LETTER OF INTENT

THIS NON-BINDING LETTER OF INTENT (this "Letter of Intent"), effective January 23, 2019 (the "Effective Date"), memorializes the intentions of **Dartmouth-Hitchcock Health**, a New Hampshire voluntary corporation with a principal place of business at One Medical Center Drive, Lebanon, New Hampshire 03756, ("D-HH") and **GraniteOne Health**, a New Hampshire voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire 03102 ("GraniteOne") (D-HH and GraniteOne are sometimes referred to individually as a "Party" and collectively as the "Parties") to join together in a combination transaction described below (the "Combination"). As set forth in Section 4 of this Letter of Intent, the Parties intend that each of CMC Healthcare System, Catholic Medical Center, Monadnock Community Hospital and Huggins Hospital (each described in detail below), will join the Combination and become a party to the Definitive Agreement.

1. The Parties to the Combination. The Parties to the Combination are as follows:

(a) D-HH. D-HH is the coordinating organization for a group of member entities comprising a regionally distributed academic healthcare system that serves patients primarily in New Hampshire and Vermont (the "D-HH System"). The D-HH System provides acute care hospital services, primary care and multispecialty ambulatory clinical services to patient populations in primary and secondary service areas in the States of New Hampshire and Vermont. The D-HH System is anchored by Dartmouth-Hitchcock Medical Center ("DHMC"), an academic medical center located in Lebanon, New Hampshire that is composed of Mary Hitchcock Memorial Hospital, a three hundred ninety-six (396) bed hospital and Level One Trauma Center for adult and pediatric patients ("MHMH"), and the Lebanon site of the Dartmouth-Hitchcock Clinic, a multi-specialty physician group practice ("DHC"). MHMH and DHC function in coordination with the academic mission of the Geisel School of Medicine at Dartmouth. The D-HH System also includes several members for whom D-HH serves as the sole corporate member, including: Cheshire Medical Center, a one hundred sixty-nine (169) bed hospital located in Keene, New Hampshire ("Cheshire"), Alice Peck Day Memorial Hospital, a twenty-five (25) bed critical access hospital located in Lebanon, New Hampshire ("APD"), New London Hospital, a twenty-five (25) bed critical access hospital located in New London, New Hampshire ("NLH"), Mt. Ascutney Hospital and Health Center, a thirty-five (35) bed acute care hospital located in Windsor, Vermont ("MAHHC") and the Visiting Nurse and Hospice for Vermont and New Hampshire, serving patients in the southeast region of Vermont and the southwest region of New Hampshire ("VNH") (each a "D-HH Member" and collectively, the "D-HH Members"). DHC also has clinical practice sites located in Manchester, Concord, Bedford and Nashua, New Hampshire, and Bennington, Vermont.

(b) The GraniteOne System. GraniteOne is the sole corporate member of Monadnock Community Hospital ("MCH") and Huggins Hospital ("HH") and the co-member - along with CMC Healthcare System ("CMCHS") - of Catholic Medical Center ("CMC"), all of which comprise the GraniteOne Health system (the "GraniteOne System") (CMC, MCH and HH are individually referred to herein as a "GraniteOne Member" and collectively as the "GraniteOne Members"). GraniteOne is responsible for establishing and overseeing system-wide strategy and integrating activities of the GraniteOne System. The GraniteOne System is anchored by CMC, a three hundred thirty (330) licensed bed acute care hospital. With the second highest acuity case

mix in the State, CMC serves as a transfer center for hospitals throughout the State of New Hampshire and has various professional service relationships involving its nationally ranked New England Heart and Vascular Institute ("NEHVI"). MCH and HH are each twenty-five (25) bed critical access hospitals located in Peterborough and Wolfeboro, New Hampshire. Their participation in the formation of GraniteOne was the result of a long history of clinical collaborations with CMC. Collectively, GraniteOne serves patients in the primary and secondary service areas of the GraniteOne Members and is a resource to patients throughout the State through NEHVI and the CMC transfer center.

