APPENDIX VI(8)

Statement of Dartmouth-Hitchcock Health ("D-HH") of Intent to Continue to Fulfill the Charitable Objects of Catholic Medical Center ("CMC"), Monadnock Community Hospital ("MCH") and Huggins Hospital ("HH") (collectively, the "Hospitals")

As required by New Hampshire RSA 7:19-b (III), D-HH hereby sets forth the manner in which it proposes to collaborate with the Hospitals to continue to fulfill their charitable objects, as reflected in Articles 1 and 2 of the Combination Agreement (Appendix B1):

ARTICLE 1. STATEMENT OF PURPOSE AND MUTUAL VISION

To assist the public and regulatory agencies to understand the Parties' commitments to improving the health and health care of the communities they will continue to serve through the System, the Parties declare the following purposes for the Combination and their shared vision of its benefits.

1.1 Furtherance of Charitable Purposes. Each of D-HH, GOH, CMC, MCH and HH seeks to further its charitable purposes, and those of its respective subsidiaries, to enhance the health status of individuals in the communities it serves and to advance health care through education, research, and the improvement of clinical practice while preserving its unique local identity and traditions. Each Party believes that its respective charitable purposes can best be achieved by creating an integrated health care delivery system that optimizes the efficient use of resources to improve access to high quality patient care that results in better outcomes while reducing cost, inconvenience, and variability in clinical pathways and protocols.

1.2 Compatible Missions and Cultures. The Parties share a common and unifying mission to promote health and improve the delivery of health care by providing greater access to cost-effective, high quality health care and health care-related services without pecuniary gain or discrimination based on race, creed, gender, or ability to pay. Through multiple and varied clinical collaborations between and among them in areas such as general and orthopedic surgery, obstetrics, cancer care, and cardiovascular care, among others, the Parties have gained deep experience and appreciation for each other's values, patient-centered care cultures, and the benefits of integrated health care delivery. Having realized those benefits in part, the Parties believe that their compatible missions will be served and advanced best by creating a more fully integrated health care delivery system that meets the health-related needs of the patients and communities they serve and avoids unnecessary and costly duplication of services, fragmented and inconvenient access to care, and variability in outcomes.

1.3 Integrated Health Care Delivery. Through a bi-regionally distributed care delivery model, the System will maximize clinical integration opportunities by aligning service delivery to ensure that patients receive the highest quality, acuity-appropriate care at the most convenient, cost-effective site of service across the continuum of care. The System will facilitate this clinical integration by fostering collaboration among providers, allocating resources strategically,

transferring patients rationally, preserving existing services in rural hospitals as feasible, expanding services where desired, utilizing telehealth services, and ensuring the interoperability and eventual integration of the Parties' electronic medical records systems. In order to implement these clinical integration strategies and tactics, maximize benefits to patients, and achieve operational efficiencies, the Parties also must integrate their governance structures, financial affairs, and administrative functions subject, however, to the provisions of Sections 2.6, 3.4.3 and 3.4.4 of this Agreement.

1.4 Improve Access to Services. Increased demand for health care services has strained the capacity of the Parties to provide access to high quality, cost-effective health care to the patients and communities they serve, leaving patients to seek care out-of-state, at higher cost or inconvenient sites of service. The Combination will enable the Parties to offer mission-critical inpatient, outpatient and ambulatory services by more effectively utilizing existing capacity, expanding capacity where necessary, deploying innovative digital tools for remote specialty care, and enhancing services across the continuum of care, thereby improving the timeliness of care and curbing the outmigration from New Hampshire that leads to higher costs and greater inconvenience. The System will build upon the Parties' history of clinical collaborations to offer a broader array of specialty services, particularly in southern New Hampshire, in the areas of behavioral health, pediatrics, oncology, orthopedics, spine care and pain management, obesity and bariatrics, and cardiovascular care, among others. Significantly, more patients will have access to clinical trial opportunities here in New Hampshire, obviating their need to seek such advanced care out-of-state. Additionally, the Combination will enable the Parties to invest jointly in critical infrastructure and the workforce required to support the expanded breadth of services, at a lower cost of capital and more strategically and efficiently than if the Parties sought to do so independently.

