

COMBINATION AGREEMENT

by and among

DARTMOUTH-HITCHCOCK HEALTH

GRANITEONE HEALTH

CATHOLIC MEDICAL CENTER

CMC HEALTHCARE SYSTEM

ALLIANCE AMBULATORY SERVICES

ALLIANCE HEALTH SERVICES

CATHOLIC MEDICAL CENTER PHYSICIAN PRACTICE ASSOCIATES

HUGGINS HOSPITAL

and

MONADNOCK COMMUNITY HOSPITAL

DATED: September 30, 2019

TABLE OF CONTENTS

RECITALS1

ARTICLE 1. STATEMENT OF PURPOSE AND MUTUAL VISION 4

 1.1 Furtherance of Charitable Purposes 4

 1.2 Compatible Missions and Cultures 4

 1.3 Integrated Health Care Delivery 5

 1.4 Improve Access to Services 5

 1.5 Continuous Quality Improvement..... 5

 1.6 Address Workforce Needs 6

 1.7 Reinforce Rural Health Care..... 6

 1.8 Population Health Management..... 7

 1.9 Financial Sustainability..... 7

ARTICLE 2. GUIDING PRINCIPLES 8

 2.1. Commitment to Community Health Care Needs 8

 2.2. Commitment to Integrated, Quality, Efficient Services..... 8

 2.3. Commitment to Identity and Charitable Mission..... 8

 2.4. Compliance with Applicable Charitable and Tax-Exempt Requirements 8

 2.5. Principles Underlying the Provision of Health Care Services 9

 2.6. Catholic Identity and Health Care Mission of CMC and CMCHS Subsidiaries 9

 2.7. D-HH’s Academic Health Care Mission 10

 2.8. Rural Health Care and Critical Access Hospitals 11

ARTICLE 3. DESCRIPTION OF COMBINATION AND GOVERNANCE 12

 3.1 ESTABLISHMENT OF COORDINATING ORGANIZATION FOR THE
 COMBINED SYSTEM 12

 3.2 CORPORATE STRUCTURE 12

 3.2.1 D-HH GO as Sole Member of HH and MCH..... 12

 3.2.2 D-HH GO as Co-Member of CMC and the CMCHS Subsidiaries 12

 3.3 GOVERNANCE 13

 3.3.1 General..... 13

 3.3.2 D-HH GO Board of Trustees 13

 (a) *Responsibilities* 13

 (b) *Composition of System Board*..... 13

 (c) *Nomination and Election Process*..... 14

 (d) *Chair of the System Board* 14

 3.3.3 CMC, CMCHS Subsidiaries, HH and MCH Boards of Trustees 14

 3.3.4 CMCHS Board of Trustees 15

 3.3.5 Member Leadership Council and Rural Hospital Group 15

 (a) *Member Leadership Council*..... 15

 (b) *Rural Hospital Group* 16

 3.4 RESERVED AND RETAINED POWERS 16

 3.4.1. D-HH GO Reserved Powers Applicable to HH and MCH..... 16

 (a) *Approval Rights Over Certain Actions of HH and MCH
 Board of Trustees* 17

	(b) <i>Rights of D-HH GO to Initiate or Enforce Actions by HH and MCH</i>	19
3.4.2	Reserved Powers of D-HH GO, CMCHS and the Bishop Applicable to CMC and the CMCHS Subsidiaries	20
	(a) <i>Approval Rights Over Certain Actions of CMC Board of Trustees</i> ...	21
	(b) <i>Rights of D-HH GO to Initiate Actions by CMC and the CMCHS Subsidiaries</i>	24
3.4.3	Additional Reserved Powers of CMCHS and the Bishop Applicable to CMC and the CMCHS Subsidiaries	26
3.4.4	Reconciliation of Conflict in Exercise of D-HH GO and Bishop’s Reserved Powers.....	27
3.4.5	Retained Powers of CMC, the CMSHS Subsidiaries, HH and MCH.....	27
	(a) <i>Ex Officio Positions; Member Board Nominees</i>	27
	(b) <i>Member Board Chair</i>	27
	(c) <i>Input on Actions Pertaining to Member President and Chief Executive Officer</i>	27
	(d) <i>Strategic Planning and Operational Oversight</i>	28
	(e) <i>Donor-Restricted Funds</i>	28
	(f) <i>Fundraising</i>	28
	(g) <i>Intellectual Property</i>	28
ARTICLE 4.	SYSTEM MANAGEMENT AND REPORTING	29
4.1	CLINICAL STRUCTURE.....	29
4.1.1	Pluralistic Model.....	29
4.1.2	Existing Contractual Commitments.....	29
4.1.3	Diversity of Member Organizations	29
4.2	ADMINISTRATIVE MANAGEMENT STRUCTURE	29
4.2.1	System Chief Executive Officer	29
4.2.2	Regional Leadership and Reporting Relationships.....	30
	(a) <i>Regions</i>	30
	(b) <i>Regional Presidents – Appointment and Special Provision</i>	31
	(c) <i>Regional Presidents – Authority and Responsibilities</i>	31
	(d) <i>Adherence to Catholic Moral Teachings and Compliance with the ERDs and Canon Law in Region II Management</i>	32
	(e) <i>Adherence to Catholic Moral Teaching and Compliance with the ERDs and Canon Law in Region II Clinical Operations</i>	33
4.2.3	Member Leadership and Reporting Relationships.....	35
ARTICLE 5.	SYSTEM INTEGRATION	36
5.1	STRATEGIC PLAN AND INITIATIVES.....	36
5.1.1	System Board Strategic Planning.....	36
5.1.2	Member Board Strategic Planning.....	36
5.2	OPERATIONAL PLANNING	36
5.2.1	System-Wide Operations	36
5.2.2	Member Board Operational Responsibilities.....	36
5.3	CLINICAL PROGRAM DEVELOPMENT.....	37
5.3.1	Inpatient Services.....	37
5.3.2	Specialty Services	38

	(a) <i>Behavioral Health</i>	38
	(b) <i>Pediatrics</i>	39
	(c) <i>Oncology</i>	40
	(d) <i>Orthopedics</i>	41
	(e) <i>Spine Care and Pain Management</i>	42
	(f) <i>Obesity and Bariatrics</i>	43
	(g) <i>Heart and Vascular</i>	43
5.3.3	Continuation of Services.....	45
	(a) <i>Evaluation of Services</i>	45
	(b) <i>Process for Implementing Changes in Clinical Services</i>	45
5.3.4	System Commitments to HH and MCH	45
5.3.5	Telehealth Services	46
5.3.6	Clinical Quality and Process Improvement	48
5.3.7	Teaching and Research Programs.....	49
5.4	INFORMATION TECHNOLOGY	50
5.4.1	Interim Interoperability.....	50
5.4.2	Full Integration.....	50
5.5	FINANCIAL MANAGEMENT	50
5.5.1	Endowment Funds	50
5.5.2	Financial Performance and Allocation of System Resources and Expenses.....	51
	(a) <i>Financial Principles</i>	51
	(b) <i>Financial Monitoring and Improvement Planning</i>	51
	(c) <i>Reallocation of Member Assets by System</i>	52
5.5.3	Dartmouth-Hitchcock Obligated Group	52
5.5.4	Defined Benefit Pension Plan	53
5.5.5	Capital and Financial Investments	53
	(a) <i>CMC Hospital Expansion</i>	53
	(b) <i>Future Capital Projects Planning</i>	54
5.5.6	Philanthropy	55
5.6	CONSOLIDATION OF ADMINISTRATIVE FUNCTIONS	55
ARTICLE 6.	IMPLEMENTATION OF COMBINATION	56
6.1	CLOSING; COMBINATION DATE	56
	6.1.1 Closing	56
	6.1.2 Combination Date	56
6.2	TRANSACTIONS IN CONNECTION WITH THE CLOSING	56
	6.2.1 Obligations of D-HH.....	56
	6.2.2 Obligations of GOH.....	57
	6.2.3 Obligations of HH and MCH.....	57
	6.2.4 Obligations of each of CMC and the CMCHS Subsidiaries.....	58
6.3	CONDITIONS PRECEDENT TO OBLIGATIONS OF THE PARTIES.....	58
	6.3.1 Representations and Warranties True and Correct	58
	6.3.2 Performance of Covenants.....	58
	6.3.3 Governmental and Third-Party Consents, Approvals, Authorizations	59
	6.3.4 Completion of Due Diligence	59
	6.3.5 Corporate Approvals.....	59

6.3.6	No Material Adverse Event	59
6.3.7	Failure to Satisfy Conditions	59
ARTICLE 7.	REPRESENTATIONS AND WARRANTIES; INDEMNIFICATION	61
7.1	REPRESENTATIONS AND WARRANTIES.....	61
7.1.1	Organization and Good Standing.....	61
7.1.2	No Capital Stock; Membership.....	61
7.1.3	Corporate Powers.....	61
7.1.4	Authorization; Binding Agreement.....	61
7.1.5	No Conflicts: Required Consents.....	61
7.1.6	Tax-Exempt Status; Taxes	61
7.1.7	Financial Information.....	62
	(a) <i>Financial Statements</i>	62
	(b) <i>Absence of Undisclosed Liabilities</i>	62
	(c) <i>No Adverse Actions</i>	63
7.1.8	Medicare And Medicaid Participation; Reimbursement Contracts; Accreditation.....	63
7.1.9	Third Party Cost Reports	63
7.1.10	Employee Benefit Plans.....	63
	(a) <i>Compliance</i>	63
	(b) <i>Absence of Claims</i>	64
	(c) <i>COBRA</i>	64
7.1.11	Compliance With Laws.....	64
7.1.12	Legal Proceedings; Claims	64
7.1.13	No Cash Consideration/Merger	64
7.1.14	Absence Of Certain Changes Or Events.....	65
7.1.15	Opportunity For Due Diligence	65
7.2	MUTUAL INDEMNIFICATION	65
ARTICLE 8.	PRE-CLOSING COVENANTS OF THE PARTIES	66
8.1	ACCESS AND INFORMATION.....	66
8.2	GOOD FAITH EFFORTS; COOPERATION.....	66
	8.2.1 Satisfaction of Conditions.....	66
	8.2.2 Cooperation.....	66
8.3	HART-SCOTT-RODINO ACT FILINGS	66
	8.3.1 Pursuit of Regulatory Approvals	66
	8.3.2 Conduct of the Parties with Respect to Regulatory Agencies	67
	8.3.3 Costs.....	67
8.4	CONDUCT OF BUSINESS IN THE ORDINARY COURSE	67
8.5	INTEGRATION PLANNING	67
8.6	CONFIDENTIALITY AND JOINT DEFENSE AGREEMENT.....	67
8.7	EXCLUSIVITY	68
ARTICLE 9.	DISPUTE RESOLUTION	69
9.1	INFORMAL DISPUTE RESOLUTION	69
	9.1.1 Pre-Combination Disputes	69
	9.1.2 Post-Affiliation Disputes	69
9.2	NON-BINDING MEDIATION	69
9.3	BINDING ARBITRATION.....	69

ARTICLE 10. TERMINATION	70
10.1 TERMINATION EVENT(S).....	70
10.1.1 Termination Prior to Combination Date	70
(a) <i>Failure to Satisfy Conditions</i>	70
(b) <i>Mutual Consent of Parties' Boards for Failure To Achieve</i> <i>Combination Goals</i>	70
(c) <i>Material Adverse Event</i>	70
10.1.2 Termination At Any Time	70
(a) <i>Material and Uncured Breach</i>	70
(b) <i>Material Change in Law or Regulation</i>	71
10.2 CONSEQUENCES OF TERMINATION	71
ARTICLE 11. MISCELLANEOUS PROVISIONS	72
11.1 NO ASSIGNMENT	72
11.2 GOVERNING LAW.....	72
11.3 APPLICATION OF LEGAL PRINCIPLES.....	72
11.3.1 Waiver.....	72
11.3.2 Integration.....	72
11.3.3 No Third Party Beneficiaries	72
11.3.4 Severability	72
11.3.5 Survival.....	72
11.3.6 Availability of Rights and Remedies	73
11.4 JOINT COMMUNICATIONS; PUBLIC STATEMENTS	73
11.5 NOTICES.....	74
11.6 EXECUTION, DELIVERY AND COUNTERPARTS.....	75
11.7 INTERPRETATION OF STATEMENTS ABOUT CLOSING ACTIONS AND DELIVERABLES	75
EXECUTION BY THE PARTIES	76

COMBINATION AGREEMENT

This COMBINATION AGREEMENT (the “Agreement”) is entered into and made effective as of September 30, 2019 (the “Agreement Date”), by and among **Dartmouth-Hitchcock Health**, a New Hampshire non-profit, voluntary corporation with a principal place of business at One Medical Center Drive, Lebanon, New Hampshire (“D-HH”), and **GraniteOne Health**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire (“GOH”), and **CMC Healthcare System**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire (“CMCHS”), and **Catholic Medical Center**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire (“CMC”), and **Alliance Ambulatory Services**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire (“AAS”), **Alliance Health Services**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire (“AHS”), **Catholic Medical Center Physician Practice Associates**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire (“CMCPPA”), and **Huggins Hospital**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 240 South Main Street, Wolfeboro, New Hampshire (“HH”), and **Monadnock Community Hospital**, a New Hampshire non-profit, voluntary corporation with a principal place of business at 452 Old Street Road, Peterborough, New Hampshire (“MCH”). Each of D-HH, GOH, CMCHS, CMC, AAS, AHS, CMCPPA, HH, and MCH is referred to individually herein as a “Party” and collectively they are referred to as the “Parties.”

RECITALS

A. WHEREAS, D-HH is the coordinating organization of a multi-member, integrated academic health system (the “D-HH System”) that delivers a full spectrum of health care services to the general public of New Hampshire, Vermont and northern New England, and is the sole corporate member of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic, which operate jointly as Dartmouth-Hitchcock (“D-H”). The D-HH System is anchored by Dartmouth Hitchcock Medical Center (“DHMC”) in Lebanon – New Hampshire’s only academic medical center – and comprised of three rural critical access hospitals (“CAHs”), an acute care community hospital, a post-acute and hospice care provider, and multi-specialty community group practices throughout its service area (collectively the “D-HH System Members”), and operates to strengthen and augment its members’ provision of high quality, cost-effective health care, scientific research, and medical education to promote public health and welfare;

FINAL FOR SIGNATURE

B. WHEREAS, GOH is the supporting organization of a multi-member health care delivery system comprised of CMC, MCH and HH (the “GOH System”). GOH is the sole corporate member of MCH and HH, and the co-member of CMC, along with CMCHS, and operates to support, enhance and expand the breadth, depth and quality of cost-effective health care services available to the communities served by its members;

C. WHEREAS, CMC is an acute care, three-hundred-thirty (330) licensed bed community hospital in Manchester offering a full range of medical and surgical services, including emergency care, obstetrics and gynecology, women’s fertility, breast care, orthopedic care, urology, weight management, gastroenterology, inpatient and outpatient rehabilitation, outpatient behavioral health care, and is a nationally-recognized provider of heart and vascular care at its New England Heart and Vascular Institute (“NEHVI”);

D. WHEREAS, CMCHS is the co-member of CMC together with GOH, and is the sole member of AAS, AHS, and CMCPA (each a “CMCHS Subsidiary” and collectively the “CMCHS Subsidiaries”), and serves as the public juridic person of diocesan right under the Code of Canon Law of the Roman Catholic Church (“Canon Law”), responsible for ensuring CMC’s adherence to the Ethical and Religious Directives for Catholic Health Care Services of the United States Conference of Catholic Bishops (“ERDs”), and is subject to certain powers reserved to the Roman Catholic Bishop of Manchester (the “Bishop”);

E. WHEREAS, AAS owns and operates interests in various ambulatory care facilities, AHS manages the professional services relationship between CMC and D-HC Manchester, and CMCPA employs the physicians who provide health care services to patients of CMC and other facilities within CMCHS;

F. WHEREAS, MCH is a twenty-five (25) bed CAH that provides emergency care; inpatient medical, surgical, orthopedic, and obstetric services; outpatient primary and specialty care services; and behavioral health services to the residents of the Town of Peterborough and surrounding communities. MCH is a participant in the New England Alliance for Health (“NEAH”), wholly owned by Mary Hitchcock Memorial Hospital (“MHMH”), a D-HH System member, and offering services and a collaborative forum for rural health care providers;

G. WHEREAS, HH is a twenty-five (25) bed CAH that provides emergency care, inpatient medical, surgical and orthopedic services, and outpatient primary and specialty care services to the residents of the Town of Wolfeboro and surrounding communities;

H. WHEREAS, D-HH and GOH, and all of the respective members within each of the two systems, share a common commitment to promoting the delivery of high quality, cost-effective health care to the communities of New Hampshire and Vermont served by their members and

FINAL FOR SIGNATURE

affiliates, and to improving the health of those populations by deploying and coordinating resources to achieve efficient and effective patient management that enables patients to receive care at the most appropriate, convenient and cost-effective sites;

I. WHEREAS, the Parties believe that the combination of the D-HH System and the GOH System described in this Agreement (the “Combination”) will allow them mutually to benefit from each other’s clinical, educational, and technological resources so that, together, they remain at the forefront of patient care, quality assurance, health care technology, information systems, and population health management;

J. WHEREAS, evinced by the numerous successful and durable clinical collaborations between and among them, the Parties recognize the compatibility of their charitable purposes to improve the health and health care of individuals in the communities they serve through education, research and the advancement of clinical practice;

K. WHEREAS, the Parties recognize the commonality of their patient-centered care cultures and, informed in part by organizational culture assessments conducted by D-H and CMC, also recognize the complementary nature of their organizational cultures;

L. WHEREAS, as demonstrated by long-standing clinical affiliations, D-HH has acknowledged and supported CMC’s Catholic identity and adherence to the ERDs, including the acknowledgement of CMC’s value of life;

M. WHEREAS, the Parties envision that the establishment of a bi-regional, more fully integrated health care delivery system centered around the state’s only academic medical center, DHMC, in Lebanon and the GOH high acuity urban community hospital in Manchester will serve better the diverse needs of New Hampshire’s rural and urban communities, including through commitments to reinforce, enhance, and add needed specialty services across the Parties’ rural service areas and to address the complex needs of more urban populations in Greater Manchester and southern New Hampshire, including the acute need for substance use disorder treatment and behavioral health care;

N. WHEREAS, with the advice of experienced consultants and counsel, the Parties have analyzed their respective strategic options and have worked collaboratively to negotiate the myriad issues involved in creating a financially, administratively and clinically integrated health care delivery system;

O. WHEREAS, D-HH and GOH entered into a non-binding Letter of Intent dated January 23, 2019, and now wish to make a specific and binding commitment to develop a combined health care system comprised of the components of the D-HH System and GOH System (as combined,

FINAL FOR SIGNATURE

the “System”), and for D-HH, MCH and HH to reconstitute a coordinating organization which will preserve the Parties’ local identities, cultures, and traditions, and to which CMC will subsequently be joined; and

P. WHEREAS, the Parties wish to set forth the complete terms, conditions, and steps required to implement the Combination and to govern their relationships following integration, and to state their commitment to the Combination subject to: (i) further due diligence; (ii) appropriate review by regulatory authorities; and (iii) any mutually acceptable modifications resulting from such further due diligence, regulatory review, and public input received pursuant to the process required by New Hampshire RSA 7:19-b.