2. The Rationale and Goals for the Combination.

The Parties have been successful in developing a patient-centered approach to care by utilizing their resources responsibly to deliver more coordinated, convenient and cost-effective care for patients throughout New Hampshire and Vermont. In southern New Hampshire, D-HH and CMC have worked together to care for patients and communities for nearly fifteen (15) years. Through clinical collaborations in obstetrics, cancer care, endocrinology, gastroenterology, rheumatology and pulmonary care, through administrative collaboration and joint formation of the family-centered special care nursery and The Mom's Place at CMC, and through joint community engagement activities, the Parties have gained deep experience and appreciation for each other's values, cultures, and the benefits of integrated health care delivery. The Parties now intend to seek a tighter integration of their clinical, administrative, and operational resources to better serve their patients and communities, and to achieve the following primary objectives identified to date and further improvements to be identified in due diligence:

(a) Improved Access

Increased demand for health care services has strained the capacity of the Parties to provide access to high quality, affordable health care in the communities they serve across New Hampshire and Vermont. The Parties' capacity constraints in the face of this growing demand – driven largely by an aging population with chronic and higher acuity health care needs – requires patients to seek care out-of-state, at higher cost and greater inconvenience. The ongoing substance use disorder crisis and shortage of behavioral health resources has further strained the Parties' capacity. Combining their respective systems will enable the Parties to provide mission-critical access by more effectively utilizing existing capacity, expanding capacity where necessary, and enhancing services across the continuum of care to offer patients a high quality, lower cost, New Hampshire-based alternative to out-of-state providers.

The Parties intend to build upon their history of clinical collaboration to provide more integrated, coordinated care delivery and a broader array of specialty services, particularly in southern New Hampshire. For the first time, patients in southern New Hampshire will have local access to tertiary and quaternary services, such as pre- and post-surgical transplant care, obviating the need to travel long distances for outpatient services. By combining to act together, the Parties can achieve their shared mission to improve local access to high quality health care services more quickly and with greater efficiency than if they must act on their own. Additionally, the Combination would allow the Parties to invest jointly in critical infrastructure to support those

enhanced services, at a lower cost of capital and more strategically and efficiently than if the Parties sought to do so independently, as more fully described in Section 7 below.

(b) Reinforce Rural Health Care

The Parties each face mounting challenges to their respective, long-standing commitments to serving rural health care needs across the region. This commitment is most clearly demonstrated by the fact that each Party's system includes multiple critical access hospitals among its members, all of whom would be strengthened by the Combination, and whose patients will benefit by being able to access care locally. The Parties' flagship hospitals, DHMC and CMC, are New Hampshire's leading transfer centers, caring for patients who cannot obtain the proper level of care in their community. The Parties intend to use their combined expertise and resources to more rationally coordinate patient transfers for the most appropriate and cost-effective level of 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. Acting together, the Parties intend to reinforce the fraying rural health care delivery network by utilizing their combined human and technological resources to ensure continued access to care for rural communities, e.g., deploying clinical specialists and building upon their existing telehealth capabilities state-wide and across the region.

The problem of access to rural health care is exacerbated by the dearth of health care workers generally and the difficulty in recruiting and retaining providers, particularly in rural communities. Together, the Parties' intend to use their respective strengths – D-HH as a rural health system with a nationally recognized academic medical center providing tertiary and quaternary care and CMC as a nationally recognized acute care hospital in a more urban setting – to recruit, educate and retain the clinical workforce that New Hampshire desperately needs to meet the complex medical demands of our aging population.

(c) Population Health and Improved Quality

The paradigm shift to alternative payment models by government and commercial payers requires a sharper focus by providers on better health and health care outcomes, which, in turn, requires greater alignment among providers across the continuum of care in order to efficiently coordinate care, manage the total cost of care, and improve population health. In response to the rapid and fundamental changes in the health care marketplace nationally, regionally and locally, the Parties' operations and delivery of health care must evolve to facilitate their respective missions. The Parties believe that the Combination is the most effective vehicle for achieving the necessary alignment and efficiency, best positioning them to deliver integrated, high quality care in a cost-effective manner, particularly in southern New Hampshire.

In addition to the Parties' complementary primary care physician network, patients in southern New Hampshire will have access to a broader array of specialty services across the continuum of care. The Parties' combined systems would provide seamless care coordination of ambulatory services, acute, tertiary and quaternary inpatient services, and post-acute skilled nursing care and home health services. Together, the Parties would augment existing clinical collaborations by offering enhanced pediatric services, cancer subspecialty services, new spine

and neurosurgical services, and tele-specialty services in neonatology, pharmacy, and emergency and intensive care. Additionally, the Parties would be better positioned to employ data analytics to advance population health initiatives for the treatment of chronic heart, pulmonary and diabetic conditions, improving patient health while reducing cost and inconvenience. Significantly, the Parties intend to capitalize on, and buttress, existing relationships to improve veteran's health care and intensify their efforts to address the state's behavioral health and substance use disorder crises.