1.5 Continuous Quality Improvement. The System will take a comprehensive approach to quality improvement by measuring the Parties' performance against established benchmarks to improve patient experience, safety, and timeliness of care while aiming to reduce adverse events, readmissions and length of stay, among other quality metrics. The Parties expect that the Combination will enable them to reduce site-sensitive variability in outcomes by sharing best practices and data analytics, standardizing clinical protocols and care pathways, and deploying D-H's advanced quality measurement infrastructure across the combined system. The safe and effective delivery of health care in today's complex health care environment demands sustained investment in state-of-the-art technology, equipment, information systems, infrastructure, and professional staff. The Combination will help to assure the Parties' joint investment in those necessary resources as they strive to improve the quality of their health care and health care delivery.

1.6 Address Workforce Needs. The System will draw on the Parties' respective strengths to educate, recruit, develop, and retain the workforce required to meet the complex medical needs of the communities they serve. With an academic medical center providing tertiary and quaternary care in a rural setting, acute care community hospitals in both urban and rural settings, multiple CAHs throughout New Hampshire and Vermont, and a post-acute home health and hospice provider, the System will offer opportunities for growth and diversity of experience to attract high-demand clinicians, associate providers, nurses and support staff. The dearth of local, qualified health care workers is reflected in both the number of vacancies and the premium temporary labor expense incurred by the Parties. The Combination will enable them to develop strategies to address this acute labor shortage, which is exacerbated by the region's challenging demographics, and expand the reach of programs like D-H's "Workforce Readiness Institute" and CMC's Transition to Professional Practice and LNA Apprenticeship Program, each of which offers training opportunities for careers in health care with a proven record of retaining licensed or certified program graduates within the D-HH System. The Combination also will create opportunities to expand graduate medical education in New Hampshire by establishing residency programs to train and retain the future clinical workforce, without which rural health care will be jeopardized further and local communities will suffer the adverse health, social, and economic consequences.

1.7 Reinforce Rural Health Care. As the rural health care delivery network continues to slowly erode with the contraction or closure of programs and services, the stress on the Parties' resources increases proportionally and unsustainably. DHMC and CMC are the state's largest transfer centers, respectively, receiving referrals from throughout New Hampshire and Vermont, and both institutions are laboring under severe capacity constraints. The Combination will enable them to meet the high demand for their services, which they are unable to do presently, while reinforcing the fraying rural health care delivery network. By expanding efforts to deploy clinical specialists to rural communities, utilizing its combined human and technological resources, and building upon D-H's robust telehealth capabilities, the System will help to ensure that rural patients continue to enjoy local access to acuity-appropriate care while simultaneously reducing the Parties' transfer request volumes. The System will include multiple CAHs and rural providers across New Hampshire and Vermont among its members, all of whom will be strengthened by a more integrated, regionally distributed care delivery model, and whose patients will benefit by continued access to local, acuity-appropriate care.

1.8 Population Health Management. The paradigm shift to alternative payment models and value-based care requires a sharper focus by providers on better health and health care outcomes, which, in turn, requires greater alignment among providers in order to efficiently coordinate care, manage the total cost of care, and improve population health. The System will offer patients seamless coordination across the continuum of care, from primary care to post-acute skilled nursing and home health care. Drawing upon experience gained through participation in government and commercial alternative payment models, the System will utilize more effectively

the Parties' population health capabilities and facilitate their joint participation in accountable care organizations and other innovative payment and health care delivery arrangements. A greater number of patients will benefit from the Parties' use of data analytics derived from a combined pool to treat more effectively community health threats like substance use disorder, obesity, and diabetes. The Parties believe that the Combination will catalyze their population health initiatives for the benefit of patients and is the most effective vehicle for achieving alignment of operations, coordination of services, and efficiency in health care delivery.