NOW THEREFORE, in consideration of the foregoing premises and the mutual promises and covenants contained in this Agreement, and for other good and valuable consideration received, the Parties hereby agree as follows:

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 locally. 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 demonstrated record of allocating financial, strategic, operational, and human resources within its system where and 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 Catholic Identity and Health Care Mission of CMC and CMCHS Subsidiaries. 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. The Parties agree that each reference to "CMC" in this Section 2.6 will be deemed to include a reference to each of the CMCHS Subsidiaries.

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.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 3. DESCRIPTION OF COMBINATION AND GOVERNANCE

3.1 ESTABLISHMENT OF COORDINATING ORGANIZATION FOR THE COMBINED SYSTEM

On or prior to the Combination Date (defined in Section 6.1.2 below), 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 the CMCHS Subsidiaries, and be responsible for the strategic direction and management of the System (“D-HH GO”). The Parties agree that the name of the System will be re-evaluated within three (3) to five (5) years after the Combination Date to reflect branding of the System, changes in the market and the evolution of the System. As described in Section 11.7 below, CMCHS and CMC will not be involved in the reconstitution of D-HH or any other acts necessary to prepare D-HH to serve as the coordinating and managing organization of the System, or in the substitution of D-HH GO as the sole member of MCH and HH.

3.2 CORPORATE STRUCTURE

3.2.1 D-HH GO as Sole Member of HH and MCH. On or before the Combination Date, each of HH and MCH will amend its respective Articles of Agreement and Bylaws to: (i) establish D-HH GO as its sole member in replacement of GraniteOne; (ii) reserve to D-HH GO the powers described in Section 3.4.1 below but subject to the retained powers described in Section 3.4.5; and (iii) add support of, and participation in, the combined System as one of its corporate purposes.

3.2.2 D-HH GO as Co-Member of CMC and the CMCHS Subsidiaries. On or before the Combination Date but following the actions described in Section 3.2.1 above, each of CMC and the CMCHS Subsidiaries will amend its respective Articles of Agreement and Bylaws to: (i) establish D-HH GO as one of its two corporate members, along with CMCHS; (ii) reserve to D-HH GO the powers described in Section 3.4.2 below but subject to the restrictions described in Sections 3.4.3 and 3.4.4 and the retained powers described in Section 3.4.5; and (iii) add support of, and participation in, the combined System as one of its corporate purposes subject to the provisions of Section 2.6 above.

3.3 GOVERNANCE

3.3.1 General. Each of the Parties will retain its separate legal identity and, except as may be expressly stated in this Agreement to the contrary, will retain ownership and responsibility for its assets and liabilities. To effectively manage and maintain the high level of integration and communication required to achieve the Parties' goals for the Combination, however, the Parties agree that certain powers and responsibilities will be reserved to the D-HH GO Board of Trustees (the "System Board") subject to the powers and responsibilities reserved to the Bishop and CMCHS over only CMC and the CMCHS Subsidiaries, certain powers and responsibilities will be retained by the respective Boards of Trustees of CMC, the CMCHS Subsidiaries, HH and MCH, and the System Board will have representation among those Boards and will be informed by the Member Leadership Council and Rural Hospital Group, all as described below.

3.3.2 D-HH GO Board of Trustees.

(a) *Responsibilities*. The System Board responsibilities include creating and implementing the System Strategic Plan described in Section 5.1.1 below, establishing System-wide programs and initiatives designed to improve access to care and the quality and efficiency of the delivery of care throughout the System, overseeing and allocating the resources of the System in furtherance of the System Strategic Plan and the financial guidelines described in Section 5.5.2 below, identifying, evaluating and developing strategic opportunities, and negotiating the addition of new System members or the establishment of strategic relationships between the System and third parties.

(b) *Composition of System Board*. From and after the Combination Date, the System Board will be comprised of fifteen (15) trustees initially determined as follows:

(i) The System Chief Executive Officer (described in Section 4.2.1 below) will serve *ex officio* with full voting rights;

(ii) The President of Region I (described in Section 4.2.2 below) will serve *ex officio* with full voting rights

(iii) The President of Region II (described in Section 4.2.2 below) will serve *ex officio* with full voting rights;

(iv) Seven (7) 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) 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”).

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 Parties agree that the initial Trustee terms will be staggered from one (1) to three (3) years in length, and that no Trustee will serve more than three (3) consecutive terms. Each System Board Trustee will have the full right to vote and participate in the governance and affairs of D-HH GO; provided, however, that any GOH Nominee who also serves on the CMC Board of Trustees or the Board of Trustees of a CMCHS Subsidiary will make an explicit objection, and will not consent, to any decision regarding the implementation or continuation of any procedures that are not consistent with Catholic moral teaching and the ERDs.

(c) *Nomination and Election Process.* The twelve (12) non-*ex officio* System 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. Prior to the Combination Date, D-HH and GOH will identify the D-HH Nominees and the GOH Nominees, respectively, and assign each a term in accordance with the attached Schedule 3.3.2(c). If any D-HH Nominee is subject to re-election or vacates his or her position on the System Board for any reason during a transitional period equal to that individual’s first term and one (1) successive three (3) year term, then that 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 any GOH Nominee is subject to re-election or vacates his or her position on the System Board for any reason during a transitional period equal to that individual’s first term and one (1) successive three (3) year term, then that GOH Nominee will be re-elected or replaced by a majority vote only of the remaining GOH Nominees on the System Board. The Parties further agree that, after the D-HH Nominees and GOH Nominees serve their initial terms and their guaranteed successive terms, the System Board will be self-perpetuating and will elect and re-elect all of its non-*ex officio* Trustees by a simple majority vote of all of the System Board Trustees.

(d) *Chair of the System Board.* The initial Chair of the System Board 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.

3.3.3 CMC, CMCHS Subsidiaries, HH and MCH Boards of Trustees. The Boards of Trustees of CMC, each of the CMCHS Subsidiaries, HH and MCH, respectively (collectively the “Member Boards”), will retain the powers described in Section 3.4.5 below and will be responsible for the strategic planning described in Section 5.1.2 below, for Member operations as described in

Section 5.2.2 below, and for adhering to the financial management provisions of Section 5.5 below. The Member Boards also will determine the total number of individuals who will comprise their respective Member Boards, including *ex officio* positions, subject to the System Board Reserved Powers (described in Sections 3.4.1 and 3.4.2 below). 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, which appointments will be consistent with the Trustee criteria set forth in the attached Schedule 3.3.3. Up to one-third (1/3) of the Member Boards of CMC and each of the CMCHS Subsidiaries will be nominated by the System Board and appointed by CMCHS and the Bishop. The System Board will make such nominations to the CMC Board and CMCHS Subsidiary Boards consistent with the Trustee criteria set forth in Schedule 3.3.3, which CMCHS agrees are important factors in maintaining a strong and effective governing Board of CMC and each of the CMCHS Subsidiaries and ensuring their continued adherence to Catholic moral teaching, the ERDs and Canon Law. The remaining two-thirds (2/3) of the Member Boards will be comprised of *ex officio* positions and individuals nominated by the Member Boards and approved under the System Board Reserved Powers described below (the “Member Board Nominees”). The Member Board Nominees of HH and MCH will be elected by the D-HH GO acting through the System Board, and the Member Board Nominees of CMC will be appointed by CMCHS.

3.3.4 CMCHS Board of Trustees. CMCHS is not a component of the System or a participant in its establishment. The Parties agree that CMCHS will remain a co-member of CMC and the CMCHS Subsidiaries 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 and the CMC Subsidiaries, but will have no authority over any other System Member. The CMCHS Board of Trustees will retain its reserved powers over CMC and the CMCHS Subsidiaries, which CMCHS reserved powers 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 or the CMCHS Subsidiaries cannot require CMC or any of the CMCHS Subsidiaries to implement any programs, services or procedures that are against the moral teaching of the Catholic Church or inconsistent with the ERDs or Canon Law.

3.3.5 Member Leadership Council and Rural Hospital Group.

(a) *Member Leadership Council*. The System will create a Member Leadership Council comprised of one or more senior management executives employed by each System Member, e.g., CEO, CFO, CMO, and/or one or more representatives of each System Member Board of Trustees, e.g., Board Chair, Vice Chair. The Member Leadership Council will be convened and led by the System CEO or his or her designee at regular intervals to be determined, but no less than quarterly, to review, discuss, and advise on System-wide management issues, including but not limited to strategic planning,

integration progress, financial planning and budgeting, operations, clinical matters and governance. The Member Leadership Council will serve an advisory role to the System Board, whose Chair or designee will have a standing invitation to attend and participate in Member Leadership Council meetings. The System CEO or his or her designee will be responsible for ensuring that matters raised and discussed at the Member Leadership Council are communicated to the System Board.

(b) *Rural Hospital Group.* The Member Leadership Council will form a subgroup comprised of one or more of the senior management executives of the rural hospitals (including the CAHs) which are Members of the System (the “Rural Hospital Group”). At each meeting of the Member Leadership Council, a breakout session will be scheduled for a meeting of the Rural Hospital Group. The Rural Hospital Group will review and discuss strategic, clinical, financial and/or operational issues or challenges unique to rural community hospitals and CAHs in the 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. The Regional Presidents, System CEO and System Board Chair will have standing invitations to attend and participate in meetings of the Rural Hospital Group.

3.4 RESERVED AND RETAINED POWERS.

The Parties acknowledge that the System must be well-integrated to accomplish their mutual goals for the effective and efficient delivery of quality health care described in Article I above. The Parties also acknowledge that the Member hospitals and other provider organizations in the 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 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 System, and (ii) the Board of Trustees of each of CMC, HH and MCH will retain certain powers and responsibilities for health care in their respective communities, as described below.

3.4.1 D-HH GO Reserved Powers Applicable to HH and MCH. Each of HH and MCH agree to reserve to D-HH GO as its sole corporate member the following powers and authority (together with the D-HH GO powers and authority over CMC as described in Section 3.4.2 below, the “System Board Reserved Powers”), subject to any process or criteria imposed by any other provision of this Agreement on the exercise of the System Board Reserved Powers:

(a) *Approval Rights Over Certain Actions of HH and MCH Board of Trustees.* Prior to becoming effective, each of the following actions of HH and MCH must be approved by the System Board or by a committee of the System Board (the majority of which committee will be composed of System Board Trustees) to which any of the following approval rights is delegated by the System Board:

(i) Nominees to HH and MCH Boards of Trustees; Size of Boards. Beginning with the selection of any new Trustee after the Combination Date, the nomination by each of HH and MCH of individuals to serve as elected members of its Board of Trustees (sometimes individually referred to as a “Member Board”) as described in Section 3.3.3, and the establishment by each of HH and MCH of the total number of Trustees to serve on its respective Member Board for any upcoming period of time. If the System Board objects to any Member Board nominee based on an inconsistency with the criteria described in Schedule 3.3.3, then the Member Board will identify a new nominee for System Board approval.

(ii) Amendments of Articles of Agreement and Bylaws. The approval by the respective Member Board of any proposed amendment or repeal of the Articles of Agreement or Bylaws of HH or MCH, respectively, which proposed amendment or repeal would (a) impact the powers reserved to the System Board in this Section 3.4.1, or (b) reasonably be expected to have any material strategic, competitive or financial impact on the System.

(iii) Operating and Capital Budgets of HH and MCH. The respective Member Board’s final adoption (and any subsequent revision) of the annual operating and capital budgets of HH and MCH, respectively, including without limitation the establishment by a Member Board of reserves, and any vote by a Member Board to propose an action (other than those addressed by Sections 3.4.1 (a) (iv) and (v) below) which may result in an unbudgeted expense or series of expenses equaling or exceeding an amount of Five Hundred Thousand Dollars (\$500,000.00).

(iv) Indebtedness. The vote of a Member Board to incur any unbudgeted indebtedness or other borrowings (such as capital leases) that exceed the principal amount of Five Hundred Thousand Dollars (\$500,000.00).

(v) Disposition of Assets. Unless contemplated by an approved budget, the vote of a Member Board to sell, convey, assign, or lease, or grant a mortgage or other lien or encumbrance on, assets of HH and MCH, respectively, in excess of Five Hundred Thousand Dollars (\$500,000.00), as measured by net book value.

(vi) Auditing Firm. The appointment by a Member Board of a firm of independent public accountants to conduct an independent audit of the financial statements of HH and MCH, respectively.

(vii) Clinical Service or Programs. The decision of a Member Board to eliminate or add any health care service or program, change any licenses, or otherwise make a change to the operating character or CAH designation of HH and MCH, respectively.

(viii) Academic and Research Matters. A Member Board's adoption or material revision of any policies of HH and MCH, respectively, relating to academic and research programs (except for student internship arrangements with training programs for nursing, physical, occupational therapy and speech/language pathology services, and other similar services), and any decision by a Member Board to enter into or terminate an academic affiliation.

(ix) Exercise of HH and MCH Reserved Powers. Unless waived by the System Board in writing in its discretion, the proposed exercise by a Member Board of any reserved powers or rights that it holds over any subsidiary or other organization or arrangement in which it has a controlling ownership interest.

(x) Strategic Plans. A Member Board's adoption or material revision of any strategic initiative or plan of HH and MCH, respectively.

(xi) Key Strategic Relationships. A decision of a Member Board to establish (whether by contract, joint venture or subsidiary entity), modify or terminate a "Key Strategic Relationship," defined as the ownership of, or contractual participation in, a network, system, affiliation, joint venture, alliance, proprietary health plan product (e.g. a so-called "narrow network") or similar arrangement entered into with an organization that is not a member in the System.

(xii) Merger/Change of Control; Divestiture. A decision of the Member Board to: (a) merge or consolidate HH or MCH, respectively, into another entity or otherwise conduct a change of control transaction; (b) acquire substantially all of the assets of another entity; or (c) sell or lease substantially all of the assets of HH and MCH, respectively, to any person or entity.

(xiii) Bankruptcy; Closure; Dissolution. Any decision by a Member Board to (a) commence bankruptcy or other insolvency proceedings, or (b) close, liquidate and dissolve HH and MCH, respectively, and/or any of their respective affiliates.

(b) *Rights of D-HH GO to Initiate or Enforce Actions by HH and MCH.* In addition to the approval rights described in Section 3.4.1(a) above and the appointment rights described in Section 3.3.3 above, the System Board will have the right to initiate the following actions to be taken or directed by HH and/or MCH:

(i) Removal of Member Board Trustees. Following consultation with the Chair of the Member Board, the System Board may remove any trustee of the Member Board if the System Board determines, in its reasonable good faith discretion, that such removal is in the best interests of the System. In making the foregoing determination, the System Board will consider the impact of such removal on HH or MCH, respectively, and on the interests and representation of the communities it serves.

(ii) Member President and Chief Executive Officer. Following consultation with the Chair of the Member Board and the applicable Regional President and consideration of any evaluation or recommendation by the Member Board under Section 3.4.5(c) below, the System Board acting through the System CEO or his or her designee will retain sole authority to hire, evaluate, compensate and terminate the President and Chief Executive Officer of HH and MCH, respectively.

(iii) Participation in System Strategies. To the extent applicable and determined by the System Board to be in the best interest of the System, HH and MCH, respectively, will participate (and the System Board may mandate its participation) in System-wide strategies, delivery networks, products (including risk-based reimbursement arrangements) and other similar initiatives consistent with the System strategic plan(s) and designed to further the establishment of an integrated and sustainable health delivery system.