The Parties have a demonstrated record of leadership in providing high-quality care. DHMC and CMC are nationally recognized as the best hospitals in the State of New Hampshire. The Parties' combination would catalyze quality improvement efforts by standardizing best practices, promoting the sharing of data analytics, and reducing variability in outcomes. The Parties also intend to expand the reach of New Hampshire's only academic medical center in order to deliver cutting-edge care and offer new clinical trial opportunities to patients in southern New Hampshire, and to build upon D-H's existing obstetrics residency program at CMC by offering expanded graduate medical education opportunities and a higher level of care for patients locally.

(d) Efficiency

From the delivery of health care services to operational expenses to capital investment in supporting infrastructure, the Combination would create synergies to achieve cost savings. Through their payer partnerships and the expertise gained from their participation in alternative payment models like shared savings programs and risk-based payer contracts, the Parties have a proven record of utilizing system-wide resources to gain efficiencies in health care delivery. The Parties' intend to maintain and extend their proven record of using these savings to improve quality and access to care. Additionally, the Parties intend to coordinate across multiple shared services to derive the considerable benefits of tighter system integration and realize system-wide operational efficiency over time. Finally, the Combination would allow the Parties to invest jointly in critical infrastructure at a lower cost of capital and more strategically and efficiently than if the Parties sought to do so independently.

3. Implementation of the Combination. The Definitive Agreement (as defined in Section 10 below) will provide for a series of related transactions and satisfaction of certain conditions set forth in Section 11 of this Letter of Intent, and any additional conditions set forth in the Definitive Agreement, upon completion of which the Combination will be consummated (the "Combination Date"). The governance, clinical, operational and financial elements of the more integrated health care delivery system currently envisioned by the Parties (the "System") and intended to be effectuated by the transactions on the Combination Date are described in Sections 4 through 11 below.

4. Structure and Governance of the System. The Parties intend to implement the following legal, governance and management elements of the System on the Combination Date, as they may be modified in the Definitive Agreement:

(a) Transition of the System Organization to Serve as a Co-Member of CMC and Sole Member of MCH and HH. On or prior to the Combination Date, D-HH will file with the New Hampshire Secretary of State an Affidavit of Amendment to its Articles of Agreement to: (i) revise its corporate name from "*Dartmouth-Hitchcock Health*" to "*Dartmouth-Hitchcock Health*

GraniteOne"; (ii) amend and restate its Bylaws; and (iii) make such other changes and revisions to its key governing documents that are necessary or desirable so that it can continue to serve as the sole corporate member of the D-HH Members, and also serve as the sole corporate member of MCH and HH and a co-member (along with CMCHS) of CMC, and be responsible for the strategic direction and management of the System (the "System Organization"). The Parties agree that the name of the System will be re-evaluated in three (3) to five (5) years to reflect branding of the System, changes in the market and the evolution of the System. On or before the Combination Date, CMC, MCH and HH will amend their respective Articles of Agreement and Bylaws to establish the System Organization as the sole member of MCH and HH and the co-member of CMC and to include participation in the System among their corporate purposes. As a co-member of CMC and the sole member of MCH, HH (and of the D-HH Members), the System Organization will have the right to exercise such powers as may be conferred on it by law and the amended Articles of Agreement and Bylaws of CMC, MCH and HH as described in the Definitive Agreement and Section 4(d) of this Letter of Intent. The System Organization will maintain its recognized exempt status from federal income tax pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and its public charity status pursuant to Section 509(a)(2) of the Code. The Parties agree that maintaining and furthering the mission of Catholic healthcare is paramount to CMC. Accordingly, 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 Organization. CMCHS and CMC will not be involved in the reconstitution of D-HH, or help to prepare D-HH to serve as the System Organization.