1.9 Financial Sustainability. The System will help to stabilize and strengthen the financial profile of its member charitable organizations, which confront the structural problem of rising expenses and steadily diminishing reimbursement from public payors, and downward price pressure from private payors. The System's bi-regionally distributed care delivery model will enable the Parties to provide acuity-appropriate, volume-supported services that meet patient and community needs, operate more efficiently by obviating costly duplication of services, and offer more medically complex services in the most cost-effective and convenient setting. Just as D-HH has a demonstrable record of allocating financial, strategic, operational, and human resources within its system when necessary, so too will the System enable the Parties to provide such support where and when necessary. Moreover, like existing D-HH members, assuming all conditions for participation are satisfied, CMC, MCH and HH anticipate that they will have the opportunity to participate in the Dartmouth-Hitchcock Obligated Group, which will consolidate the System's debt and offer the potential for less costly access to capital markets.

ARTICLE 2. GUIDING PRINCIPLES.

The Parties understand that today's rapidly changing health care environment requires nimbleness in response to evolving patient needs, innovations in health care delivery and reimbursement models, and improvements in medical care and hospital administration. While the Parties can develop strategic and operational plans to pursue the purposes and vision of the Combination set forth above, they cannot anticipate or prescribe in a written agreement their collective response to the many unforeseen circumstances they are certain to encounter. Accordingly, the Parties agree that the following principles will help guide the evolution of their relationship and the operation of the System so that the spirit of this Agreement, and the purpose and mutual benefits of the Combination, can be preserved:

2.1. Commitment to Community Health Care Needs. The health care needs of the communities served by the Parties are paramount, and the integration of D-HH, GOH, CMC, MCH and HH into a combined system will be designed and implemented to meet best the needs of the patients and communities served by all of the Parties.

2.2. Commitment to Integrated, Quality, Efficient Services. Through a bi-regionally distributed care delivery model, the Parties will align service delivery to 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 order to fulfill this commitment, the Parties and their

subsidiaries and affiliates will integrate their clinical services, governance structures, financial affairs, and administrative functions, and consistent with the terms of this Agreement, the Parties agree to align their activities, and those of their subsidiaries and affiliates, with the strategic plans established for the System.

2.3. Commitment to Identity and Charitable Mission. The Parties acknowledge the compatibility of their charitable missions, and those of their subsidiaries and affiliates, and no Party will be required to take any action that is materially inconsistent with, or in contravention of, its respective charitable mission. The System is designed and the Combination will be implemented to ensure a patient-centered culture consistent with the identities and values of each of the Parties, and operated efficiently to meet the needs of the communities they serve.

2.4. Compliance with Applicable Charitable and Tax-Exempt Requirements. The Parties at all times will be operated in a manner consistent with the charitable missions of the Parties and their subsidiaries and affiliates, and none of them will be required to take any action pursuant to this Agreement which may impair or jeopardize its tax-exempt or public charity status under federal income tax law, or its charitable status under state law.

2.5. Principles Underlying the Provision of Health Care Services. In providing health care services within the combined System, the Parties are committed to observing the following principles:

2.5.1. Promoting and maintaining population health through wellness and preventative measures, research and data analytics, health education, and the achievement of high quality clinical outcomes;

2.5.2. Meeting local community expectations regarding the provision of services that can be maintained in a financially reasonable manner and consistent with the strategic plans established for the System;

2.5.3. Directing patients and providers to receive and deliver care at the most appropriate sites within the combined system and supporting the health needs of patients and communities in the most appropriate, convenient and cost effective manner, while ultimately respecting the choice of patients and the medical judgment of providers;

2.5.4. Advancing the knowledge, training, development, recruitment and retention of health care professionals;

2.5.5. Preserving universal access to appropriate health care services for all who are vulnerable and/or in need, regardless of ability to pay;

2.5.6. Recognizing the inherent dignity of all patients and respecting each Party's core values and identity; and

2.5.7. Providing a true continuum of health care services and creating opportunities for joint participation in a wide variety of health care ventures including managed care products, rehabilitation services, primary care development, behavioral health services, nursing care, wellness and prevention services.

