the Proposed Combination is permitted under New Hampshire law without probate court or regulatory approval beyond the giving of this Notice and the process under NHRSA 7:19-b. See NHRSA 564-B:4-419(a) and (h). As described in this Notice, each of the Parties has negotiated specific provisions of the Combination Agreement which protects the unique features of the manner in which it administers its charitable trust. See Combination Agreement Sections 2.6, 2.7 and 2.8. CMC and the CMCHS Subsidiaries also have preserved the

mechanisms by which they retain and further their Catholic identity, as confirmed by the Bishop and described in Subsection B below. The powers retained by CMC, the CMCHS Subsidiaries, HH and MCH, the qualifications imposed on the Combined System Board's exercise of its reserved powers over those Parties, and the bi-regional management structure of the Combined System, as described in this Notice, also preserve the manner in which the Parties' respective charitable missions are administered. Each of the Parties (except D-HH and GraniteOne, as the coordinators of their respective health systems) already operates and administers its charitable trust under a health system structure in which the coordinating entity is its corporate member with certain reserved powers that must be exercised by the coordinating entity board with a limited fiduciary duty to each system member. Therefore, the combination of these systems into a single similarly-structured health system does not result in a deviation from the Parties' existing administration of their charitable organizations, and thus does not require probate court approval pursuant to a writ in deviation under NHRSA 547:3-c. To the extent that the Proposed Combination results in any modification of the existing administration by the Parties of their charitable trusts, the modification is the result of the determination by the Parties' trustees, in the exercise of their fiduciary roles and duties as demonstrated by the efforts described in this Notice, that operating under the Combined System will ensure the sustainability of their charitable missions, enhance the efficient administration of their charitable organizations, and reduce their costs of their operations. See Section IV(b) above; See also Appendix I(2). Therefore, these modifications are consistent with the powers granted to the Parties' governing boards under NHRSA 564-B:4-419(a)(1), (3) and (4), and thus do not require court approval. NHRSA 564-B:4-419(k).

B. MORAL CATHOLIC TEACHING, THE ERDS AND CANON LAW

The Proposed Combination is structured to preserve identities of CMC and the CMCHS Subsidiaries as Catholic healthcare institutions. As with CMC's participation in GraniteOne, CMC engaged the Most Reverend Peter A. Libasci, D.D., Roman Catholic Bishop of the Diocese of Manchester and national ethicists from the NCBC from the beginning of discussions with D-HH. The ultimate responsibility for preserving CMC's Catholic identity, analyzing the moral considerations of collaborative arrangements, and interpreting and applying the ERDs and Canon Law rests solely with the diocesan bishop. See Sixth Ed. ERD Part 6, Introduction and Nos. 67 – 69.[64] From a moral analysis perspective, there are two sources of authority to guide the Bishop. The first source is the Congregation for the Doctrine of the Faith published principles titled "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services" making clear that full integration of Catholic and Non-Catholic healthcare partnerships may be sought to meet health care needs of the community. These principles served as a key basis for CMC's participation in GraniteOne. Building upon these principles, the second source is Part 6 to the ERDs entitled "Collaborative Arrangements with Other Health Care Organizations and Providers" providing even further clarity and guidance for diocesan bishops to assess collaborations with secular organizations.

To assist the Bishop with his moral assessment and to determine whether the Proposed Combination is appropriately structured to meets these obligations, CMC worked with the then NCBC President, nationally recognized bioethicist, Dr. John Haas, and his colleague Dr. John Di Camillo. Drs. Haas and Di Camillo assessed the Proposed Combination throughout its

[64] See: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf

development, having met with CMC and the Bishop in September 2018, and having assessed the Letter of Intent prior to execution and the Combination Agreement. Throughout the process and in an extensive moral analysis, the NCBC concluded that the terms are consistent with the necessary tenets of the moral Catholic teachings and will enable CMC to remain consistent with its religious mission. A public summary of the NCBC analysis was prepared for purposes of educating the Catholic community which was distributed to Catholic and pastoral leadership and available at the proposed Combination website. See Appendix V(2); see also https://www.forahealthiernh.org/wp-content/uploads/2019/11/CMC-D-HH-NCBC-highlights-final.pdf. The public summary describes how the Proposed Combination is morally sound based on traditional moral principles, and in particular the CDF Principles and the ERDs, and is incorporated herein by reference. As the NCBC notes, the Combination Agreement is explicit and reiterative in its respect for the Catholic moral teaching, canon law, the ERDs and the authority of the Bishop with respect to CMC and the CMCHS Subsidiaries. See Appendices V(2) and I(1) (notable Articles in the Combination Agreement applicable and informative to CMC's continued adherence to the moral Catholic teachings and the ERDs include Articles 2.6, 2.3, 2.7, 3.3.2, 3.3.3, 3.4.2, 3.4.3, 3.4.4, 4.1.3, 4.4.2(d)-(e), 5.3.3(a), 5.5.2(c) and 11.7).