(iv) Participation in System Programs and Initiatives. As determined and directed by the System Board, HH and MCH will participate in, and fulfill the requirements of, System-wide programs and initiatives designed to improve access, quality and/or costs of services to patients including those of HH and MCH, respectively. Subject to the process set forth in Section 5.6 as applicable, such programs and initiatives may include but not be limited to group purchasing, Information Technology (IT) system integration, quality improvement measures, shared finance functions, and shared corporate services. The System Board will determine the locations from which such programs and services are provided. The System Board may assess all participating System members a fee or other reasonable charge for such programs or initiatives provided that such fee or other

charge is assessed proportionately against all System members to whom such programs or initiatives are available.

(v) Changes in Clinical Services. The System Board may initiate changes in the clinical services provided by either HH or MCH if those changes are necessary to implement the System strategic plan and System-wide objectives, to further the clinical program development contemplated by Section 5.3 below, or to improve the financial position of HH or MCH in connection with the System Board's approval of the Member's operating and capital budgets under Section 3.4.1(a)(iii) above. Prior to the implementation of any clinical changes, D-HH GO will collaborate with the Member in evaluating the Member's clinical programming as described in Section 5.3.3 below. The System Board also will evaluate the impact of the proposed change on: (i) the ability of HH or MCH to meet the health needs of the communities in its service area; (ii) the ability of HH or MCH to continue to qualify as a CAH after the proposed change; (iii) the quality and efficiency with which the Member can deliver its health services; and (iv) the charitable purpose of the Member. The System Board also will give the appropriate Member Board an opportunity to address the proposed change and to provide any additional information, and will consider any input from the Member Board in good faith. After completion of the evaluation process and consistent with Section 5.3.3 below, the Member agrees to implement the clinical changes required by the System Board in accordance with a mutually-agreed upon schedule.

(vi) Powers Enumerated in Other Sections of this Agreement. HH and MCH agree that the System Board's authority to initiate action at the Member level is not limited to those powers listed in this Section 3.4.1(b), and acknowledge that other provisions of this Agreement provide the System Board with certain authority and reserved powers, including but not limited to: Section 3.3.3 with respect to the right to appoint representatives to the Member Boards; Section 5.1.1 with respect to the establishment of a System strategic plan; Section 5.2.1 with respect to the development and negotiation of joint ventures, affiliations or reorganizations with prospective System members or with other parties or health systems; Section 5.5.2 with respect to the financial management of the System including the power to reallocate certain of the assets of HH and/or MCH; and Section 5.6 regarding the consolidation of administrative functions.

3.4.2 Reserved Powers of D-HH GO, CMCHS and the Bishop Applicable to CMC and the CMCHS Subsidiaries. Each of CMC and the CMCHS Subsidiaries agrees to reserve to D-HH GO as one of its corporate members the following powers and authority to the extent applicable to the activities, governance and operation of each organization (together with the D-HH GO powers and authority over HH and MCH as described in Section 3.4.1 above, the "System Board Reserved

Powers”). The Parties acknowledge and agree that the System Board Reserved Powers over CMC and the CMCHS Subsidiaries must be exercised in conjunction with the powers over CMC and the CMCHS Subsidiaries that are reserved to CMCHS and the Bishop (collectively the “Bishop’s Reserved Powers”) and which Bishop’s Reserved Powers shall be exercised to ensure that CMC and each of the CMCHS Subsidiaries adheres with the Catholic moral teaching, the ERDs and Canon Law, as described below:

(a) *Approval Rights Over Certain Actions of CMC Board of Trustees.* Prior to becoming effective, each of the following actions of CMC and the CMCHS Subsidiaries must be approved by both (1) the System Board or by a committee of the System Board (the majority of which committee will be composed of System Board Trustees) to which any of the following approval rights is delegated by the System Board, and (2) CMCHS, unless otherwise stated below:

(i) Nominees to CMC and CMCHS Subsidiaries Boards of Trustees; Size of Boards. The nomination by CMC and each of the CMCHS Subsidiaries of individuals to serve on its Board of Trustees (sometimes referred to as the “CMC Board” and “CMCHS Subsidiary Boards” as applicable) as described in Section 3.3.3, and the establishment by CMC and each CMCHS Subsidiary of the total number of Trustees to serve on the CMC Board and CMCHS Subsidiary Boards, respectively, for any upcoming period of time. If either the System Board or CMCHS objects to any CMC Board or CMCHS Subsidiary Board nominee based on an inconsistency with the criteria described in Schedule 3.3.3, then the CMC Board or the CMCHS Subsidiary Board, as applicable, will identify a new nominee for System Board and CMCHS approval.

(ii) Amendments of Articles of Agreement and Bylaws. The approval by the CMC Board or any CMCHS Subsidiary Board of any proposed amendment or repeal of the Articles of Agreement or Bylaws of CMC or a CMCHS Subsidiary, as applicable, which proposed amendment or repeal would (with respect to the System Board approval) (a) impact the powers reserved to the System Board in this Section 3.4.2, or (b) reasonably be expected to have any material strategic, competitive or financial impact on the System, or (c) with respect to the CMCHS approval, impact the powers reserved to CMCHS or the Bishop.

(iii) Operating and Capital Budgets of CMC and CMCHS Subsidiaries. The final adoption (and any subsequent revision) by the CMC Board and the CMCHS Subsidiary Boards of the annual operating and capital budgets of CMC and its subsidiaries and the CMCHS Subsidiaries and their subsidiaries, respectively, including without limitation the establishment by the CMC Board and

the CMCHS Subsidiary Boards of financial reserves, and any vote by the CMC Board or any CMCHS Subsidiary Board to propose an action (other than those addressed by Sections 3.4.2(a)(iv) and (v) below) which may result in an unbudgeted expense or series of expenses equaling or exceeding an amount of: (A) with respect to CMC and CMCPA, One Million Dollars (\$1,000,000.00), and (B) with respect to any CMCHS Subsidiary other than CMCPA, Two Hundred and Fifty Thousand Dollars (\$250,000.00).

(iv) Indebtedness. The vote of the CMC Board to incur any unbudgeted indebtedness or other borrowings (such as capital leases) that exceed the principal amount of One Million Dollars (\$1,000,000.00), and the vote of any CMCHS Subsidiary Board to incur any unbudgeted indebtedness or other borrowings (such as capital leases) that exceed the principal amount of Two Hundred Fifty Thousand Dollars (\$250,000.00).

(v) Disposition of Assets. Unless contemplated by an approved budget, the vote of (A) the CMC Board to sell, convey, assign, or lease, or grant a mortgage or other lien or encumbrance on, assets of CMC in excess of One Million Dollars (\$1,000,000.00), as measured by net book value, and (B) any CMCHS Subsidiary Board to sell, convey, assign, or lease, or grant a mortgage or other lien or encumbrance on, assets of any CMCHS Subsidiary in excess of Two Hundred Fifty Dollars (\$250,000.00), as measured by net book value.

(vi) Auditing Firm. The appointment by the CMC Board and each of the CMCHS Subsidiary Boards of a firm of independent public accountants to conduct an independent audit of the financial statements of CMC and its subsidiaries and of the CMCHS Subsidiaries and their subsidiaries, respectively, which requires the approval only of the System Board.

(vii) Clinical Service or Programs. Subject to the provisions of Section 2.6 above, the decision of the CMC Board or any CMCHS Subsidiary Board (as applicable) to eliminate or add any health care service or program, change any licenses, or otherwise make a change to the operating character of CMC or any of its subsidiaries or of any CMCHS Subsidiary or its subsidiaries, respectively, which action requires the approval only of the System Board unless after receipt of prior notice CMCHS determines that the proposed action may impact the Catholic identity of, or adherence to Catholic moral teaching, the ERDs and Canon Law by, CMC or the CMCHS Subsidiaries, in which case CMCHS's approval also will be required.

(viii) Academic and Research Matters. Subject to the provisions of Section 2.6 above, the adoption or material revision by the CMC Board or any CMCHS Subsidiary Board of any policies of CMC or a CMCHS Subsidiary, respectively, relating to academic and research programs (except for student internship arrangements with training programs for nursing, physical, occupational therapy and speech/language pathology services, and other similar services), and any decision by the CMC Board or CMCHS Subsidiary Boards to enter into or terminate an academic affiliation, which action requires the approval only of the System Board unless after receipt of prior notice CMCHS determines that the proposed action may impact the Catholic identity of, or adherence to Catholic moral teaching, the ERDs and Canon Law by, CMC or the CMCHS Subsidiaries, in which case CMCHS's approval also will be required.

(ix) Exercise of CMC and CMCHS Subsidiary Reserved Powers. Unless waived by the System Board in writing in its discretion and subject to the provisions of Section 2.6 above, the proposed exercise by the CMC Board or any CMCHS Subsidiary Board of any reserved powers or rights that it holds over any subsidiary or other organization or arrangement in which it has a controlling ownership interest.

(x) Strategic Plans. The adoption or material revision by the CMC Board or any CMCHS Subsidiary Board of any strategic initiative or plan of CMC and/or its subsidiaries or a CMCHS Subsidiary or its subsidiaries, respectively, which action requires the approval only of the System Board unless after receipt of prior notice CMCHS determines that the proposed action may impact the Catholic identity of, or adherence to Catholic moral teaching, the ERDs and Canon Law by, CMC or the CMCHS Subsidiaries, in which case CMCHS's approval also will be required.

(xi) Key Strategic Relationships. A decision of the CMC Board or any CMCHS Subsidiary Board to establish (whether by contract, joint venture or subsidiary entity), modify or terminate a "Key Strategic Relationship," defined as the ownership of, or contractual participation in, a network, system, affiliation, joint venture, alliance, proprietary health plan product (e.g. a so-called "narrow network") or similar arrangement entered into with an organization that is not a member in the System, which action requires the approval only of the System Board unless after receipt of prior notice CMCHS determines that the proposed action may impact the Catholic identity of, or adherence to Catholic moral teaching, the ERDs and Canon Law by, CMC or the CMCHS Subsidiaries, in which case CMCHS's approval also will be required.

(xii) Merger/Change of Control; Divestiture. A decision of the CMC Board or any CMCHS Subsidiary Board to: (a) merge or consolidate CMC or any of its subsidiaries or the CMCHS Subsidiary or any of its subsidiaries, as applicable, into another entity or otherwise conduct a change of control transaction; (b) acquire substantially all of the assets of another entity; or (c) sell or lease substantially all of the assets of CMC and/or any of its subsidiaries or a CMCHS Subsidiary and/or any of its subsidiaries, respectively, to any person or entity.

(xiii) Bankruptcy; Closure; Dissolution. Any decision by the CMC Board or a CMCHS Subsidiary Board to (a) commence bankruptcy or other insolvency proceedings, or (b) close, liquidate and dissolve CMC and/or any of its subsidiaries or the CMCHS Subsidiary and/or any of its subsidiaries, as applicable.

(b) *Rights of D-HH GO to Initiate Actions by CMC and the CMCHS Subsidiaries*. In addition to the approval rights described in Section 3.4.2(a) above and the appointment rights described in Section 3.3.3 above, but subject to the provisions of Section 2.6 above, the System Board will have the right to initiate the following actions to be taken or directed by CMC and/or its subsidiaries or the CMCHS Subsidiaries and/or their respective subsidiaries, subject to the rights of CMCHS and the Bishop to assure compliance with Catholic moral teaching, the ERDs and Canon Law as described below:

(i) Removal of Member Board Trustees. Following consultation with the Chair of the CMC Board or the respective CMCHS Subsidiary Board, as applicable, the System Board may propose the removal of any trustee of the CMC Board or a CMCHS Subsidiary Board if the System Board determines, in its reasonable good faith discretion, that such removal is in the best interests of the System. In making the foregoing determination, the System Board will consider the impact of such removal on CMC and the CMCHS Subsidiary and on the interests and representation of the communities they serve. Such action, however, must be approved by CMCHS under its reserved powers, which approval will not be withheld unless the proposed removal would jeopardize adherence by the CMC Board or the CMCHS Subsidiary Board, as applicable, with Catholic moral teaching, the ERDs and Canon Law.

(ii) CMC and CMCHS Subsidiary President and Chief Executive Officer. Following consultation with the Chair of the Member Board, the System CEO and the applicable Regional President, the System Board will retain sole authority to evaluate and compensate the President and Chief Executive Officer of CMC (the “CMC CEO”) and any President and Chief Executive Officer of a CMCHS

Subsidiary (each a “CMCHS Subsidiary CEO”). The System Board also may initiate the hiring or termination of the CMC CEO or any CMCHS Subsidiary CEO, which hiring or termination must be approved by CMCHS, which approval will not be withheld unless the proposed removal would jeopardize adherence by the CMC Board or the CMCHS Subsidiary Board, as applicable, with Catholic moral teaching, the ERDs and Canon Law.

(iii) Participation in System Strategies. To the extent applicable and determined by the System Board to be in the bests interest of the System, CMC and each CMCHS Subsidiary will participate in System-wide strategies, delivery networks, products (including risk-based reimbursement arrangements) and other similar initiatives consistent with the System strategic plan(s) and designed to further the establishment of a more fully integrated and sustainable health delivery system, with the understanding that the obligation of CMC and the CMCHS Subsidiaries to support or participate in System initiatives will not include any strategies or activities which violate Catholic moral teaching, the ERDs or Canon Law.

(iv) Participation in System Programs and Initiatives. As determined and directed by the System Board, CMC and the CMCHS Subsidiaries will participate in, and fulfill the requirements of, System-wide programs and initiatives designed to improve access, quality and/or costs of services to patients including those of CMC and the CMCHS Subsidiaries (as applicable), with the understanding that the obligation of CMC and the CMCHS Subsidiaries to support or participate in System programs and initiatives will not include those which violate Catholic moral teaching, the ERDs or Canon Law. Subject to the process set forth in Section 5.6 as applicable, such programs and initiatives may include but not be limited to group purchasing, Information Technology (IT) system integration, quality improvement measures, and shared corporate services. The System Board will determine the locations from which such nonclinical programs and services are provided. The System Board may assess all participating System members a reasonable charge for such programs or initiatives provided that such charge is assessed proportionately against all System members to whom such programs or initiatives are available.

(v) Changes in Clinical Services. The System Board may initiate changes in the clinical services provided by CMC and any CMCHS Subsidiary if those changes are necessary to implement the System strategic plan and System-wide objectives, to further the clinical program development contemplated by Section 5.3 below, or to improve the financial position of CMC or any CMCHS Subsidiary

in connection with the System Board's approval of the operating and capital budgets of CMC and the CMCHS Subsidiaries under Section 3.4.2(a)(iii) above, provided such changes are consistent with Catholic moral teaching, the ERDs and Canon Law, CMC's values and do not result in the alienation of ecclesiastical goods. Prior to the implementation of any clinical changes, D-HH GO will collaborate with CMC and the CMCHS Subsidiary, as applicable, in evaluating the clinical programming of CMC and the CMCHS Subsidiaries, respectively, as described in Section 5.3.3 below. The System Board also will evaluate the impact of the proposed change on: (i) the ability of CMC or the CMCHS Subsidiary to meet the health needs of the communities in its service area; (ii) the quality and efficiency with which CMC or the CMCHS Subsidiary can deliver its health services; and (iii) the charitable purpose of CMC or the CMCHS Subsidiary, as applicable. The System Board also will give the CMC Board and the CMCHS Subsidiary Board, as applicable, an opportunity to address the proposed change and to provide any additional information, and will consider any input from the CMC Board or any CMCHS Subsidiary Board, as applicable, in good faith. After completion of the evaluation process and consistent with Section 5.3.3 below, CMC and the CMCHS Subsidiary Boards agree to implement the clinical changes required by the System Board in accordance with a mutually-agreed upon schedule.

(vi) Powers Enumerated in Other Sections of this Agreement. Each of CMC and the CMCHS Subsidiaries agrees that the System Board's authority to initiate action at the Member level is not limited to those powers listed in this Section 3.4.2(b), and acknowledge that other provisions of this Agreement provide the System Board with certain authority and reserved powers (subject to Section 2.6), including but not limited to: Section 3.3.3 with respect to the right to appoint representatives to the Member Boards; Section 5.1.1 with respect to the establishment of a System strategic plan; Section 5.2.1 with respect to the development and negotiation of joint ventures, affiliations or reorganizations with prospective System members or with other parties or health systems; Section 5.5.2 with respect to the financial management of the System including the power to reallocate certain of the assets of CMC and the CMCHS Subsidiaries; and Section 5.6 regarding the consolidation of administrative functions.

3.4.3 Additional Reserved Powers of CMCHS and the Bishop Applicable to CMC and the CMCHS Subsidiaries. In addition to the powers reserved to CMCHS as described in Section 3.4.2 above, 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.

3.4.4 Reconciliation of Conflict in Exercise of D-HH GO and Bishop's Reserved Powers. If there is a conflict between a ratification of the Bishop's Reserved Powers and the exercise of the Reserved Powers of the System Board with respect to CMC and its subsidiaries and the CMCHS Subsidiaries, then the decision of the Bishop will govern unless the System Board has objected to the proposed action. For those actions which require the approval or ratification of both the Bishop or CMCHS and the System Board and either or both of them has objected, then each of CMC and the CMCHS Subsidiaries, as applicable, will revise its proposed action 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.