2.6 CMC's Catholic Identity and Health Care Mission. The Parties acknowledge that CMC is a Catholic organization with the mission of carrying out Christ's healing ministry by offering health, healing and hope to every individual who seeks CMC's care. As a ministry of the Catholic Church, CMC adheres to Catholic moral teaching, particularly as expressed in the ERDs and operates in accordance with Canon Law, and must continue to do so. Although the Parties agree to establish a more fully-integrated health care system, CMC will continue to offer prophetic Christian witness and will not participate in or endorse any System activity which is contrary to Catholic moral teaching, the ERDs or Canon Law, and conversely the components of the System outside of CMC will not be restricted by Catholic moral teaching, the ERDs or Canon Law. The System can never require CMC to engage in any action contrary to Catholic moral teaching, the ERDs or Canon Law, including direct abortions; reproductive technologies using donor gametes or in which conception occurs outside a women's body, including in vitro fertilization and donor insemination; the cryopreservation or destruction of human embryos; the procurement of embryonic stem cells through the destruction of human embryos; research at CMC that is not consistent with Catholic moral teaching, the ERDs or Canon Law and has not gone through the CMC Institutional Review Board which applies the ERDs; the withholding or withdrawing of medically assisted nutrition and hydration or of any medical intervention with the purpose of causing death as a means to alleviate suffering; and physician-assisted suicide if it becomes legal in the State of New Hampshire. Whether or not expressly stated in this Agreement, CMC's integration into the System is subject to this Section 2.6, and the Parties agree to cooperate in establishing procedures or other mechanisms to ensure that the System does not cause or require CMC to violate, or to impose upon other Members or components of the System other than CMC, Catholic moral teaching, the ERDs or Canon Law. The Parties further agree that CMCHS will remain a co-member of CMC and will continue to serve as the public juridic person and corporate mechanism by which the Bishop will exercise his powers and oversight over CMC. CMCHS's reserved powers over CMC will coexist with those of the System Board as described in Sections 3.4.3 and 3.4.4 below. The Parties agree, however, that the exercise by the System Board of the System Board Reserved Powers described in Section 3.4.2 below with respect to CMC cannot require CMC to implement any programs, services or procedures that are against the moral teachings of the Catholic Church or in violation of the ERDs or Canon Law.

2.7 D-HH's Academic Health Care Mission. The Parties acknowledge that D-HH is New Hampshire's only academic health system whose mission includes delivering innovative, high quality care across a broad range of services to patients and families regardless of where or how a patient chooses to utilize the health system. The Parties also acknowledge that, subject to the provisions set forth generally in Section 2.6 above and more specifically in Sections 3.4.3 and

3.4.4, the provisions specific to CMC will neither be imposed upon nor mandatory for other System Members, who will not be precluded from providing services or conducting research and medical education activities prohibited by Catholic moral teaching, the ERDs or Canon Law, including, among other things, the provision of reproductive health services. As more fully described in Section 5.3.7 below, the Parties recognize that the geography and combined resources of the System will create new opportunities for academic synergies, enabling them to advance knowledge in the basic, translational, and clinical sciences across a broader urban/rural population, offering more patients access to best practices in care, and making the System a dynamic educational hub for health and allied health professions training to prepare the region's future health care workforce.

2.8 Rural Health Care and Critical Access Hospitals. Both the D-HH and GOH systems include among their members CAHs that provide critical health care services to the rural areas of New Hampshire. The Parties intend the System to support and enhance the quality and accessibility of health care in rural areas, which support and enhancement includes reinforcing the viability of the CAHs in the System as long as they remain the appropriate vehicle for delivering health care services in rural areas served by the System.

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Dated as of this 23rd day of December, 2019.

DARTMOUTH-HITCHCOCK HEALTH

By: _____
Joanne M. Conroy, MD, CEO &
President, duly authorized

DARTMOUTH-HITCHCOCK HEALTH

By: _____
Edward Stansfield, Vice-Chair, D-HH
Board of Trustees, duly authorized

(Signature Page to Statement of Dartmouth-Hitchcock Health pursuant to N.H RSA 7:19-b (III))