Separate and apart from the ERDs, canon law imposes requirements on a religious sponsor to obtain certain approvals related to the alienation of stable patrimony or other collaborations. Alienation is the conveyance or transfer of ecclesiastical goods to another.[65] This can be carried out by sale, gift, exchange or other recognized means.[66] The term "stable patrimony" is generally regarded as ecclesiastical goods consisting of those assets that are designated via a formal inventory by the leadership of a juridic person for the long-term security

[65] See: https://www.trcri.org/page/temporal_goods_qa
[66] Id.

of the sponsored works.[67] These assets typically include land, buildings, investments and endowments. If there is an alienation of ecclesiastical goods over certain thresholds set forth by canon law, then approval of either the Vatican or the diocesan bishop is required depending upon the sponsorship of the public juridic person. In the case of CMC, CMCHS is the public juridic person of diocesan right which requires approval of the Bishop. As noted in the previous discussion of the differences between the Proposed Combination and CMC's prior collaboration efforts with D-HH (see Notice Section III(I)), CMCHS is not changing its governance structure or its reserved powers over CMC. D-HH, as reconstituted as Dartmouth-Hitchcock Health GraniteOne, will be substituted for GraniteOne, keeping the co-membership structure to ensure the continued oversight over CMC by its public juridic person. Actually, the CMCHS reserved powers and those approval rights of the Bishop have increased to provide significant safe-guards and protections of CMC's Catholic identity and against any alienation of its ecclesiastical goods.

To assist the Bishop and the Vicar for Canonical Affairs for the Diocese of Manchester with their assessment of CMC's continued compliance with Canon Law as a member of the proposed Combination, CMC retained well-regarded[68] Canonist, Francis G. Morrisey, OMI, PhD, JCD, Professor Emeritus (and former Dean) of Saint Paul University in Ottawa, Ontario Canada. On September 16, 2019, Fr. Morrisey advised that the Proposed Combination, based upon the Combination Agreement, will not impair CMC's ability to continue to comply with the norms of the 1983 Code of Canon Law of the Roman Catholic Church, as promulgated by the

[67] Rev. Francis Morrisey, OMI, Ph.D., JCD, Canon Law – What is Stable Patrimony? Health Progress (March – April 2008), p. 14.

[68] Fr. Morrisey was ordained to the Roman Catholic priesthood in 1961. He is Professor Emeritus of Canon Law at Saint Paul University, Ottawa where he served as the Dean of the Faculty of Canon Law from 1972 – 1984. He is Consultor for the Vatican as well as for numerous conferences of bishops and religious institutes. He has been invited to speak in more than 50 countries and has authored 400 publications on Church-State relations, Canon law, Health care and religious life. He recently was awarded the Lifetime Achievement Award from the Catholic Health Association of the United States. See: https://www.chausa.org/assembly-2019/awards/lifetime-achievement-award.

Supreme Roman Pontiff.[69] Fr. Morrisey's conclusion is based on an assessment that CMC's Catholic identity is adequately preserved and that the Proposed Combination will not result in the alienation of ecclesiastical goods[70] due to the continued role that CMCHS and the Bishop will have in the oversight of CMC as a member of the System. With respect to the need for an ongoing assessment of alienation, Fr. Morrisey concluded that there are sufficient safeguards in place to prevent a future alienation of assets for uses against the Canon Law or for procedures contrary to the ERDs. In fact, Fr. Morrisey noted that the Combination Agreement includes "more reserved rights than we would normally see in similar agreements" which he concluded "is excellent from a canonical point of view".[71]

On September 23, 2019, the Bishop recognized the Parties' efforts to "protect the essential Catholic identity of CMC" and granted his approval by way of issuing his *nihil obstat*. See Appendix V(1) (copy of the *nihil obstat* and transmittal letter acknowledging that the Parties' "significant time and effort that have been devoted to the consideration and vetting of the [Proposed Combination] will, in turn, guarantee a better future serving the health care needs of all in New Hampshire[.]). See also https://www.forahealthiernh.org/wp-content/uploads/2019/11/Nihil-Obstat-11-22-19.pdf. CMC and the Diocese continue to be engaged with the faithful Catholic community to listen and answer questions that they may have about the Proposed Combination.