3.4.5 Retained Powers of CMC, the CMCHS Subsidiaries, HH and MCH. The Parties agree that each of CMC, the CMCHS Subsidiaries, HH and MCH will retain the following powers:

(a) *Ex Officio Positions; Member Board Nominees.* *Ex officio* positions on the Member Boards will be determined in accordance with the Member's respective bylaws. Each of CMC, the CMCHS Subsidiaries, HH and MCH will nominate individual trustees who, together with the *ex officio* trustees, comprise at least two-thirds (2/3) of the trustees serving on their respective Member Boards, subject to the System Board Reserved Powers (and the Bishop's Reserved Powers with respect to CMC and the CMCHS Subsidiaries) to approve each nominee.

(b) *Member Board Chair.* The Chair of the respective Member Boards of CMC, the CMCHS Subsidiaries, HH and MCH will be selected by each Member Board from among the trustees nominated by CMC, the CMCHS Subsidiaries, HH and MCH, respectively.

(c) *Input on Actions Pertaining to Member President and Chief Executive Officer.* Although the power to hire, evaluate, compensate and terminate the President and Chief Executive Officer of CMC, the CMCHS Subsidiaries, HH and MCH (each a "Member CEO") is reserved to the System Board acting through the System CEO or designee (subject to the right of CMCHS to approve the hiring or termination of the CMC CEO), each Member Board and the applicable Regional President will have the right to provide to the System CEO or designee an evaluation of their respective Member CEO prior to any compensation determination, and a recommendation prior to any proposed

hiring or termination of their respective Member CEO of which the System CEO or designee will notify the Member Board Chair. If the System CEO or designee decides to hire or terminate a Member CEO when the Member Board has provided a contrary evaluation or recommendation, the System CEO or designee will consult with the System Board Chair before taking any action.

(d) *Strategic Planning and Operational Oversight.* Subject to Article 5 below and the System Board’s Reserved Powers, each of CMC, HH and MCH will retain primary responsibility for identifying the health needs of the communities it serves, developing a strategic plan (consistent with the System Strategic Plan described in Section 5.1 below) for meeting those needs, and overseeing the delivery and safety of health care services at its respective hospital and any related facilities.

(e) *Donor-Restricted Funds.* Subject to the System Board’s Reserved Powers and the intent of donors, each of CMC, the CMCHS Subsidiaries (if applicable), HH and MCH will retain responsibility for determining whether and how much to appropriate from its donor-restricted funds for qualifying expenditures, consistent with the requirements of New Hampshire RSA 292-B:4, the Uniform Prudent Management of Institutional Funds Act.

(f) *Fundraising.* Each of CMC, HH and MCH will retain the authority to determine and implement fundraising activities conducted by the Member Hospital in its respective service area, and to approve any fundraising efforts proposed by the System Board in the Member Hospital’s respective service area.

(g) *Intellectual Property.* Each of CMC, the CMCHS Subsidiaries, HH and MCH will retain 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. The Parties acknowledge that CMC intends to maintain the 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, and that any change in such names will be determined solely by CMC, CMCHS and the Bishop.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 4. SYSTEM MANAGEMENT AND REPORTING

4.1 CLINICAL STRUCTURE

4.1.1 Pluralistic Model. The 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). While maintaining the pluralistic medical staff model, the System Board subsequently may establish a System-wide clinical management and reporting structure to ensure and enhance the quality of care and the dissemination of best practices throughout the System.

4.1.2 Existing Contractual Commitments. For the avoidance of doubt and to ensure stability, collaboration, continuity and a smooth transition for the Combination, each of the System and System Members, as applicable, will honor the terms of employment and other contractual commitments that they each have to physicians, other providers and senior management existing on and after the Combination Date.

4.1.3 Diversity of Member Organizations. The 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. Consistent with the provisions of Section 2.6 above, no provider employed or contracted by CMC or by any of the CMCHS Subsidiaries and acting in the course of the provider's duties to CMC or a CMCHS Subsidiary, as may be applicable, and its patients may be required or permitted to make referrals to any Member of the System for procedures that are inconsistent with Catholic moral teaching, the ERDs or Canon Law.

4.2 ADMINISTRATIVE MANAGEMENT STRUCTURE

4.2.1 System Chief Executive Officer. The 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 achieve the purposes and shared vision for the System set forth in Article 1 of this Agreement, ensuring adherence to the guiding principles set forth in Article 2 of this

FINAL FOR SIGNATURE

Agreement – including respect for the diverse identities and traditions of System Members and advancing the mission of New Hampshire’s only academic health system, and galvanizing clinical, operational, and financial integration efforts across the System. The System CEO will appoint and oversee the Regional Presidents in the performance of their responsibilities as set forth in Section 4.2.2(c) below.

The System CEO’s duties and responsibilities will be more fully set forth in a System CEO position description approved by the System Board or appropriate committee of the System Board.

The initial System CEO will be Joanne M. Conroy, MD.

4.2.2 Regional Leadership and Reporting Relationships. The System Members will be managed regionally as described below.

(a) *Regions*. As of the Combination Date, the System will consist of two Regions (each a “Region”). Region I generally will include the following: Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Clinic Keene, Lebanon and Putnam, New London Hospital, Mt. Ascutney Hospital and Health Center, Cheshire Medical Center, Alice Peck Day Memorial Hospital, Visiting Nurse Association and Hospice for Vermont and New Hampshire 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, Dartmouth-Hitchcock Clinic 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 on the Combination Date, and any southern New Hampshire facilities and practices that become part of the 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. The Parties agree that the System Board will reevaluate the regional structure on or about the second (2nd) anniversary of the Combination Date, and may vote any time thereafter to alter the membership or structure of the Regions or replace them in their entirety with a new operational and management reporting structure. Any vote to restructure or eliminate the Regions prior to the sixth (6th) anniversary of the Combination Date will require both a majority vote of the D-HH Nominees then serving on the System Board and a majority vote of the GOH Nominees then serving on the System Board. If HH or MCH requests a transition to a different region during the reevaluation, then the System Board (including majorities of both the D-HH Nominees and the GOH Nominees) will approve such a transition unless the interests of the System are inconsistent with the request.

(b) *Regional Presidents – Appointment and Special Provision.* 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 GOH and CMC. The identity of the initial President of Region II is critical to successfully achieving the objectives of the Combination as set forth in Article 1 of this Agreement, and the Parties recognize the important role of the GOH Members in determining the leadership of Region II during implementation of the System. For these reasons, while the initial President of Region II will be Joseph Pepe, MD, the Parties further agree that for six (6) consecutive years following the Combination Date (subject to the possible restructuring described in Section 4.2.2(a) above) the appointment of the Region II President will be subject to the approval of a majority of the GOH Nominees (as defined in Section 3.3.2 above), who must exercise their fiduciary duties to the System and consider the needs of Region II and the necessary skills and experience of a successor Region II President. The President of Region I and the President of Region II are collectively referred to as the “Regional Presidents.” Except for the foregoing provisions and subject to the possible restructuring described in Section 4.2.2(a) above, the Regional Presidents will be appointed by the System CEO and approved by the System Board.

(c) *Regional Presidents – Authority and Responsibilities.* The Regional Presidents will report to the System CEO. Subject to Section 4.2.2(d) below, the Regional Presidents will be responsible for overseeing and coordinating the implementation, management and evaluation of the System strategies, clinical initiatives and operational programs at the 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 System Members in the assigned Region, recognizing that System Members may cooperate and collaborate with each other outside their assigned Region consistent with the System strategic plan. The responsibilities and authority of the Regional Presidents will include the following:

(i) With respect to Region II, leading, coordinating, and supervising (A) the President and CEO of each of the System Members within Region II, who will have a reporting relationship to the Region II President, (B) in collaboration with the D-HH GO Chief Clinical Officer, the physician administrator of each of the D-HC Facilities and the D-HC Regional Medical Director in Region II, who will have a primary reporting relationship to the Region II President, and (C) in collaboration with the D-HH GO Chief Operating Officer, the D-HC Vice President of Community Group Practice Business Operations;

(ii) Leading the development of the new integrated delivery system in the respective region;

(iii) Implementing strategies to:

(A) Improve access for the communities served by the System Members in the region, and meet the growing health needs of the population;

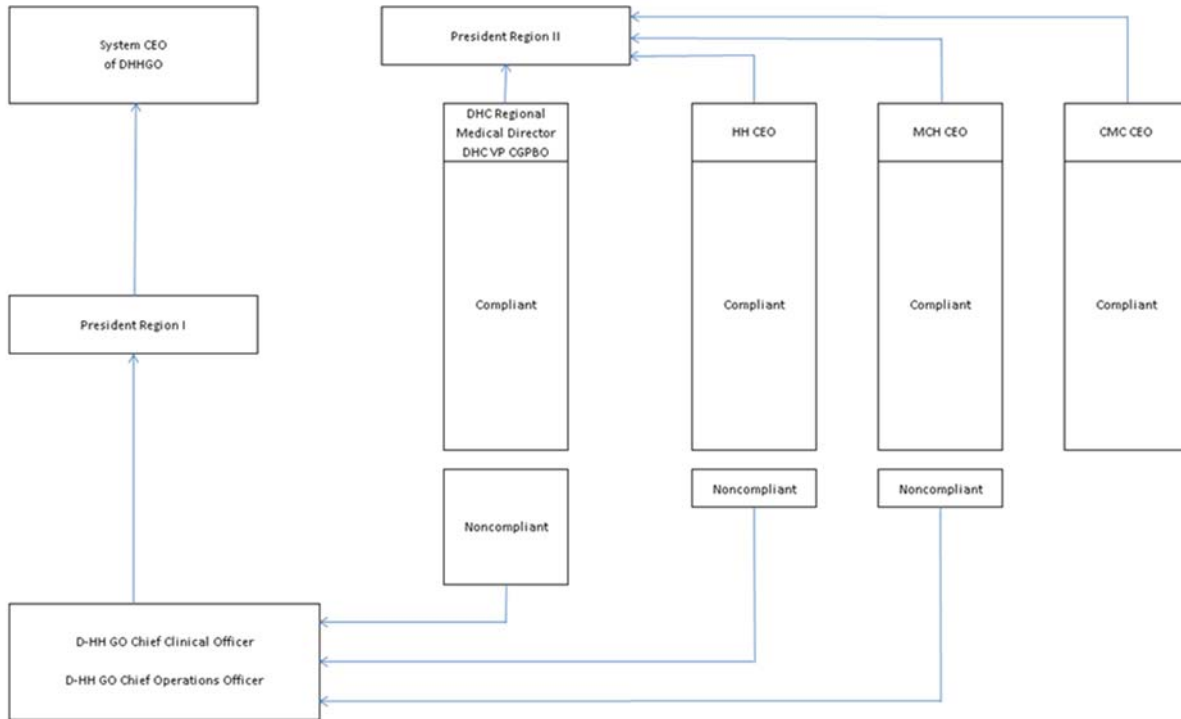
(B) Coordinate with System leadership to develop integrated clinical programs focusing on strengthening existing practice leaders and developing new and enhanced programming;

(C) Develop a comprehensive geographic plan for the provision of clinical programs to enhance access throughout the System over the next five (5) or more years; and

(D) Develop the workforce plan to achieve the objectives of the Combination and strategic plans of the System.

(d) *Adherence to Catholic Moral Teaching and Compliance with the ERDs and Canon Law in Region II Management.* This Section 4.2.2(d) applies only for so long as the CMC President and CEO also serves as the President of Region II. As the administrator of both Catholic and non-Catholic facilities, 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. Currently, all of the day-to-day business and clinical operations of D-HC in Region II are overseen by the Vice President of Community Group Practice Business Operations and the D-HC Regional Medical Director. Both are D-H employees and those employment arrangements and positions will remain intact after the Combination Date. The Vice President of Community Group Practice Business Operations currently reports to the D-HH Chief Operating Officer. The D-HC Regional Medical Director currently reports to the D-HH Chief Clinical Officer who reports to the D-HH CEO. After the Combination, the Vice President of Community Group Practice Business Operations and the D-HC Regional Medical Director will continue to be responsible for the day-to-day business and clinical operations but D-HH GO will require each administrator to bifurcate those operations and procedures into those consistent with Catholic moral teaching, the ERDs and Canon Law and those operations and procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law. Other secular Member Hospitals and facilities

in Region II will continue to be responsible for their day-to-day operations, including those procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law. After the Combination, those hospital Member CEOs, D-H employed Vice President of Community Group Practice Business Operations and the D-HC Regional Medical Director will report to the D-HH GO Chief Operating Officer and Chief Clinical Officer with respect to operations and procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law.



(e) *Adherence to Catholic Moral Teaching and Compliance with the ERDs and Canon Law in Region II Clinical Operations.* In addition to maintaining its existing reporting structure for those operations that are inconsistent with Catholic moral teaching, the ERDs and Canon Law, D-HH GO will undertake and require the following with respect to D-HC clinical operations:

- (i) D-HC will require ERD training (which may be online) among its providers practicing in Region II to ensure respect and understanding of the ERDs and CMC’s Catholic Identity and the needs of Catholic patients who seek their care at CMC.
- (ii) D-HC will uphold CMC’s existing Annual ERD Certification of D-HC Physicians Credentialed at CMC.

(iii) D-HC will track and make available to CMC on an annual basis the number, nature and location of procedures that were performed that are inconsistent with the ERDs. As detailed above, those procedures and any potential future procedures that are inconsistent with the ERDs will be identified and D-HC will explicitly require and confirm that these will be under the authority of the D-HC employed Medical Director(s) that manage D-HC services in Region II. With regard to reporting and oversight of the Medical Director(s), all matters pertaining to procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law will be reported directly to the Chief Clinical Officer and Chief Operating Officer of D-HH GO.

(iv) A “hotline” to the Office of Catholic Identity at CMC for reporting of alleged violations of the ERDs will be established and staffed to enable the faithful to express concerns, ask questions and alert CMC of any matters that may need to be addressed.

(v) D-HC agrees to cooperate and participate in the CMC ERD Audit Process which includes an annual assessment and report to the Bishop on ERD compliance.

(vi) D-HC acknowledges that financial matters related to procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law cannot be managed by an administrator of a Catholic facility.

(vii) D-HC acknowledges that CMC will be including the following disclosure for CMC patients who are referred to a D-HC OB/GYN specialists or other specialists:

“CMC is a member of Dartmouth-Hitchcock Health GraniteOne. While CMC and its providers and facilities are committed to following Catholic moral teaching and the ERDs, other members, providers and facilities in the system are not. You are being referred to a specialist or facility which is not Catholic and could be engaging in actions contrary to Catholic moral teaching and the ERDs. You are not being referred for any purpose contrary to Catholic moral teaching and the ERDs. Any procedures or educational materials they may offer that are not consistent with the ERDs are not approved by or within the scope of authority of CMC. If you have any questions about Catholic moral teaching and the ERDs or a procedure you are considering and whether it is consistent with these, then please contact the CMC Office of Catholic Identity at (603) 663-6440.”

(viii) D-HC also will display the following disclosure in those Region II waiting rooms and exam rooms that are utilized in a manner not consistent with the ERDs:

“Dartmouth-Hitchcock Health GraniteOne includes both Catholic and non-Catholic member hospitals. Only its Catholic members are committed to following Catholic moral teaching, including the ERDs. This is a non-Catholic provider and facility. Any procedures or educational materials that are not consistent with Catholic moral teaching and the ERDs are the sole responsibility of this provider or facility and its non-Catholic parent organizations. If you have questions about Catholic moral teaching and the ERDs or a procedure you are considering and whether it is consistent with these, then please contact the CMC Office of Catholic Identity at (603) 663-6440.”

4.2.3 Member Leadership and Reporting Relationships. Each of the System Members will be served by a chief executive officer (each a “Member CEO”), who may be employed by the System and may serve as the chief executive officer for more than one Member. Unless a subsequent change to the System’s regional structure is approved by the System Board as described in Section 4.2.2(a) above, 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 System strategic plan and Member strategic plan, oversight of hospital administration, operations, and finances, and supervision of Member personnel reporting to the Member CEO. The Member CEO also will perform such duties as may be determined by the Regional President or, in the case of Region I if the System CEO and the Region I President are the same person, his or her designee after consultation with the Member Board Chair or Member Board Chair designee; provided that the CMC CEO may not be required to perform any duties which conflict with the ERDs or the principles of Canon Law or which would violate the principles described in Section 2.6 above.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 5. SYSTEM INTEGRATION

5.1 STRATEGIC PLAN AND INITIATIVES

5.1.1 System Board Strategic Planning. The System Board will develop and implement a System-wide long-term strategic plan for achieving the System's goals (the "System Strategic Plan"). The System Strategic Plan will be designed to further the charitable mission of D-HH GO, support the charitable missions of the System's Members (subject in the case of CMC and the CMCHS Subsidiaries to Section 2.6 above), address the ongoing changes in the delivery of and reimbursement for wellness and health care services, and implement and maximize the goals and synergies identified in this Agreement. The System Strategic Plan will include, but not be limited to, clinical programming, services and procedures, quality standards and measures, operating and capital budgets, System-wide resource allocation and investment policies. The Parties expect that the System Strategic Plan will be prepared within one (1) year after the Combination Date, and that thereafter the System Board will regularly evaluate the System Strategic Plan and update or modify it from time to time to ensure that it continues to meet the goals and purposes of the System and the System's Members.

5.1.2 Member Board Strategic Planning. Each Member Board will develop and implement a strategic plan for meeting the identified health needs of the communities it serves. Each System Member's strategic plan must be consistent with the System Strategic Plan, and must be approved by the System Board pursuant to the System Board Reserved Powers; provided that CMC's strategic plan and any strategic plan adopted by the CMCHS Subsidiaries will be subject to the provisions of Section 2.6 above and the Bishop's Reserved Powers.