(b) Legal and Governance Structure of GraniteOne Members and D-HH Members. CMCHS, CMC, MCH and HH will each continue as separately incorporated organizations and separately licensed acute care hospitals at their respective current locations and in furtherance of their respective charitable missions. Subject to future regulatory changes, MCH and HH will maintain their status as Critical Access Hospitals ("CAH") and will covenant in the Definitive Agreement to comply with CAH requirements in order to maintain this status. Although the Board of Trustees of the System Organization (the "System Board") will have the right to appoint representatives (subject to the reserved powers of CMCHS and the Bishop as such appointments pertain to CMC) in the manner to be detailed further in the Definitive Agreement, the Board of Trustees of each of the D-HH Members and GraniteOne Members will remain in place and continue to retain all of their legal authority to govern the provision of health care services at their respective facilities, except for those actions specifically reserved to the System Board as generally outlined in Section 4(d) of this Letter of Intent and as set forth in the Definitive Agreement. The role of CMCHS as the public juridic person to CMC as well as the powers reserved to the Roman Catholic Bishop of the Diocese of Manchester (the "Bishop") over CMCHS will not be impacted by the System Organization and the Combination.

(c) The System Board of Trustees. From and after the Combination Date, the System Board will be governed by fifteen (15) trustees initially comprised as follows:

1) Each of the System Chief Executive Officer ("CEO") and the President of Region I (both of whom initially will be Joanne Conroy, MD) will serve *ex officio* with full voting rights;

2) The President of Region II (who initially will be Joseph Pepe, MD, President and CEO of CMC) will serve *ex officio* with full voting rights;

3) Seven (7) System Board Trustees will be designated by the D-HH Board of Trustees; and

4) Five (5) System Board Trustees will be designated by the Board of Trustees of GraniteOne.

If one (1) individual holds more than one (1) of the foregoing offices, he or she will have one (1) vote for each office held. The twelve (12) non-*ex officio* Board positions will be filled by individuals qualified by knowledge, skill, experience and willingness to contribute to the achievement of the purposes of the System Organization. The specific manner in which the System Board will be nominated and appointed will be set forth in greater detail in the Definitive Agreement; provided that D-HH and GraniteOne will each retain sole responsibility for designating their respective appointees to the System Board for a transitional period which will be no less than the first and one (1) successive three (3) year term for each of those appointees, as permitted within agreed-upon term limits. The Parties agree that the initial Trustee terms will be staggered as determined by the Parties prior to the Combination Date and that no Trustee will serve more than three (3) consecutive terms. The Parties further agree that, after service of the initial terms (and any guaranteed successive term), the System Board will be self-perpetuating and will elect and re-elect all of its non-*ex officio* Trustees. Each Trustee will have the full right to vote and participate in the governance and affairs of the System Organization. The initial Chairperson is critical to the successful transition and implementation of the Combination and will be mutually-agreed upon by the Parties prior to the Combination Date.

(d) Reserved Powers of the System Board. In order to balance the Parties' intent that the respective Board of Trustees of each of the D-HH Members and GraniteOne Members will continue to govern the provision of health care services at their respective health care facilities with the desire to achieve the benefits and mutual goals of a more integrated health care delivery system, the Definitive Agreement will set forth the specific responsibilities of the System Board and those of the D-HH Members and GraniteOne Members (sometimes referred to collectively as the "System Members"). The Definitive Agreement also will specify certain mutually agreed-upon powers reserved to the System Board ("Reserved Powers"), and any governance requirements related to the exercise of those powers, which may include the right to initiate action by the System Members (subject to Section 4(f) as such rights to initiate action by the System Board pertains to CMC). These Reserved Powers will include, but not be limited to, the development of a system-wide strategic plan and approval of System Member strategic plans for consistency therewith; approval of annual capital and operating budgets; approval of borrowings (debt) and dispositions of material assets; approval of key strategic relationships such as the acquisition, disposition, or investment in any other corporation, partnership, limited liability company or joint venture; approval of the sale, disposition, mortgage, or encumbrance of any assets dedicated to healthcare service operations; approval of the institution of any bankruptcy, insolvency or reorganization proceedings; approval of capital investments; approval of the development, implementation, continuation or termination of clinical programs, services and procedures; and approval of the amendment of the Articles of Agreement or Bylaws of a System Member to the extent it would impact the Reserved Powers or reasonably could be expected to

have a material strategic, competitive or financial impact on the System or any of its Members, *provided* that the System will not require CMC to implement any programs, services or procedures that are against the teachings of the Catholic Church or in violation of the *Ethical and Religious Directives for Catholic Health Care Services* of the United States Conference of Catholic Bishops (the "ERDs") or otherwise contrary to the Code of Canon Law and, accordingly, any decision by the System Board which is not in compliance with the ERDs will remain the decision of those System Board Trustees designated by D-HH and not those designated by GraniteOne.