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[69] Ltr to Jason E. Cole, Vice President & General Counsel of CMC from Rev. Francis Morrisey dated September 16, 2019 summarizing review of the Combination Agreement. This letter is confidential and CMC does not consider it subject to the New Hampshire Right to Know Law, RSA 91-A.

[70] In determining that no alienation of ecclesiastical goods, the authority to approve CMC's participation in the proposed Combination and CMC's compliance with the Canon Law is exclusively that of the diocesan Bishop. See Canons 1292-1294.

[71] Ltr to Jason E. Cole, Vice President & General Counsel of CMC from Rev. Francis Morrisey dated September 16, 2019 summarizing review of the Combination Agreement. This letter is confidential and CMC does not consider it subject to the New Hampshire Right to Know Law, RSA 91-A.

C. ANTITRUST LAWS

1. RSA 358-A, Regulation of Business Practices for Consumer Protection

The Proposed Combination is lawful because it will not adversely impact competition for health care services in New Hampshire. See RSA 358-A *generally*. To demonstrate this, the Parties, through their respective legal counsel, have been actively engaged with the New Hampshire Antitrust Bureau (the "Bureau") since April 2019 and have submitted information voluntarily, including substantial economic analysis of the Proposed Combination, and in response to formal information requests. The Parties will make an additional submission to the Bureau with further analysis of the pro-competitive effects anticipated by the Proposed Combination and requesting the Bureau's letter of "no objection".

2. Section 7 of the Clayton Act, 15 U.S.C. § 18

The Proposed Combination does not violate the Clayton Act because it will not substantially lessen competition for health care services in New Hampshire. See § 7, 15 U.S.C.A. § 18. The Parties, through their respective legal counsel, have been actively engaged with the United States Federal Trade Commission (the "FTC") since April 2019 and have submitted information in response to voluntary information requests including a substantial economic analysis of the Proposed Combination. The Parties plan to submit a Premerger Notification filing with the FTC pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. § 18a and the application regulations, 16 C.F.R. Parts 801, 802 and 803. Through the filing and continued engagement, the Parties anticipate that the FTC will take no further action of its thorough review of the Parties' submissions.

VI. STANDARDS OF CERTIFICATION AND STATEMENTS OF COMMITMENT TO NEW HAMPSHIRE COMMUNITIES AND CHARITABLE PURPOSES (NHRSA 7:19-b, III and NHRSA 7:19-b, II(e))

Appendices VI(1) – VI(7) include certifications of the Chair of the Board of Trustees of the Parties affirming that the standards set forth in New Hampshire RSA 7:19-b(II) has been met.

Appendices VI(8) and VI(9) include statements of D-HH (as the "acquirer") and GraniteOne (acknowledging the D-HH statement) specifying the manner in which it proposes to ensure that the reconstituted D-HH as Dartmouth-Hitchcock Health GraniteOne will continue to fulfill the charitable objects of the Parties.

(*signature pages follow*)

Respectfully submitted by the duly-authorized representatives of the undersigned this 30th day of December, 2019.

GRANITEONE HEALTH

By: _____
Joseph Pepe, M.D., its duly authorized CEO

CATHOLIC MEDICAL CENTER

By: _____
Joseph Pepe, M.D., its duly authorized President and CEO

MONADNOCK COMMUNITY HOSPITAL

By: _____
Cynthia K. McGuire, FACHE, its duly authorized President and CEO

HUGGINS HOSPITAL

By: _____
Jeremy Roberge, CPA, its duly authorized President and CEO

ALLIANCE AMBULATORY SERVICES

By: _____
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President and CEO

ALLIANCE HEALTH SERVICES

By: _____
Joseph Pepe, M.D., its duly authorized
President and CEO

CATHOLIC MEDICAL CENTER PHYSICIAN PRACTICE ASSOCIATES

By: _____
Joseph Pepe, M.D., its duly authorized
President and CEO

(signature pages of the Joint Notice to the Director of Charitable Trusts Pursuant to New Hampshire RSA 7:19-b)

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