5.2 OPERATIONAL PLANNING

5.2.1 System-Wide Operations. The Parties agree to continue to evaluate and develop ways to integrate their operations to further the objectives of the Combination, including the enhancement of the quality of care throughout the System, the achievement of economic efficiencies, and the dissemination of best practices. The System Board will be responsible for establishing and overseeing System-wide operational programs and initiatives. The System Board also will have the authority to develop and/or negotiate joint ventures, affiliations or reorganizations with prospective System members or with other parties or health systems in furtherance of the System Strategic Plan.

5.2.2 Member Board Operational Responsibilities. Consistent with the System Strategic Plan and the integration planning under Section 5.2.1 above, and subject to the System Board's Reserved Powers (which include the power to require participation in System-wide programs and initiatives such as System-wide credentialing) and the Bishop's Reserved Powers with respect to

CMC and the CMCHS Subsidiaries (as applicable) only, each Member Board will be responsible for evaluating, implementing and overseeing the delivery and safety of health care services at and from its respective hospital and any related facilities. Such operational responsibilities include, but are not limited to: (i) preparation of community needs assessments on a regular basis and as required by applicable law; (ii) oversight of compliance with legal, licensing, applicable accreditation and reimbursement program participation standards and requirements; (iii) implementation and oversight of quality and safety standards for patient care; (iv) risk management; (v) oversight and approval of medical staff bylaws and granting of clinical privileges; (vi) adoption of annual operating and capital budgets for the Member for approval by the System Board; (vii) identification and recommendation of capital needs; and (viii) identification and recommendation of recruitment and/or retention needs.

5.3 CLINICAL PROGRAM DEVELOPMENT

To the extent legally permissible and, with respect to CMC and the CMCHS Subsidiaries only, consistent with the provisions of Section 2.6 above, the Parties agree to continue to evaluate and develop ways in which to integrate their clinical programming to further 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; support of services appropriately provided in rural locations to promote access to care in the most efficient and economical setting; 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. The specific clinical programming commitments and processes identified by the Parties to date as having the greatest potential for immediate benefit to patients are more fully described in Sections 5.3.1 and 5.3.2 below.

5.3.1 Inpatient Services

The Parties acknowledge that rising demand for high quality inpatient services, fueled by an aging population with chronic and higher acuity health care needs, has surpassed their present ability to provide access to these mission-critical services. Capacity constraints at DHMC and CMC, in particular, force the denial of more than 3,000 inpatient admissions per year combined, requiring many of these patients to seek care out-of-state at higher cost and greater inconvenience. Additionally, approximately 8,000 patients from southern New Hampshire annually seek inpatient services in Massachusetts hospitals often at greater expense and inconvenience than if such services were available locally. This rising demand for inpatient services is projected to continue unabated in correlation with New Hampshire's aging population, one-quarter of which will be 65 years of age or older by 2040.

FINAL FOR SIGNATURE

The Parties agree that the System will be better-positioned to meet inpatient demand by more efficiently utilizing the existing capacity of its member hospitals, including HH and MCH, and centralizing transfer operations to identify System-wide bed availability to ensure that patients receive care in the most convenient, acuity-appropriate site of service. While greater combined capacity and process improvement will reduce inpatient admission denials in some measure, the Parties agree that new capacity will be required to meet existing and projected demand. A planned 60-bed inpatient tower at DHMC will be augmented by a substantial expansion project on the CMC campus, to be developed, financed (subject to the limitation in Section 5.5.2(c) with respect to HH and MCH assets), and constructed by the System as more fully described in Section 5.5.5 below. The creation of new inpatient capacity on the CMC campus will benefit patients in multiple ways by, for example, offering a New Hampshire-based alternative to more expensive and inconvenient out-of-state care, facilitating patient transfers from the relatively higher cost academic medical center at DHMC to a more cost-effective and convenient setting, especially for patients from southern New Hampshire, and creating needed vacancy at DHMC for patients requiring more complex care.

5.3.2 Specialty Services

(a) *Behavioral Health.* The Parties recognize and are committed to addressing New Hampshire's behavioral health needs, fueled in large part by a substance use disorder ("SUD") crisis that indiscriminately afflicts both urban and rural communities. This scourge is most prevalent 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. While both D-HH and GOH are demonstrated leaders in behavioral health care, evinced in part by their participation in "Doorway-NH" and MHMH's and CMC's regional leadership of New Hampshire's Delivery System Reform Incentive Program ("DSRIP") to strengthen and integrate behavioral health care for those served by the Medicaid program, their separately allocated resources are asymmetrical and fragmented.

The Parties agree that D-HH offers a broad range of inpatient and outpatient mental health and SUD treatment programs from which patients in GOH's service areas will benefit substantially. The Combination will enable the System to draw on the expertise of specialists and sub-specialists at DHMC in support of adult and child emergency psychiatric services and outpatient psychiatric care at CMC, HH, and MCH. D-HH currently provides tele-psychiatry support to both D-HH System members and non-members in New Hampshire and Vermont, offering HH, MCH and CMC, which currently purchases tele-psychiatry services from a third-party vendor, the opportunity to obtain such support in an integrated System.

Well-aware of the importance of early psychiatric intervention, the Parties will expand D-HH's established collaborative care model to primary care sites throughout the System, integrating

mental and physical health care services and SUD screening in order to identify and address the totality of patient needs at the first visit. This well-studied best practice improves care quality and treatment compliance, and avoids unnecessary, costly emergency department visits and hospitalizations. Additionally, while GOH System members currently do not have inpatient psychiatric capacity, the Combination will facilitate direct access to the System's 21-bed inpatient psychiatric unit at DHMC, enhancing patient care coordination and management while reducing barriers to access and fragmented care.

The Parties also agree to integrate and broaden their respective outpatient addiction treatment programs, share best practices, measure outcomes, and implement standardized screening tools and care pathways across the System. Each of DHMC and CMC offers medication for substance use disorder ("MOUD") treatment and a specialized addiction treatment program for pregnant and parenting women, i.e., "Mom's In Recovery" at DHMC and "Roots for Recovery" at CMC. In addition to expanding access to these intensive outpatient treatment programs and consultation services, the Combination will enable the Parties, and CMC in particular, to replicate DHMC's "Behavioral Intervention Team" ("BIT") model, an innovative, multidisciplinary, behavioral health care delivery model for inpatients with co-occurring medical conditions.

The Parties agree to prioritize the behavioral health needs of their patients and communities, and to use their combined expertise, experience, and human and technological resources to reduce opioid dependence and other SUDs and improve the mental and physical well-being of those served by the System.

(b) *Pediatrics.* The Parties recognize that southern New Hampshire is home to more than two-thirds of the state's children yet the region lacks sufficient access to routine pediatric outpatient services and comprehensive pediatric urgent/emergent care. The Children's Hospital at Dartmouth-Hitchcock ("CHaD") on the DHMC campus is New Hampshire's only full-service children's hospital, offering dedicated pediatric and adolescent inpatient services and comprehensive care in over 30 pediatric medical and surgical specialties and sub-specialties, including Level I trauma care and pediatric intensive care. CHaD also operates a Level III neonatal intensive care unit ("Level III NICU") that provides advanced, subspecialty care for critically ill newborns. CMC operates the Special Care Nursery at The Mom's Place ("SCN"), a Level II nursery that offers family-centered newborn care.

The Parties agree that a main objective of the Combination is to address the dearth of pediatric outpatient and urgent/emergent hospital services in southern New Hampshire. By deploying clinicians and/or employing telehealth, the System will draw on the diverse expertise of CHaD specialists and sub-specialists in support of new or expanded neonatal and pediatric capabilities at CMC. Mindful that D-HH physicians already collaborate with CMC to deliver more than 1,200 babies annually, the Parties agree that the System will facilitate the delivery of more

complex neonatal services at CMC's SCN, buttressed by the complementary services of CHaD's Level III NICU, in order to offer patients a more convenient, cost-effective site of neonatal services. Additionally, the Parties agree to commit System expertise and resources to enable CMC to offer advanced pediatric emergency services to the nearly 1,300 pediatric patients who seek emergency care annually at CMC, many of whom require more complex care than CMC is currently equipped to provide and, consequently, must be transferred to less convenient, often more expensive, locations. The Parties further agree to optimize the use of System urgent care facilities to offer acuity-appropriate pediatric patients a convenient alternative to the emergency department. Finally, with enhanced urgent/emergent care options and access to specialty expertise, the System will be positioned better to create a short stay pediatric inpatient unit at CMC.

The Parties agree that the Combination will enable the System to aggregate D-HH's robust pediatric outpatient presence in southern New Hampshire, CHaD's specialty and sub-specialty expertise, and CMC's neonatal, emergency department, and inpatient facilities to offer neonatal and pediatric services across the continuum of care and otherwise unavailable in southern New Hampshire.

(c) *Oncology.* The Parties acknowledge that cancer is the leading cause of death in New Hampshire and, by utilizing its combined resources, the System can deliver more comprehensive, convenient, and cost-effective care for cancer patients. D-HH, in partnership with the Geisel School of Medicine at Dartmouth College, is home to the Norris Cotton Cancer Center ("NCCC") in Lebanon, one of only 50 National Cancer Institute-designated "Comprehensive Cancer Centers" in the nation, performing cutting edge basic and clinical research and providing high quality, multi-disciplinary clinical care across a broad range of specialties and sub-specialties. One of NCCC's four regional sites is co-located on CMC's campus in Manchester, where D-HH physicians collaborate with CMC to provide certain outpatient, infusion, and inpatient oncology services and other local cancer survivorship resources.

The Parties agree to utilize their combined resources to expand existing cancer care capabilities and create new medical and surgical treatment options and wraparound services. For example, System synergies will enable patients to receive complex outpatient and pre- and post-operative transplant care locally while travelling to DHMC only for complex surgery and inpatient services. In southern New Hampshire, the System will supplement CMC's existing breast and colorectal surgical oncology services by deploying providers of more complex surgical, and pre- and post-operative care for pulmonary, esophageal, colorectal, endocrine, gynecologic and hematologic cancer conditions, offering a more convenient, less costly alternative for patients who presently seek such treatment out-of-state. The System will capitalize on NCCC's nationally renowned clinical and research infrastructure to export and standardize care protocols/pathways to ensure consistent care quality and patient safety regardless of the site of service. Significantly, the Combination will enable the System to offer wider access to advanced clinical trial opportunities

for eligible patients, many of whom reside in the larger population centers of southern New Hampshire. As referenced in Section 5.3.4(c) below, the System will seek to enhance and develop cancer treatment services at HH and MCH (including initiating infusion services at HH) by deploying oncological specialists to those and other member hospitals, providing patients more convenient, less costly access to specialty care than is presently available in those communities.

In order to optimize the System's distributed cancer care model, centralized patient transfer operations will coordinate and expedite access to the most convenient, acuity-appropriate site of service across the System's outpatient, inpatient, ambulatory and infusion facilities, efficiently aligning System resources to manage the total cost of care.

(d) *Orthopedics.* The Parties recognize that the need for comprehensive surgical and non-surgical orthopedics care is expected to grow in correlation with the aging of New Hampshire's population and agree to integrate their respective orthopedic capabilities in order to offer a full range of inpatient, outpatient and ambulatory services to patients throughout the System's service areas. D-HH orthopedics and sports medicine specialists and sub-specialists provide advanced adult and pediatric medical and/or surgical care for the full spectrum of orthopedic-related conditions and injuries, including hip and knee joint replacement, foot and ankle, shoulder and elbow, and hand and wrist, among others. They also provide orthopedic services for patients who require multi-disciplinary, specialty and sub-specialty care for spine, trauma and oncological conditions, among others.

CMC has developed a dedicated inpatient orthopedics unit which provides more complex orthopedic services in collaboration with independent, community-based physicians, who will continue to be an integral component of the System's coordinated patient care and pluralistic physician model. HH and MCH provide routine orthopedic care but face mounting physician and associate provider workforce challenges that threaten their ability to meet community needs. The Parties agree that the combination of their complementary resources will enable the System to allocate those resources appropriately and optimize capacity to serve the needs of its patients.

The System will deploy specialists and sub-specialists to CMC's inpatient orthopedic unit to expand access to complex orthopedic procedures like joint replacement and revision surgery for patients in southern New Hampshire, more than 1,000 of whom annually seek inpatient orthopedic care out-of-state or at DHMC, which, due to capacity constraints, is forced to deny admission to hundreds of orthopedic patients annually. Additionally, the System will proactively manage the transition of appropriate inpatient procedures to the hospital outpatient setting and utilize the System's existing and planned ambulatory surgery center capacity in Manchester to expand access to the rapidly growing volume of orthopedic procedures performed in the less costly ambulatory setting, ensuring that patients receive the most acuity-appropriate, convenient and cost-effective care across the inpatient, outpatient and ambulatory care continuum. As referenced in Section

5.3.4(a) below, the Parties agree that the System will seek to deploy providers to HH and MCH to support general orthopedic care, pre- and post-operative care, and low complexity procedures appropriate for a CAH.

By fully implementing its distributed care model throughout its integrated service areas, the System will broaden and expedite patient access to high quality orthopedic care, create needed vacancy at DHMC and CMC for higher acuity patients, and support the financial sustainability of its community and CAH Members.

(e) *Spine Care and Pain Management.* The Parties understand that chronic pain, specifically back and spine-related pain, is a common condition that restricts mobility, impairs activities of daily living, diminishes workforce productivity, and may lead to opioid dependence and substance use disorder. Chronic spine and pain conditions are expected to rise in correlation with New Hampshire's aging population and the Parties agree to integrate their respective capabilities in order to offer comprehensive non-surgical and surgical spine care and novel approaches to pain management for patients throughout the System's service areas.

D-HH, through the Spine Center at DHMC, currently offers a full range of non-surgical and surgical spine-related services such as rehabilitation, functional restoration, spinal cord and nerve stimulation, spinal fusion, and neurosurgery, as well as a wide range of clinical and procedural pain treatments through the Pain Management Center at DHMC and the Pain Clinic at Cheshire. CMC currently offers certain surgical spine capabilities through its successful collaboration with independent, community-based physicians, who will continue to be an integral component of the System's coordinated patient care and pluralistic physician model. CMC also offers some pain management services, inpatient and outpatient rehabilitation for spinal cord injuries, occupational therapy services, and a tele-neuro/spine program.

The Parties agree that the System will deploy specialists and sub-specialists in order to develop comprehensive, multi-disciplinary spine-related services at CMC, utilizing existing and new capacity to expand access to the complex inpatient spine procedures for which more than 500 patients from southern New Hampshire annually seek such care out-of-state or at DHMC. The Parties further agree to optimize CMC's existing collaboration with the New Hampshire Neurospine Institute and the use of D-HH's planned ambulatory surgery center in Manchester to ensure that patients receive the most acuity-appropriate, convenient and cost-effective care across the System's integrated inpatient, outpatient and ambulatory care continuum. The System also will support outpatient and pre- and post-operative spine care at HH and MCH and other Member hospitals by deploying specialists and/or employing telemedicine, offering patients more convenient, less costly access to specialty care than is presently available in those communities while supporting the financial sustainability of its community and CAH Members.

The Parties agree that the System will augment existing pain management capabilities by deploying specialists to CMC and expanding telemedicine services to connect Member and non-Member hospitals in order to broaden patient access to innovative approaches to pain management for behavioral health, oncology, orthopedics and spine care, among other disciplines, while offering evidence-based, clinically proven alternatives to traditional opioid prescribing practices.

(f) *Obesity and Bariatrics.* The Parties acknowledge the need to address New Hampshire's adult and childhood obesity problem – a condition that afflicts 28% of the State's adult population and 15% of the State's high school age population – and obesity-related chronic health conditions like diabetes, hypertension, arthritis, and heart disease.

Through its New England Weight Management Institute, CMC offers medical interventions to prevent obesity, manage weight loss, and promote health and wellness through anti-obesity medication, nutritional programs, and counseling, all of which will be augmented by DHMC's Weight and Wellness Center programs, including the innovative Culinary Medicine Program, which aims to translate current research about healthful foods, nutrition, and cooking into a vision of food as medicine. D-HH, through its Manchester clinic, also operates New Hampshire's only obesity program for children and adolescents. The Parties agree that the System will build upon their existing obesity-related care networks by deploying advanced practice providers and/or exploring the potential for telehealth to offer local access to adult, adolescent and pediatric bariatric consultations and pre- and post-operative care at HH and MCH and other rural sites of service. The Parties further agree to utilize the System's expanded primary care network to facilitate early screening and medical intervention for a higher volume of obese and/or overweight patients, obviating or reducing the need for invasive surgical procedures and expediting the diagnosis and management of obesity-related chronic health conditions. To the extent that patients require surgical intervention, both DHMC and CMC offer comprehensive bariatric surgical expertise in gastric bypass, sleeve gastrectomy, and minimally-invasive laparoscopic and/or endoscopic procedures.

The Parties agree that by integrating their existing medical and surgical capabilities and implementing a distributed care model the System will expand access to convenient and cost-effective obesity-related health care to enhance health and wellness throughout its service areas.

(g) *Heart and Vascular.* The Parties understand that heart disease is the second leading cause of death in New Hampshire and its incidence is projected to quadruple over the twenty year period from 2010 to 2030 in correlation with the state's aging population. The Parties agree that by utilizing their combined resources and complementary expertise the System can offer expanded access to more comprehensive, convenient, and cost-effective heart and vascular care for patients throughout its service areas.