D-HH recognizes that certain of the Reserved Powers, as applied to CMC, will be shared by the System Board with CMCHS and the Bishop. The powers reserved to and executed by CMCHS and the Bishop will be generally in the nature of ratification rights. If there is a conflict between a ratification of the Bishop or CMCHS's reserved powers with respect to CMC (the "Bishop's Reserved Powers") and the Reserved Powers of the System Board with respect to CMC, then the decision of the Bishop will govern the decision with respect to CMC.

(e) Management. The System will have a CEO and such other individual management officers as are determined to be necessary by the System Board. The initial System CEO will be Joanne Conroy, M.D. The System CEO role and responsibilities will be set forth in the Definitive Agreement. The System Members will be managed regionally. Region I will be managed by the President of Region I, who initially will be the President and CEO of MHMH Joanne Conroy, MD. Region II will be managed by the President of Region II, who initially will be the President and CEO of CMC Joseph Pepe, MD. Region I generally will include the following: MHMH, DHC Keene, Lebanon and Putnam, NLH, MAHHC, Cheshire, APD, VNH and any other current northern New Hampshire and Vermont facilities and practices that are part of the D-HH System. Region II generally will include the following: CMC, HH, MCH, DHC Concord, Manchester and Nashua and any other current southern New Hampshire facilities and practices that are part of the D-HH System or GraniteOne System. As the administrator of both Catholic and non-Catholic facilities, the President of Region II will only oversee those operations that are consistent with the ERDs. Operations that are inconsistent with the ERDs will be overseen by the President of Region I. The identity of the initial President of Region II is critical to successfully achieving the objectives of the Combination as set forth in Section 2 of this Letter of Intent, and the Parties recognize the important role of the GraniteOne Members in determining the leadership of Region II during implementation of the combined system. For these reasons, while the initial President of Region II will be Joseph Pepe, MD, the Parties further agree that the appointment of the Region II President shall be subject to the approval of a majority of the GraniteOne appointees to the System Board, and their successors, for six (6) consecutive years following the Combination Date.

The roles and responsibilities of the Presidents of Region I and II will be set forth in detail in the Definitive Agreement, although the Parties anticipate that the key responsibilities will include the following:

- Supervising the President and CEO of each of the System Members within the respective region, who will have a reporting relationship to the respective Regional President;
- Leading the development of the new delivery system in the respective region;
- Implementing strategies to:

- Improve access for the community and meeting the growing needs of the population;

- Coordinating with system leadership to develop integrated clinical programs focusing on strengthening existing practice leaders and developing new and enhanced programming;

- Developing a comprehensive geographic plan for the provision of clinical programs over the next five (5) or more years;

- Developing the workforce plan to achieve the objectives of the Combination and strategic plans of the System;

- Developing a pluralistic physician model for community practice physicians, community hospital medical staff, participation by independent physicians and academic physicians. Consistent with a pluralistic physician model, for the avoidance of doubt and to ensure stability, collaboration, continuity and a smooth transition for the Combination, the Parties intend that the System and System Members, as applicable, will honor physician employment contract terms existing on and after the Combination Date.

The System will create a Member Leadership Council on which each of the current and future System Members will have representation. The Member Leadership Council will be comprised of senior management executives employed by the System Members or representative members of the System Member Boards of Trustees and will review, discuss and advise on management issues on a system-wide level, including strategic planning, budgeting, clinical matters and shared-savings models. The Member Leadership Council also will serve an advisory role to the System Board and the System Members.

(f) Compliance with Ethical and Moral Principles of the Catholic Church and Code of Canon Law. 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 the ERDs and operates in accordance with the Code of Canon Law. The System can never require CMC to engage in any action contrary to the ERDs.

5. Hospital Operations, Financial Decisions, and Strategic Planning. All debts, liabilities, assets and duties of a System Member will remain the obligation and property of such Member after the Combination Date, although the Parties expect that one or more of CMC, MCH and HH will join the Dartmouth-Hitchcock Health Obligated Group at some point after the Combination Date, provided they meet the qualifications and their respective Boards of Trustees approve their joinder. Each System Member also will retain ownership and control of all of its endowment funds, subject to the Reserved Powers and any donor-restrictions. The respective Boards of Trustees of the Parties will continue to be responsible for making operational and financial decisions as required by law, subject to a system-wide strategic plan approved by the System Board and the Reserved Powers. Subject to the limitations of Section 4(f) of this Letter of Intent, the system-wide strategic plan will include, but not be limited to, clinical programming,

services and procedures, operating and capital budgets, system-wide asset allocation and investment policies.