FINAL FOR SIGNATURE

CMC is home to NEHVI, a nationally recognized center of excellence in the diagnosis and treatment of cardiovascular disease, specializing in heart failure care, general and interventional cardiology, cardiothoracic surgery, and vascular surgery. DHMC is home to the Heart and Vascular Center at Dartmouth-Hitchcock, providing comprehensive cardiovascular medicine and surgical services, including advanced procedures otherwise available only at academic medical centers in Massachusetts. The Parties agree that by combining and building upon their respective heart and vascular care capabilities the System will enable providers to cross-train and jointly develop innovative treatment options, share best practices, and collaborate to create new and expanded access at NEHVI to the most advanced techniques and procedures for patients in southern New Hampshire, more than 1,400 of whom annually seek inpatient heart and vascular care out-of-state at higher cost. For example, the Parties anticipate that their combined resources will achieve the scale necessary to establish specialized programs otherwise unavailable in New Hampshire like left ventricular assist device (“LVAD”) implantation, for which the need is projected to grow by 74% in southern New Hampshire’s more populous communities by 2027. The Parties also anticipate that the System will enable them to align and distribute resources more efficiently, including through centralized patient transfer operations, to offer expanded access at NEHVI for nearly 300 patients from southern New Hampshire who annually seek inpatient care at DHMC, which, due to capacity constraints, is forced to deny admission to several hundred heart and vascular patients annually. The Parties agree that the CMC expansion project to be developed, financed, and constructed by the System as more fully described in Section 5.5.5 below, will include new and renovated cardiac catheterization and electrophysiology laboratories and supporting infrastructure to offer greater access to outpatient and non- and minimally-invasive procedures at NEHVI.

The Parties further agree that the System will reinforce and enhance existing support for cardiology services, consultation, and pre- and post-operative care at HH and MCH, as well as at other Member and non-Member hospitals, by deploying specialists and/or employing telehealth to offer patients lower complexity heart and vascular services appropriate for a CAH than is presently available in those communities. By fully implementing its distributed care model the System will offer more convenient, less costly access to integrated, acuity-appropriate heart and vascular care throughout its service areas, support the financial sustainability of its CAHs and other rural health care providers across New Hampshire, and create needed vacancy at DHMC and CMC for higher acuity patients.

Finally, as referenced in Section 5.3.7 below, the System’s combined resources will enable the Parties to explore the expansion of graduate medical education (“GME”) programs to include a cardiovascular rotation at NEHVI for residents and fellows and a cardiac surgery fellowship currently unavailable in New Hampshire.

5.3.3 Continuation of Services.

(a) *Evaluation of Services.* The Parties are dedicated to their respective missions, levels of excellence and commitment to rural healthcare, and recognize the importance of maintaining their existing level of hospital and other health care services to the extent feasible under evolving standards of quality, cost, effectiveness and reimbursement. D-HH GO will support the continued availability of services necessary and appropriate for the communities served by CMC, HH and MCH and, with respect to HH and MCH, as both necessary to maintain CAH status and appropriate for a comparable rural hospital (collectively the “Core Services”), subject to the following evaluation process. The Regional Presidents, in consultation with the Member CEOs and their respective clinical leaders, will evaluate regularly the effectiveness and efficiency of clinical services provided by the Members in addressing the health needs of the communities they serve. The evaluation will include consideration of the following: (i) the synergies created by the Combination and the goals of the Parties stated in Article 1 above; (ii) quality; (iii) cost; (iv) reimbursement; (v) profitability; (vi) outcomes; (vii) access; (viii) provider retention and recruitment needs and challenges; and (ix) community needs. If the evaluation pertains to any clinical services or operations in Region II that are not consistent with Catholic moral teaching, the ERDs or Canon Law and Section 4.2.2(d) remains applicable, then the evaluation of such services or operations and the process under Section 5.3.3(b) below will be the responsibility of the D-HH GO Chief Clinical Officer or Chief Operating Officer. No Core Service will be terminated, however, for the sole reason that the Core Service is not profitable.

(b) *Process for Implementing Changes in Clinical Services.* The Member CEOs and their respective clinical leaders will have an opportunity to review the data reviewed by the Regional Presidents, to provide additional data and information, to review the preliminary analysis of the Regional Presidents, and to provide their own analysis and recommendations. If a Regional President recommends a material change in clinical services by any Member, the recommendation will be presented to the System CEO and the applicable Member CEO and its clinical leadership will be invited to participate in the presentation. If the System CEO agrees with the recommended change, then the System Board will evaluate the recommendation in accordance with the process and standards set forth in Sections 3.4.1(b)(v) (with respect to HH and MCH) and 3.4.2(b)(v) (with respect to CMC) above. Notwithstanding the foregoing, the Parties agree that NEHVI is an integral component of CMC’s services and will not be relocated, reduced or eliminated without the prior approval of the CMC Board, in its discretion.

5.3.4 System Commitments to HH and MCH. As set forth in Sections 1.7, 1.9 and 2.8 above, the Parties recognize the need to reinforce the rural health care network by expanding access to local, acuity-appropriate care for rural populations and thereby promote the long-term financial sustainability of the System’s rural Members. Specifically, as to HH and MCH, the Parties agree that following the Combination Date, the System promptly will evaluate the feasibility of:

- (a) Deploying general and orthopedic surgical services (together with subparagraphs (b), (c) and (d) below, the “Services”) in order to expand access to surgical procedures appropriate in a CAH setting and to optimize the hospitals’ operating room capacity;
- (b) Deploying specialists for outpatient services and minor surgical procedures in urology and geriatrics;
- (c) Enhancing cancer treatment services at both HH and MCH with particular attention to initiating chemotherapy infusion services at HH; and
- (d) Supporting appropriate services in ophthalmology, bariatrics and behavioral health.

The feasibility analysis generally will take into account but not be limited to an evaluation of the local demand for the Services, the resources available to meet the demand for the Services, the most convenient, cost-effective, acuity-appropriate site of service for patients in those communities, and the best interests of the System as a whole and of its Members. If, following its analysis, the System determines that it is feasible to provide one or more of the Services at HH and MCH, then the System promptly will develop an appropriate implementation plan.

5.3.5 Telehealth Services

The Parties acknowledge that in order to realize their mutual vision and achieve the objects of the Combination, among which are improving local access to services, improving patient safety and quality of care, responding to community needs, addressing workforce challenges, and reinforcing rural health care providers, the System must align and optimize existing telehealth capabilities and further develop this powerful tool. As referenced throughout the discussion of clinical program development in Section 5.3.2 above, the Parties agree that telehealth services are a critical component of their vision for a fully integrated, regionally distributed health care delivery network.

D-HH and GOH each has an established telehealth presence, albeit somewhat duplicative and reliant on third-party vendors for some services. D-HH has invested heavily in telehealth over several years and currently provides one or more advanced services in emergency (“tele-ED”), intensive care (“tele-ICU”), pharmacy, neurology, psychiatry, intensive care nursery (“tele-ICN”), and specialty care to 19 member and non-member hospitals throughout New Hampshire and Vermont, including tele-pharmacy services at HH and MCH. D-HH also is developing “direct to consumer” urgent care and behavioral health services as well as remote patient monitoring. GOH

FINAL FOR SIGNATURE

supports tele-stroke and tele-neurology services at CMC, HH and MCH, as well as neurology, neuro/spine, hospitalist, and cardiology telehealth services at rural, non-member hospitals in New Hampshire. CMC also purchases tele-psychiatry services from a third-party vendor and is planning to explore the development of a bariatrics service.

The Parties agree that their combined telehealth resources and infrastructure will enable them to align and expand telehealth services at CMC, among other locations, where D-HH currently has no connectivity. For example, the System will facilitate the development of tele-ICU services at CMC, using interactive audiovisual technology to connect board-certified intensivists at DHMC with bedside teams at CMC to provide real-time care, consultation and 24/7 patient monitoring. This will expand access to more convenient critical care for New Hampshire patients who presently are forced to seek such care out-of-state, reduce ICU length of stay and mortality rates through more prompt care interventions driven by advanced analytics, and through more efficient utilization relieve capacity constraints at DHMC and CMC to better accommodate critical care patient demand. Additionally, by supporting tele-ICU services at participating Member and non-Member hospitals throughout its regional care delivery network, the System will ensure that patients receive high quality critical care in the most convenient, acuity appropriate location.

The Parties agree that their increased scale, including a larger base of available providers, will enable them to strengthen their internal telehealth capabilities, reduce over time their reliance on third-party vendors who lack integration with the Systems quality and cost initiatives, avoid unnecessary and costly duplication of services, and defray the high cost of human resources and technical infrastructure necessary to support robust telehealth programming. The Parties further agree that the System will facilitate the development of telehealth services by CMC providers and the combined telehealth capabilities and expertise at both CMC and D-H will enable them to offer an expanded menu of services across the System's network and beyond, which will benefit rural health care providers and their patients in particular by: i) expanding access to high quality specialty care otherwise unavailable in those communities; ii) giving patients a lower cost, more convenient specialty care alternative; iii) offering a virtual solution to the rural health care workforce crisis; iv) stemming the contraction of low volume, high complexity specialty services in rural communities; and v) supporting the financial sustainability of rural providers.

Finally, the Parties agree to optimize the potential of telehealth technology to provide remote patient monitoring and "direct to consumer" services, offering appropriate patients lower cost access to care from the convenience of their homes.

5.3.6 Clinical Quality and Process Improvement

The Parties are deeply committed to consistent clinical quality and process improvement, and the highest standards of patient care and safety as top priorities. The Parties agree to strive continuously to ensure that the System is a high reliability, high value health care organization, offering patients throughout its service areas high quality, safe, and cost-effective care. The System will achieve these strategic objectives by establishing standards of care that exceed regulatory requirements, measuring performance against those established benchmarks, sharing best practices, and minimizing inefficient or “non-value-added” care variation, all of which has proven to reduce the total cost of care.

While both D-HH and GOH bring to the Combination quality improvement infrastructure upon which the System will build and expand, the Parties recognize that D-HH, with the resources and expertise of an academic medical center at its core, has developed a mature quality improvement regime that includes its Value Institute (which oversees the conduct of more than 50 care quality and process improvement projects annually), its Analytics Institute (which provides analytical tools to support care quality and process improvement initiatives), its Patient Safety Training Center (which simulates real-world provider-patient encounters using programmable mannequins and live actors), and its System Quality Management Council (a system-wide, standard setting body), all of which require significant financial investments. These resources are used to establish system-wide, data-driven patient care and process improvement goals, against which performance is measured regularly to promote accountability. Best practices are derived from the data and packaged as “care bundles” for implementation by System Members, driving standardization of care pathways, care quality, and patient experience.

The Parties agree to deploy their integrated quality improvement resources to develop and monitor adherence to System-wide quality, safety, and patient experience goals, such as reducing serious safety events and hospital-acquired conditions (“HACs”). In order to facilitate this work the Parties agree to convene a System Quality Management Council, modeled on the D-HH Quality Management Council, on which each Member will be represented and responsible for patient care and process improvement goal-setting, data-driven performance measurement, and implementation of best practices. The Parties further agree to utilize the System’s Analytics and Value Institutes to tailor care quality and process improvement initiatives to local needs and expand access to proven training programs for System providers and other health care professionals. The System will enable the Parties to spread the high cost of such tools and infrastructure across multiple Members, most of whom alone are financially incapable of making such investments.

In addition to an emphasis on data-driven, measurable care quality and process improvement, the System’s quality improvement efforts, as referenced in Sections 5.3.2 and 5.3.5 above, will include deploying specialists and subspecialists and/or employing telehealth in order

to expand local access to specialty care while concentrating high-risk, low-volume services at acuity-appropriate sites like CMC and DHMC.

5.3.7 Teaching and Research Programs

The Parties recognize that high quality patient care begins with strong medical education, research and training, and agree that D-HH GO will be an academic health system with DHMC as its sole academic medical center and primary campus for teaching, research and GME programs. MHMH, in partnership with Dartmouth-Hitchcock Clinic, the Geisel School of Medicine at Dartmouth, and the Veteran's Affairs Medical Center in White River Junction, Vermont, sponsors more than 50 accredited residency and fellowship programs training more than 500 medical students and post-graduates. Demonstrating their shared commitment to training obstetrician gynecologists ("OB/GYN") in women's health care, MHMH and CMC have partnered for several years to offer OB/GYN residents a second-year rotation at CMC to expose them to an urban community practice and NaPROTECHNOLOGY®. The Parties understand that local training is crucial to the future of the region's health care workforce as one-quarter of the OB/GYN program's graduates have remained to practice in New Hampshire, which ranks 45th nationally in physician workforce retention.

The Parties recognize that the geography and combined resources of the System will create opportunities for new academic synergies, enabling them to advance knowledge in the basic, translational, and clinical sciences across a broader urban/rural population, offering more patients easier access to innovative treatments and 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. The Parties agree that, over time, CMC will become the System's primary community teaching hospital in southern New Hampshire, offering diverse learning experiences to medical students, interns, residents and fellows in an urban, acute care hospital setting, as well as faculty appointments for eligible and interested medical staff. The System's combined resources and urban and rural sites of service will offer opportunities to establish new GME programs in, for example, cardiac surgery or rural-based internal medicine and the Parties agree to explore the feasibility of establishing such new programs.

The System also will offer more convenient, expanded access to clinical trials for patients from southern New Hampshire and rural communities across its service areas. CMC currently conducts more than a dozen clinical trials advancing new SUD treatments and heart and vascular techniques. D-HH has built a centralized clinical trials and research infrastructure that coordinates over 500 active trials and studies and provides clinical trial and grant management, research finance, information technology, and regulatory compliance support. The Parties agree to combine their respective clinical trial and research infrastructures to extend the reach of innovative, advanced treatments and technologies to a greater number of patients throughout New Hampshire.

5.4 INFORMATION TECHNOLOGY

The Parties acknowledge that presently they do not operate on common electronic medical record (“EMR”) and/or business system platforms but they recognize that integrating their disparate systems will facilitate and serve the objects of the Combination for the benefit of patients, providers, employees and the System. Common information system (“IS”) platforms will promote clinical integration and coordinated patient care by documenting a patient’s clinical history in a unified, System-wide medical record, eliminating unnecessary and inefficient care interventions. Access to common tools will better enable providers to direct care to the most acuity-appropriate sites of service, expedite System-wide standardization of care, and optimize clinical quality and process improvement efforts. Integrated IS platforms also will enable the System to streamline operations and avoid inefficient duplication of information management systems across multiple business units and administrative functions. Consequently, the Parties agree that the System will pursue a two-pronged IS strategy to achieve interim interoperability while preparing for full integration over time and as permitted by existing third-party contractual obligations.

5.4.1 Interim Interoperability. In order to achieve interim interoperability following the Combination Date, the Parties agree to align their existing IS systems and design clinical workflows to create a common set of Continuity of Care Documents (“CCDs”), which will allow providers to aggregate and share key clinical information about a patient to support continuity of care throughout the System. The System will seek to augment the use of CCDs by using third-party interoperability tools to develop a common data storage repository, enable data sharing between and among disparate IS platforms, and optimize provider and patient connectivity. The Parties further agree to develop common security and privacy policies governing their shared IS enterprise, and to commence technical planning for full integration to take effect as soon as legally, clinically and financially feasible.

5.4.2 Full Integration. The Parties understand that full integration of their respective IS infrastructure is temporarily prohibited by the complexity of their disparate platforms and competing third-party vendor contractual obligations. D-HH has already moved D-H (MHMH and DHC), Cheshire, and APD to shared EMR and Enterprise Resource Project (“ERP”) platforms and plans to migrate NLH are underway. The Parties agree that the System will implement common IS platforms at CMC, HH, and MCH as soon as legally, clinically and financially feasible.

5.5 FINANCIAL MANAGEMENT

5.5.1 Endowment Funds. Subject to the System Board’s Reserved Powers under Sections 3.4.1 (with respect to HH and MCH) and 3.4.2 (with respect to CMC and the CMCHS Subsidiaries) with respect to proposed expenditures, each System Member will retain ownership

and control over its Endowment Funds and the Endowment Funds will not be subject to reallocation by the System under Section 5.5.2 below. For purposes of this Agreement, “Endowment Funds” means: (i) all donor-restricted assets reflected on the Member’s financial statements as restricted and (ii) all unrestricted donations received in connection with a fundraising effort of a System Member as described in Section 5.5.6 below. In evaluating a System Member’s request for financial support from the System, however, D-HH GO may consider the amount of Endowment Funds which the System Member has available for its own support. If D-HH GO establishes a System-wide program requiring System Members to become a participant in The Dartmouth-Hitchcock Master Investment Program of Pooled Investment Accounts (the “Pooled Investment Program”), then CMC, HH and MCH will include their Endowment Funds (along with reserve funds) in the Pooled Investment Program unless the investments are not consistent with the requirements of the New Hampshire Uniform Prudent Management of Institutional Funds Act, RSA 292-B. CMC’s participation and the participation of CMCHS Subsidiaries in the Pooled Investment Program is subject to Section 2.6 and the Bishop’s Reserved Powers and such participation is further subject to CMCHS’s assessment of the Pooled Investment Program and whether it is consistent with the Socially Responsible Investment Guidelines set forth by the United States Conference of Catholic Bishops (“USCCB”). Although such funds are pooled for investment purposes, each System Member retains ownership of its funds and any earnings on those funds.