6. Clinical Programming and Services. The Parties are dedicated to their respective missions, levels of excellence and commitment to rural healthcare. The Parties acknowledge the importance of maintaining the existing level of hospital and other services provided by each of them and their respective Members within their respective communities under current applicable standards of quality, cost, volume and reimbursement. The System and the Presidents of Regions I and II will support the provision of core services within the appropriate community setting in a quality and efficient manner, as appropriate for a community hospital or necessary to maintain CAH status, as applicable. Decision-making about clinical service programming will take into account system-wide objectives and strategic planning, and aim to maximize synergies created by the Combination. When determining the effectiveness of clinical programming and services, the Parties agree that collaborative due diligence and assessments will include consideration of quality, cost, reimbursement, profitability, outcome, access, physician retention and recruitment, community need and each System Member's charitable purpose. Decision-making about clinical service programming also will include methods for enhancing behavioral health access and delivery. Following further due diligence, the Parties will set forth in the Definitive Agreements more specific details of the foregoing commitments based on their collaborative assessment.

7. Capital Priorities and Commitments. The Parties believe they must expand their capacity to meet patient needs for the reasons described in Section 2 above. To meet these needs, the Parties have been proceeding individually with a number of mission critical projects, the three most significant of which are described below. The Combination will allow joint investment in these projects at a lower cost of capital and enable certain cost and building efficiencies that would not be available to the Parties if they were to invest and build independently.

(a) *Expansion of ambulatory capacity in Region II.* For the reasons set forth above, the Parties agree that there is a need to expand access to primary and specialty care throughout southern New Hampshire and to expand access to less invasive outpatient procedures. Through a joint investment with its Member Dartmouth-Hitchcock, D-HH will be constructing a six (6) room ambulatory surgery center and creating additional capacity to provide primary and specialty care access at its DHC Manchester facility.

(b) *Expansion of CMC Campus in Region II.* For the reasons set forth above, the Parties agree that there is a need to expand CMC capacity to meet patient needs by expanding its hospital to increase capacity of NEHVI, expanding the emergency department, adding additional surgery and operating room capabilities and increasing the number of available inpatient beds.

(c) *Expansion of D-HH Lebanon Campus in Region I.* For the reasons set forth above, the Parties agree that there is a need to expand capacity at MHMH to meet patient needs by developing an inpatient tower with at least sixty (60) beds with shell space for an additional thirty (30) beds in the future, additional parking and a modest expansion of the emergency department.

Following further due diligence, the Parties will set forth in the Definitive Agreements more specific details of the foregoing commitments based on their collaborative assessment.

8. Affiliates and Joint Ventures. GraniteOne will undertake to obtain the consent of the GraniteOne Members to the Combination, to add them as signatories to the Definitive Agreement, and to terminate their existing affiliation agreement at or before the Combination Date to ensure implementation and achievement of the objectives of the transactions contemplated by the Definitive Agreement.

9. Integration Plan and Continued Identification and Development of the Combination Synergies. As soon as feasible and legally permissible, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition to a more integrated healthcare delivery system, including, without limitation, the establishment of the management structure of Regions I and II. In addition, the Parties will continue to evaluate and develop the administrative, operational and clinical integration of operations to achieve the objectives of the Combination, including enhancement of population health and wellness and prevention services, expansion of primary care practice development, enhancement of existing clinical collaborations and addition of new specialty services in southern New Hampshire, achievement of high quality clinical outcomes, reduction of risk and assurance of corporate compliance, improvement of physician recruitment and retention, achievement of efficiencies and implementation of best practices.