5.5.2 Financial Performance and Allocation of System Resources and Expenses. The System will operate as a more fully-integrated health care delivery system to further the mission of the System and its Members in a coordinated manner. One of the primary responsibilities of D-HH GO is to ensure that the collective resources of the System are used to address as effectively as possible the health care needs of all of the communities served by the System. Therefore, subject to the provisions of Section 2.6 with respect to CMC, the System Board will have the responsibility and power to ensure that the System and its Members observe sound financial practices as described below.

(a) *Financial Principles.* In managing the System’s financial resources, D-HH GO will observe, and may require the System Members to observe as applicable, the financial principles set forth in Schedule 5.5.2(a) as they may be modified from time to time by D-HH GO (the “System Financial Principles”).

(b) *Financial Monitoring and Improvement Planning.* D-HH GO will monitor the ongoing financial performance of the System Members, and the System Members agree to provide such financial information as may be requested by D-HH GO. If a System Member is unable to meet the System Financial Principles or has a material deviation from its approved operating budget, then D-HH GO may require the System Member to meet with the D-HH GO Chief Financial Officer (the “System CFO”) to discuss the Member’s

financial performance and to develop a mutually-agreeable plan to improve the Member's financial performance. The improvement plan may require the regular oversight of the System CFO or his/her designee or one or more consultants.

(c) *Reallocation of Member Assets by System.* In furtherance of the objectives described in this Section 5.5.2, the System Board also will have the power and authority to require a reallocation of a System Member's assets or resources (excluding Endowment Funds) for one or more System purposes. If the System Board determines that a reallocation of assets or resources from one or more System Members to D-HH GO for use elsewhere within the System (i) will further the System Strategic Plan, (ii) is the most appropriate way in which to fund the System need or program or initiative, (iii) will not materially impair the ability of the 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 described in Section 5.5.2(a), then the System Board will notify the Member Board(s) of the proposed re-allocation. 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. D-HH GO will not exercise its authority to reallocate assets or resources within the System, however, if it would cause (i) a default or breach of a Member's covenants or obligations under bond documents and other financing documents, or (ii) a reduction, withdrawal, suspension of or other materially adverse effect on the rating of a Member's outstanding bonds as determined as described in Section 1.3 of the D-HH GO Bylaws. Any proposed reallocation of the assets or resources of CMC or any CMCHS Subsidiary will be subject to the Bishop's Reserved Powers and the provisions of Section 2.6 above, and in no event can D-HH GO reallocate assets or resources of CMC or CMCHS to fund or implement any procedure that is inconsistent with Catholic moral teaching, the ERDs or Canon Law. The Parties agree that D-HH GO shall not reallocate any assets of either HH or MCH to fund any part of the capital costs of the DHMC patient tower or the CMC Expansion Project described in this Agreement.

5.5.3 Dartmouth-Hitchcock Obligated Group. All debts, liabilities, assets and duties of a System Member will remain the obligation and property of such Member after the Combination Date except as follows. Following the Combination Date, when the 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 the joining Member may be

required to execute an agreement which may modify some of the System Board's Reserved Powers or impose other operational requirements in recognition of the joint and several liability incurred by members of the DHOG.

5.5.4 Defined Benefit Pension Plan. D-H and CMC each previously have sponsored, and currently have suspended active participation in, a "defined benefit" Pension Benefit Plan (the "Pension Plan") as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Each of D-H and CMC will maintain a funding program designed to meet current and anticipated future liabilities under its Pension Plan, consistent with the requirements of ERISA, the Internal Revenue Code of 1986, as amended, applicable accounting standards and any other applicable law, rule or regulation. If a Pension Plan is underfunded, then the Party sponsoring the Pension Plan (the "Sponsoring Party") will report to the System CFO on a quarterly basis as to the status of the funding and initiatives designed to address any underfunding.

5.5.5 Capital and Financial Investments

(a) *CMC Hospital Expansion.* 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"). CMC has not yet finalized the details pertaining to the final scope, cost, financing, feasibility and timing of the CMC Expansion Project, 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 the following conditions:

- (i) CMC will have obtained all federal, state and municipal permits, approvals and licenses, and all third party consents, necessary for the ownership, development and operation of the CMC Expansion Project;
- (ii) CMC, in consultation with D-HH prior to the Combination Date to the extent permitted by law and in collaboration with D-HH GO after the

Combination Date, will prepare a project cost and feasibility plan (the “Expansion Project Plan”) containing the following minimum information and which is mutually acceptable to and agreed upon by D-HH and D-HH GO and CMC and CMCHS, as applicable:

(A) The scope and components of the CMC Expansion Project, and their relationship to the furtherance of CMC’s strategic and long-term financial and clinical planning and to the objectives of CMC and the Combination (or to the System Strategic Plan, if developed before the Expansion Project Plan);

(B) The projected cost of the CMC Expansion Project, broken down by components and including financing costs, professional fees and other soft costs, and contingencies, and segregating but identifying any costs for rehabilitation or re-purposing of existing CMC facilities which may result from the CMC Expansion Project (collectively the “Project Costs”);

(C) All expected sources of financing and the anticipated amounts, terms, and interest rates;

(D) The project timeline for the financing and development of the CMC Expansion Project, including any proposed phasing; and

(E) The projected revenues from the CMC Expansion Project, and a cash flow analysis demonstrating the anticipated capital recovery and the extent to which projected revenues will exceed projected operating costs (the “Projected Return on Investment”). The Projected Return on Investment measured as an internal rate of return over a twenty year period should be five percent (5%) or higher.

(iii) The Expansion Project Plan will be presented to the System Board and CMCHS and the Bishop for approval. In considering whether to approve the Expansion Project Plan, the System Board will take into consideration the resources of the System, the debt capacity of the DHOG and the Projected Return on Investment, and prevailing financial market conditions.

(b) *Future Capital Projects Planning.* The Parties acknowledge the importance of continual capital project planning. After the Combination Date and as part of the 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 System resources consistent with the System Strategic Plan and the Financial Principles.

5.5.6 Philanthropy. Subject to the approval rights under Section 3.4.5(f) above, each System Member will be expected to participate in System-wide fund raising activities in support of the System Strategic Plan, the proceeds of which will be controlled by D-HH GO. If a System Member conducts fundraising activities in its Service Area and the proceeds are expressly designated for one or more projects or uses by the System Member within its Service Area, then such fundraising proceeds will be considered to be Endowment Funds as long as they are identifiable as such on the books of the System Member.

5.6 CONSOLIDATION OF ADMINISTRATIVE FUNCTIONS

Although there are no immediate plans to do so, certain administrative functions of D-H, CMC, HH and/or MCH may be consolidated in the future with those of other System Members to achieve efficiencies while maintaining effectiveness. Any such proposed consolidation first must be presented to the Member Leadership Council for its feedback and recommendations, and then approved by the System CEO and the President of the Region(s) affected.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 6. IMPLEMENTATION OF COMBINATION

6.1 CLOSING; COMBINATION DATE

6.1.1 Closing. Within thirty (30) days after the satisfaction of all of the conditions described in Section 6.3 below, and if the Agreement has not been terminated pursuant to Article 10 below, then the Parties agree to take the actions described in Section 6.2 below in order to implement the Combination (the “Closing”). The Closing will occur at the offices of Hinckley, Allen and Snyder, LLP in Manchester, New Hampshire at a date and time mutually-acceptable to the Parties unless they agree to conduct the Closing through the exchange of electronic counterparts of all required Closing documents.

6.1.2 Combination Date. The Combination will become effective on the date on which the last of the amended governance documents described in Section 6.2 below are accepted for filing by the office of the New Hampshire Secretary of State (the “Combination Date”). Each Party agrees to use its best efforts to accomplish a Combination Date of no later than July 1, 2020.

6.2 TRANSACTIONS IN CONNECTION WITH THE CLOSING

Each of the Parties agrees to fulfill its respective obligations at the Closing as follows:

6.2.1 Obligations of D-HH. At Closing, D-HH will:

(a) *Amended Articles of Agreement*. File with the New Hampshire Secretary of State and the Clerk of the City of Lebanon, New Hampshire an affidavit of amendment to its Articles of Agreement, substantially in the form attached as Appendix 6.2.1 (a), amending its name to “Dartmouth-Hitchcock Health GraniteOne;”

(b) *Amended Bylaws*. Adopt amendments to its Bylaws, substantially in the form attached as Appendix 6.2.1(b), amending its name to “Dartmouth-Hitchcock Health GraniteOne” and reconstituting its Board of Trustees as described in Section 3.3.2 above; and

(c) *Reconstitution of Board of Trustees*. Obtain and submit at Closing the vote of the D-HH Board of Trustees, substantially in the form attached as Appendix 6.2.1(c) and effective as of the Combination Date, amending the size of the System Board, electing to the System Board the D-HH Nominees and the GOH Nominees, and accepting the resignations of those members of the D-HH Board of Trustees who are not D-HH Nominees under Section 3.3.2(b)(iii) above (collectively, the “Resigning D-HH Trustees”).

6.2.2 Obligations of GOH. At Closing, GOH will:

(a) *Consent to Name Change.* Deliver to D-HH a letter consenting to the change of the name of D-HH to “Dartmouth-Hitchcock Health GraniteOne,” which letter may be presented to the New Hampshire Secretary of State if necessary;

(b) *Amended Articles of Agreement.* File with the New Hampshire Secretary of State and the Clerk of the City of Manchester, New Hampshire an affidavit of amendment to its Articles of Agreement amending its name to one which will not conflict with the change of the name of D-HH to “Dartmouth-Hitchcock Health GraniteOne;”

(c) *Member Substitution.* Deliver any instrument necessary to document its consent to the substitution of D-HH GO for GOH as the sole corporate member of HH and MCH, and as a co-member of CMC; and

(d) *Winding Down and Dissolution.* Commence and complete the winding down and dissolution of GOH as soon as reasonably possible following the Combination Date.

6.2.3 Obligations of HH and MCH. At Closing, each of HH and MCH will:

(a) *Amended Articles of Constitution/Articles of Agreement.* File with the New Hampshire Secretary of State and the municipality in which each is located an affidavit of amendment to its Articles of Constitution or Articles of Agreement (as applicable), substantially in the form attached as Appendix 6.2.3(a)-1, and Appendix 6.2.3(a)-2, respectively, (i) substituting D-HH GO for GOH as its sole corporate member, (ii) reserving to D-HH GO (either directly or by reference to its Bylaws) the System Board Reserved Powers described in Section 3.4.1 above, and (iii) including support of the System in the corporate purposes of HH and MCH;

(b) *Amended Bylaws.* Adopt amendments to its Bylaws, substantially in the form attached as Appendix 6.2.3(b)-1, and Appendix 6.2.3(b)-2, respectively, reserving to D-HH GO the System Board Reserved Powers described in Section 3.4.1 above; and

(c) *Reconstitution of Board of Trustees.* Obtain and submit at Closing the resignations, effective as of the Combination Date, of any members of the HH Board of Trustees or the MCH Board of Trustees necessary to allow for the appointment of the System Board representatives described in Section 3.3.3 above.

6.2.4 Obligations of each of CMC and the CMCHS Subsidiaries. At Closing, but only following the completion of the actions described in Sections 6.2.1, 6.2.2 and 6.2.3 above, each of CMC and the CMCHS Subsidiaries will:

(a) *Amended Articles of Agreement.* File with the New Hampshire Secretary of State and the Clerk of the City of Manchester, New Hampshire an affidavit of amendment to its Articles of Agreement, substantially in the form attached as Appendix 6.2.4(a)-1, Appendix 6.2.4(a)-2, Appendix 6.2.4(a)-3, and Appendix 6.2.4(a)-4, respectively (i) substituting D-HH GO for GOH as one of its corporate members, (ii) reserving to D-HH GO (either directly or by reference to the Bylaws) the System Board Reserved Powers described in Section 3.4.2 above, (iii) preserving and modifying as necessary (either directly or by reference to the Bylaws) the Bishop's Reserved Powers described in Section 3.4.2 above, (iv) incorporating (either directly or by reference to the Bylaws) the provisions of Sections 3.4.3 and 3.4.4 above, and (v) including support of the System within its corporate purposes (subject to the provisions of Sections 2.6, 3.4.3 and 3.4.4 of this Agreement);

(b) *Amended Bylaws.* Adopt amendments to its Bylaws, substantially in the form attached as Appendix 6.2.4(b)-1, Appendix 6.2.4(b)-2, Appendix 6.2.4(b)-3 and Appendix 6.2.4(b)-4, respectively (i) reserving to D-HH GO the System Board Reserved Powers described in Section 3.4.2 above, (ii) preserving and modifying as necessary the Bishop's Reserved Powers described in Section 3.4.2 above, and (iii) incorporating the provisions of Sections 3.4.3 and 3.4.4 above; and

(c) Obtain and submit at Closing the resignations, effective as of the Combination Date, of any members of its Board of Trustees necessary to allow for the appointment of the System Board representatives described in Section 3.3.3 above.

6.3 CONDITIONS PRECEDENT TO OBLIGATIONS OF THE PARTIES

The obligation of the Parties to conduct the Closing and implement the Combination as described above is expressly conditioned upon the prior satisfaction of the following conditions:

6.3.1 Representations and Warranties True and Correct. The representations and warranties of the Parties remain true and correct in all material respects as of the Combination Date.

6.3.2 Performance of Covenants. The Parties perform their respective pre-Closing covenants under Article 8 below in all material respects as of the Combination Date.

6.3.3 Governmental and Third-Party Consents, Approvals, Authorizations. The Parties obtain (a) all governmental and third party consents, approvals and authorizations necessary to complete the Combination and (b) if applicable, successfully challenge in a court of competent jurisdiction and venue the withholding or denial of any such consent, approval or authorization, including but not limited to: (i) approval of the New Hampshire Director of Charitable Trusts under the so-called Change of Control Law, New Hampshire RSA 7:19-b; (ii) no action decision by the New Hampshire Attorney General, Division of Consumer Protection and Antitrust; (iii) no action decision by the Federal Trade Commission and/or the United States Department of Justice in connection with the Parties' filing under the Hart-Scott-Rodino Act; (iv) approval of the Bishop of the Roman Catholic Diocese of Manchester; and (v) any other approvals required by Canon Law or the Bishop of the Roman Catholic Diocese of Manchester.

6.3.4 Completion of Due Diligence. The completion by each Party, and receipt of satisfactory results, of due diligence into various operational, legal, financial, tax, clinical and other issues and matters (including those arising between the Agreement Date and the date of the Closing) which may impact the successful consummation of the Combination transaction. The Parties agree to conduct such diligence as promptly as possible, and in any event prior to the Closing.

6.3.5 Corporate Approvals. If any material modifications are required to this Agreement or any of the documents attached as appendices as a result of the regulatory review process, the requirements of third parties with the right to approve or consent to the Combination, or remaining due diligence, then such modifications must be approved and this Agreement ratified by the respective board of trustees of each of the Parties.

6.3.6 No Material Adverse Event. There shall not have occurred any change in law or circumstances prior to the Closing that has or, with the passage of time, is expected to have, a material adverse effect on the financial condition, business prospects or operations of any Party that impedes the ability of any Party to consummate successfully the Combination and pursue the mutual vision of the Parties expressed in Article 1 above (a "Material Adverse Event"). The Parties agree that the exclusion of any Party from participation in any health care program funded through the federal government, including without limitation Medicare or Medicaid, will constitute a Material Adverse Event. The Parties further agree that the failure, in any material respect, of any Party to institute, or achieve the projected results of, any operational and financial improvement measures or initiatives adopted by its Board of Trustees prior to the Agreement Date ("Improvement Initiatives") will constitute a Material Adverse Event.

6.3.7. Failure to Satisfy Conditions. If any one Party fails to satisfy any condition described in this Section 6.3, then each of the remaining Parties may elect in its discretion either to (i) waive in writing such failure to satisfy the conditions in Sections 6.3.1, 6.3.2, 6.3.4 and 6.3.6,

FINAL FOR SIGNATURE

if applicable, or (ii) consummate the Combination in accordance with the Agreement but without the Party which failed to meet the conditions. If the remaining Parties do not unanimously make one of the foregoing elections, then the provisions of Section 10.1.1 will apply.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 7. REPRESENTATIONS AND WARRANTIES; INDEMNIFICATION

7.1 REPRESENTATIONS AND WARRANTIES

Each Party represents and warrants to the other Parties that each statement below is true and correct as of the Agreement Date and will be true and correct as of the Combination Date, except as described in any applicable Disclosure Schedule submitted by such Party and accepted by the other Parties as evidenced by its attachment to this Agreement:

7.1.1 Organization and Good Standing. The Party is duly organized, validly existing and in good standing as a voluntary, nonprofit corporation under the laws of the State of New Hampshire. Each Party has delivered to the others a complete and accurate copy of the Party's current organizational documents, and no breach or violation of any provision of its organizational documents is outstanding.

7.1.2 No Capital Stock; Membership. The Party has no capital stock. The Party has identified to the other Parties any and all corporate members of the Party and any and all organizations of which the Party is a corporate or limited liability company member.

7.1.3 Corporate Powers. The Party has all requisite power and authority, and all necessary licenses, certifications, accreditations and permits, to own, lease and operate its properties and assets and to conduct its health care operations consistent with the manner in which such operations presently are conducted.

7.1.4 Authorization; Binding Agreement. The Party has the unconditional right, power and authority to execute and deliver this Agreement and to perform its obligations under the Agreement. This Agreement is valid and binding upon, and enforceable against, the Party in accordance with its terms.