10. Definitive Agreement. The Parties agree to negotiate in good faith a written Definitive Agreement, as referenced throughout, which will contain representations, warranties, covenants, conditions, indemnifications and other terms and conditions customary for the formation of the System and to which the Parties will mutually agree, consistent with the terms of this Letter of Intent. The Parties also will negotiate and append to the Definitive Agreement, Affidavits of Amendment for the System Organization and the GraniteOne Members, Amended and Restated Bylaws for the System Organization and the GraniteOne Members, and any related corporate and transactional documents reasonably necessary to effectuate the Combination and which are satisfactory to the Parties (the "Transaction Documents"). The Definitive Agreement also will require GraniteOne and the GraniteOne Members to prepare a Notice of Change of Control to be submitted to the New Hampshire Charitable Trust Unit pursuant to RSA 7:19-b, and the Parties to prepare any filings required by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR") ("HSR Filing"), and any filings with the New Hampshire Department of Justice Antitrust Division (to the extent such filing is different, necessary or would supplement the HSR Filing if necessary). The Parties will agree to proceed expeditiously and cooperatively with respect to meeting obligations pursuant to New Hampshire law and any other applicable laws regarding transfer of control of a healthcare trust.

11. Closing Conditions. The Parties agree that the consummation of the Combination is expressly conditioned upon customary closing conditions, including without limitation: (a) completion of satisfactory legal, financial, regulatory, cultural and other due diligence by the Parties; (b) the execution of the Definitive Agreement and Transaction Documents; (c) approval or waiver by the trustees of any trust indenture related to any outstanding bonds or other debt securities of either Party, or in the alternative an opinion of counsel, mutually agreed upon, to the effect that no such approvals are required; (d) approvals or waivers from any third party to any contract requiring such consent prior to implementation of the Combination; (e) receipt of all approvals required by the State of New Hampshire including, but not limited to, the New Hampshire Department of Justice Antitrust Division and the Charitable Trust Unit; (f) receipt of

any approvals required pursuant to HSR; (g) receipt of any other necessary regulatory approvals; (h) receipt of approval by the appropriate governing bodies of D-HH, GraniteOne, CMCHS, CMC, the Bishop of the Roman Catholic Diocese of Manchester, MCH and HH; (i) receipt of letters of nihil obstat from the Bishop of the Roman Catholic Diocese of Manchester and if applicable, the Bishop of the Roman Catholic Diocese of Burlington; (j) receipt of any approvals, letters of no objection or opinion required by Canon Law or reasonably requested by the Bishop of the Roman Catholic Diocese of Manchester and if applicable, the Bishop of the Roman Catholic Diocese of Burlington; and (k) the absence of any material adverse changes (to be defined in the Definitive Agreement) in the operations of D-HH, GraniteOne or CMC. The Parties will coordinate their efforts and agree to cooperate and assist with obtaining any applicable third party approvals, including letters of nihil obstat by the Bishop of the Roman Catholic Diocese of Manchester and if applicable, the Bishop of the Roman Catholic Diocese of Burlington and any approvals required by Canon Law. The Parties will promptly provide all required notices and cooperate to complete and submit all filings and take all other steps necessary to obtain required approvals for the Combination.

12. Due Diligence Review. Each of the Parties and their representatives, consultants, accountants and attorneys will be permitted to conduct a due diligence review of the other Party's respective business operations and facilities (including those of its respective Members) as well as their ability to complete any post-closing duties and commitments. Such reviews will be conducted cooperatively by the Parties at their own expense.

13. Confidentiality/Exclusivity. Information and data disclosed to or obtained by one Party related to the other Party, will be treated as confidential information and the Parties' use of such information shall be governed by a certain Mutual Confidentiality and Nondisclosure Agreement entered into by D-HH and CMC on December 5, 2017 and a Mutual Confidentiality and Nondisclosure Agreement entered into by D-HH and GraniteOne on December 17, 2018 (the "Confidentiality Agreements"). The Confidentiality Agreements are hereby renewed and will be in full force and effect during the term of this Letter of Intent. The Definitive Agreement will include other confidentiality terms as agreed upon by the Parties. From and after the Effective Date until the Combination Date or the termination of this Letter of Intent, each of the Parties further agrees that it will not seek, entertain or continue any solicitation, discussion or negotiation with any third party regarding a change of control transaction similar to the Combination without the consent of the other Party, and such promise of exclusivity shall be a binding obligation of one Party to the other.

14. Termination. This Letter of Intent will continue in effect from the date hereof until (a) the Parties mutually agree to terminate this Letter of Intent, or (b) one Party provides the other Party with thirty (30) days' prior written notice of termination of this Letter of Intent. Should either or both Parties terminate this Letter of Intent, all binding provisions hereof, as set forth below, and the binding provisions of the Confidentiality Agreements will survive the termination of this Letter of Intent.

15. Joint Communication/Required Disclosures. Unless the Parties otherwise mutually agree, they will not make any public announcements regarding the Combination until the Definitive Agreement has been executed. The Parties will jointly develop and implement a communication plan and process for publicly announcing the Combination, communicating the

Combination to their employees and physicians, and responding to any inquiries regarding the Combination. Public communications regarding the Combination will be approved by the Parties prior to being released. If either Party determines that it is required by law to make any disclosure concerning the Combination, then it will notify the other Party and the Parties will work cooperatively on the content of the proposed disclosure, the reasons that such disclosure is required by law, and the time and place that the disclosure will be made.

16. Expenses. Except as set forth below, each Party will be responsible for paying its own expenses relating to the Combination, including, without limitation, expenses of legal counsel, accountants, and other advisors, incurred at any time in connection with pursuing or consummating the Combination. The payment of the fees and expenses of The Chartis Group for its services as well as the filing fees associated with notices for change of control antitrust filings to the Federal Trade Commission and the State of New Hampshire will be divided equally between D-HH and GraniteOne.

17. Liability. D-HH and GraniteOne each agrees that it will be liable for any violation of the binding terms of this Letter of Intent by its trustees, officers, employees, advisors, consultants, agents, representatives, members or affiliates to the same extent as if the violation were committed by the Party.

18. Notices. Any notice required to be given under this Letter of Intent will be effective upon depositing the notice in first-class mail, overnight courier or certified mail, return receipt requested, or sent by facsimile or electronic mail with confirmation of receipt, addressed as follows:

If to D-HH:

Dartmouth-Hitchcock Health
One Medical Center Drive
Lebanon, New Hampshire 03756
Attn: John P. Kacavas, Esq., Chief Legal Officer & General Counsel
John.P.Kacavas@hitchcock.org

With a simultaneous copy to:

Hinckley Allen & Snyder LLP
650 Elm Street, Suite 500
Manchester, New Hampshire 03101
Attn: Mark S. McCue, Esq.
mmccue@hinckleyallen.com

If to GraniteOne:

GraniteOne Health

100 McGregor Street
Manchester, New Hampshire 03102
Attn: Alexander J. Walker, Executive Vice President & Chief Operating Officer
Alex.walker@cmc-nh.org

With a simultaneous copy to:

Catholic Medical Center
100 McGregor Street
Manchester, New Hampshire 03102
Attn: Jason E. Cole, Esq., Vice President & General Counsel
Jason.cole@cmc-nh.org

19. Amendments. This Letter of Intent may not be amended in whole or in part except by a written instrument signed by each of the Parties.

20. Waiver. No waiver of any binding provision, condition or covenant of this Letter of Intent will be effective against the waiving Party unless such waiver is in writing and signed by the waiving Party.

21. Third Party Beneficiary. None of the provisions contained in this Letter of Intent are intended by the Parties, nor will they be deemed, to confer any benefit on any person not a party to this Letter of Intent, except as otherwise expressly provided herein.

22. Governing Law. This Letter of Intent will be governed by and construed in accordance with the laws of the State of New Hampshire without regard to conflict of law principles. The Parties agree to submit to the jurisdiction of New Hampshire courts to resolve any disputes which may arise from or as a result of this Letter of Intent.

23. Counterparts and Signatures. This Letter of Intent may be executed in counterparts, and each counterpart will be deemed to be an original, and all such counterparts will together constitute one and the same instrument. Electronic and facsimile signatures will be deemed to be original signatures.

By executing this Letter of Intent, each of D-HH and GraniteOne confirms that it agrees in principle to the contents of this Letter of Intent and intends to proceed promptly and in good faith to complete due diligence and to finalize the Definitive Agreement and any other agreements contemplated herein or ancillary hereto. Except with respect to Sections 10, 13, 15, 16, 17 and 19, which will be binding upon the Parties, this Letter of Intent is not, and is not intended to be, an enforceable agreement or binding expression of intent of the Parties to enter into the Combination or otherwise proceed to execute the Definitive Agreements.

[*Remainder of page intentionally left blank. Signature page follows.*]

This Letter of Intent is hereby agreed to by D-HH and GraniteOne upon the Effective Date.

DARTMOUTH-HITCHCOCK HEALTH ("D-HH")

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

GRANITEONE HEALTH ("GRANITEONE")

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

[*Signature page of the Letter of Intent*]