7.1.5 No Conflicts; Required Consents. The Party's execution and delivery of this Agreement and its consummation of the Combination under the terms of this Agreement: (i) is not in contravention of the Party's organizational documents; (ii) does not require a filing with or approval by any governmental agency other than as specified in Section 6.3.3 above; (iii) will not violate any applicable law; (iv) does not and will not violate any judgment, order or decree of any court or agency to which the Party or any of its assets or operations is subject; and (v) except as disclosed on the attached Schedule 7.1.5, does not require any consent, approval, license or permit which the Party has not obtained or will not have obtained by the Closing.

7.1.6 Tax-Exempt Status; Taxes. The Party is an organization exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the

“Code”) and a public charity under Section 509(a)(1) or (2) of the Code, and has obtained a determination of such exemption from the Internal Revenue Service, which determination is in full force and effect. The Party is in material compliance with all applicable laws related to its status as a tax-exempt organization and has not taken any action or failed to take any action that could reasonably be expected to result in the loss or revocation of, or place in jeopardy, such status. The Party has filed all tax returns required to be filed by the United States Government and the State of New Hampshire, and all taxes, assessments and other governmental charges due from the Party, if any, have been duly paid, other than taxes or charges which are not as yet delinquent and have been properly accrued on the books of the Party.

7.1.7 Financial Information.

(a) *Financial Statements.* The Party has furnished to the other Parties its most recent audited financial statements consisting of a balance sheet, statement of operations and changes in net assets and cash flow for the Party and any wholly-owned subsidiaries (collectively the “Subsidiaries”) for the applicable fiscal year (collectively, the “Audited Financial Statements”). The Audited Financial Statements have been prepared by the Party’s management in accordance with generally accepted accounting principles and from the books and records of the Party, which books and records are complete and correct in all material respects, and fairly present the [consolidated] financial condition of the Party and its subsidiaries as of the date thereof and the results of their operations and changes in net assets and cash flows for the period ended on the date thereof. The Audited Financial Statements reflect reserves appropriate and adequate for all known liabilities and reasonably anticipated losses as of the date thereof, based on information known to the Party as of such date. Since the period covered by the Audited Financial Statements, there has been no material adverse change in the business or financial condition of the Party or its Subsidiaries, taken as a whole, or in any of their respective assets or liabilities from those reflected in the Audited Financial Statements, except for (i) changes in the ordinary course of business consistent with past practice and (ii) changes disclosed in writing to the other Parties.

(b) *Absence of Undisclosed Liabilities.* Except as disclosed on the attached Schedule 7.1.7, the Party and its Subsidiaries do not have any material liabilities or obligations of any nature whatsoever, due or to become due, accrued, absolute, contingent or otherwise except as reflected or reserved against in the Audited Financial Statements and except for liabilities and obligations incurred since the date of the Audited Financial Statements in the ordinary course of business and consistent with past practice, all of which liabilities have been disclosed to the other Parties.

(c) *No Adverse Actions.* Except as expressly contemplated herein, the Party has not, at any time after the date of the Audited Financial Statements: (i) written off as uncollectible, or established any extraordinary reserve with respect to, any material account receivable or other material indebtedness of the Party; (ii) amended or restated, or approved the amendment or restatement of, the organizational documents of the Party; (iii) made or changed any material tax election, entered into any settlement or compromise of any material tax liability or surrendered any right to claim a material tax refund; (iv) settled or compromised any pending or threatened legal proceeding, suit, action, claim, arbitration, mediation, inquiry or investigation, unless in connection with such settlement or compromise there was no finding or admission of any violation of any legal requirement and the sole relief provided was monetary damages; (v) made any material capital expenditure or commitment for additions to property, plant or equipment or for any other purpose, except in the ordinary course of business or as disclosed on Schedule 7.1.7; (vi) sold, transferred, leased, optioned or otherwise disposed of any assets except in the ordinary course of business; (vii) granted or incurred any obligation for any increase in the compensation of any of the employees of the Party (including any increase pursuant to any bonus, pension, profit sharing, retirement, or other plan or commitment) except in the ordinary course of business; (viii) received any written notice from any governmental authority of any liability, potential liability or claimed liability based on any violation of law; or (ix) agreed or committed to take any of the actions referred to in this Section 7.1.7.

7.1.8 Medicare And Medicaid Participation; Reimbursement Contracts; Accreditation. The Party represents and warrants that it is not excluded, voluntarily or by law, from participation in a federal or state health care program under 42 USC § 1320a-7, and that it will not perform any act or suffer any omission that will cause it to be excluded. The Party further represents and warrants that it is not in violation in any material respect with: (i) the Conditions of Participation imposed by the federal Medicare and Medicaid programs; (ii) any reimbursement contract between the Party and a commercial payer; or (iii) the requirements of any accreditation body to which the Party is subject.

7.1.9 Third Party Cost Reports. The Party represents and warrants that it has timely filed all cost reports and related information required under the Medicare and Medicaid programs, and that to the best of its knowledge the cost reports are accurate and complete in all material respects. Neither the Centers for Medicare & Medicaid Services nor any other regulatory agency is actively contesting the information contained in any cost report filed by the Party.

7.1.10 Employee Benefit Plans

(a) *Compliance.* Except as set forth on the attached Schedule 7.10, each Welfare Benefit Plan and Pension Benefit Plan, as defined in Sections 3(1) and 3(2)

ERISA, sponsored by the Party conforms (and at all times during the relevant statute of limitations period has conformed) in all material respects to, and its operation and administration are (and at all times during the relevant statute of limitations period have been) in compliance in all material respects with, all applicable requirements of ERISA, including without limitation funding requirements. Each such Plan that is required to be qualified under the Code meets all such qualification requirements in all material respects.

(b) *Absence of Claims.* There are no actions, suits, claims, proceedings or investigations pending (other than routine claims for benefits) or, to the knowledge of the Party, threatened against any such Plan.

(c) *COBRA.* Each Welfare Benefit Plan covering any present or former employee of the Party or any of its Subsidiaries which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”) has complied in all material respects with all requirements for continuation coverage under group health benefit plans under COBRA, and there are no claims against the Party or any of its Subsidiaries for a failure or alleged failure to comply with the COBRA continuation requirements.

7.1.11 Compliance With Laws. Except as disclosed on the attached Schedule 7.1.11, the Party and its Subsidiaries are in compliance in all material respects with all laws, ordinances, legal requirements, rules, regulations and orders applicable to the Party and its Subsidiaries and their respective operations, properties, assets and services, including without limitation statutes and regulations applicable to Medicare, Medicaid and any other federal health care programs, where the failure to comply would have a material adverse effect on the business or financial condition, assets or operations of the Party and its Subsidiaries, taken as a whole.

7.1.12 Legal Proceedings; Claims. Except as set forth on the attached Schedule 7.1.12, neither the Party nor its Subsidiaries has been served with any summons, complaint or written notice to arbitrate, and no suit, litigation, claim (equitable or legal), administrative arbitration, investigation or other proceeding is pending or threatened against the Party or its Subsidiaries that would materially and adversely affect the Party or its Subsidiaries or its or their business by or before any court, governmental department, commission, board, bureau, agency, mediator, arbitrator or other person or instrumentality. None of the actions, claims, suits, proceedings and matters set forth in Schedule 7.1.12 materially and adversely affects the financial condition of the Party or its Subsidiaries or materially adversely affects the ability of the Party to perform its obligations under this Agreement.

7.1.13 No Cash Consideration/Merger. No Party has transferred to or exchanged with any other Party cash or other assets, or assumed the debt or other liabilities of any Party, or exchanged

FINAL FOR SIGNATURE

any other similar financial consideration to effect the Combination. The Combination does not contemplate the merger or consolidation of any existing legal entities; the sale, purchase or lease of part or all of the Party; or the transfer of all or substantially all of the assets of the Party.

7.1.14 Absence Of Certain Changes Or Events. Except as disclosed on Schedule 7.1.14 and to the best of the Party's knowledge, no facts or circumstances exist, or are likely to occur, which might reasonably be expected to have a material adverse effect on the Party or its operations or its ability to participate in the System as contemplated by this Agreement.

7.1.15 Opportunity For Due Diligence. The Party has had full opportunity to conduct due diligence regarding legal, financial, operational, regulatory, clinical and other matters pertaining to the other Parties specifically and the Combination generally, and the completion by the Party of the actions described in Article 6 above will be conclusive evidence that the results of such diligence are satisfactory to the Party.

7.2 MUTUAL INDEMNIFICATION.

For a period of two (2) years from the Combination Date, each Party agrees that it will defend, indemnify, and hold harmless the other Parties, and the other Parties' trustees, directors, officers, employees, and agents from and against any and all claims, actions, suits, proceedings, liabilities, losses, demands, judgments, and expenses (including court costs and reasonable attorneys' fees) arising out of the falsity or material inaccuracy of any of the representations or warranties set forth in Sections 7.1.1 through 7.1.14 above. No Party will be entitled to receive indemnification, however, for special, punitive or consequential damages.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 8. PRE-CLOSING COVENANTS OF THE PARTIES

Between the Agreement Date and the Closing, the Parties agree to conduct themselves in the following manner:

8.1 ACCESS AND INFORMATION

Subject to Section 8.6 below, each Party will provide the others with access during normal business hours to the offices, properties, facilities, and books and records of the Party and the officers, directors, employees, accountants, counsel, consultants, advisors, agents and other representatives of the Party to discuss the business, financial condition or prospects of the Provider. When accessing the property or records of the Party granting access, each other Party will conduct itself in accordance with applicable laws and regulations and will ensure that it does not disrupt the operations of the Party granting access.

8.2 GOOD FAITH EFFORTS; COOPERATION

8.2.1 Satisfaction of Conditions. The Parties will use reasonable efforts and act in good faith to obtain all necessary regulatory approvals and all necessary corporate and other approvals, to seek satisfaction of the other conditions precedent described in Section 6.3 above, and to take such other actions as may be necessary or appropriate to effectuate the Combination as contemplated by this Agreement.

8.2.2 Cooperation. The Parties will cooperate with each other and provide such assistance as may be reasonably necessary in connection with the preparation of all filings with state and federal regulatory agencies, other actions required for the satisfaction of the pre-conditions described in Section 6.3 above, and/or the implementation of the Combination. The Parties will meet within ten (10) business days of the Agreement Date to develop a mutually acceptable timetable and sequencing plan to complete all required regulatory filings within a reasonable period after the Agreement Date.

8.3 HART-SCOTT-RODINO ACT FILINGS AND REGULATORY APPROVALS

8.3.1 Pursuit of Regulatory Approvals. D-HH and GOH, on behalf of CMC, the CMCHS Subsidiaries, MCH and HH, will prepare and file with the Federal Trade Commission Premerger Notifications pursuant to the Hart-Scott-Rodino Amendments to the Antitrust Improvement Act (the “HSR Notices”), and will provide copies of the HSR Notices to the Office of the New Hampshire Attorney General, Antitrust Division. Subject to Section 10.1.1(c) below, the Parties agree to use their reasonable best efforts to obtain all required regulatory approvals, including responding to all information requests in connection with the HSR Notices, defending any litigation or administrative proceedings initiated by any regulatory agency challenging the Combination, and pursuing a court action to appeal any adverse decision of a regulatory body.

FINAL FOR SIGNATURE

Notwithstanding anything to the contrary in this Agreement, no Party may be required, in connection with any demand by any regulatory agency or otherwise, to agree or commit to (A) divest, hold separate, offer for sale, abandon, limit its operations of, or take similar action with respect to any assets (tangible or intangible) or any business interest of any of them, or (B) any restrictions or actions that after the Combination Date would limit the ability of the Parties to operate as of the Combination Date.

8.3.2 Conduct of the Parties with Respect to Regulatory Agencies. No Party will meet or engage in material conversation with any regulatory agency or representative of any regulatory agency in connection with obtaining any consent, authorization, order and approval unless it consults with the other Parties in advance to the extent not precluded by applicable law or regulation. The Parties will not take or cause to be taken any action of which a Party is aware or reasonably should be aware would have the effect of delaying, impairing or impeding the receipt of any consent, authorization, order or approval of any governmental authorities referred to in this Section 8.3 or in Section 6.3.3 above.

8.3.3 Costs. The costs of pursuing and obtaining regulatory appeals, including without limitation any litigation costs, will be shared equally by D-HH and GOH; provided that each Party will be responsible for the costs of its attorneys and consultants who are not jointly engaged by two or more Parties.

8.4 CONDUCT OF BUSINESS IN THE ORDINARY COURSE .

Each of the Parties agrees to operate in the usual and ordinary course of business, consistent with its past practices. Each Party also agrees to take all reasonable efforts to implement any Improvement Initiatives and to report to D-HH and GOH quarterly on the progress of the implementation and its results.

8.5 INTEGRATION PLANNING

The Parties will continue their ongoing efforts to develop and evaluate business plans and timelines for the System integration efforts described in Article 5 above, which efforts will continue after the Combination Date and will be subject to any limitations imposed by applicable law before the Combination Date.

8.6 CONFIDENTIALITY AND JOINT DEFENSE AGREEMENT

The Parties acknowledge and agree that they remain subject to: (i) a certain Mutual Confidentiality and Nondisclosure Agreement entered into by D-HH and CMC on December 5, 2017, a certain Mutual Confidentiality and Nondisclosure Agreement entered into by D-HH and GOH on December 17, 2018, and a certain Mutual Confidentiality and Non-Disclosure Agreement dated March 18, 2019 and effective January 23, 2019 (collectively the “Confidentiality

Agreements”); and (ii) a Joint Defense and Common Interest Agreement entered into by the Parties on March 18, 2019 and effective January 23, 2019 (the “Joint Defense Agreement”). The Parties further agree that the Confidentiality Agreements and Joint Defense Agreement applies to any Confidential Information disclosed to or by a Party in connection with this Agreement or the Combination.

8.7 EXCLUSIVITY

Without the prior written approval of the other Party in its discretion, neither D-HH nor GOH, nor any of the other Parties which are D-HH Members or GOH Members, nor any of their respective members, trustees, directors, officers, employees or agents, will solicit or entertain offers, or enter into discussions, concerning a possible merger, consolidation, acquisition, change of control or other corporate affiliation, sale of substantially all assets or joint venture agreement or management agreement with any other hospital or hospital system.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 9. DISPUTE RESOLUTION

9.1 INFORMAL DISPUTE RESOLUTION

9.1.1 *Pre-Combination Disputes.* Prior to the Closing Date, each Party agrees to inform the others promptly of any concerns or of any circumstances which may impair the Party's performance of its obligations under this Agreement. The Parties agree to discuss and seek to resolve any such concerns promptly and in good faith.

9.1.2 *Post-Affiliation Disputes.* After the Closing Date, the Parties will use their best efforts to operate within the System in accordance with the applicable organizational documents and in furtherance of the mutual vision and purpose described in Article 1 above. Regular communications will be encouraged, and any concerns or disputes will be addressed promptly, in good faith, and through the application of the guiding principles described in Article 2 above.

9.2 NON-BINDING MEDIATION

Any conflicts which cannot be resolved by the Parties through good faith discussion within thirty (30) days then must be referred to non-binding mediation. Within ten (10) days following the expiration of the 30-day negotiation period, the Parties to the conflict will mutually agree on a mediator who is experienced in mediation and health care matters similar to those in contention. The Parties will share equally in the cost of the mediation. The mediation will be held promptly after the mediator is identified and will be conducted in accordance with the procedures prescribed by him or her. This step is non-binding, but the Parties to the dispute will be obligated to exert their best efforts to reach common ground and resolve their differences.

9.3 BINDING ARBITRATION

If the mediation fails to achieve a mutually agreeable resolution of the dispute, then the dispute will be submitted to binding arbitration through the American Health Lawyers Association ("AHLA") and subject to the AHLA rules of procedure. Three arbitrators will be selected from a panel provided by the arbitration service. The costs will be divided in accordance with the applicable AHLA rules. The Parties will present their points of view to the arbitration panel and will be bound by its decision. There will be no further appeal of that decision except for very unusual and rare occurrences, such as allegations of fraud.

ARTICLE 10. TERMINATION

10.1 TERMINATION EVENT(S).

Each of the Parties has expended considerable resources to effect this Combination and each is making a long-term commitment to the System. Therefore, the Parties' relationship under this Agreement and related documents will continue in perpetuity unless a Party elects in its discretion to terminate this Agreement upon the occurrence of one or more of the following events (each a "Termination Event"):

10.1.1 Termination Prior to Combination Date. Either D-HH or GOH, as applicable, will have the right in its discretion to terminate the Agreement, and either HH or MCH will have the right in its discretion to terminate its participation in this Agreement and the proposed Combination, upon the occurrence before the Combination Date of any of the following Termination Events:

(a) *Failure to Satisfy Conditions.* One or more of the Parties is unable to satisfy the conditions to Closing described in Sections 6.3.1 through 6.3.6 above despite its (their) good faith efforts required under Sections 8.2 and 8.3 above.

(b) *Mutual Consent of Parties' Boards for Failure To Achieve Combination Goals.* The written consent of the Parties upon a determination by their respective Boards of Trustees that the mutual vision and purpose of the Combination, as described in Article 1 above, is unlikely to be furthered or achieved.

(c) *Material Adverse Event.* The occurrence of a Material Adverse Event under Section 6.3.6 which remains uncured (i) at the time all other conditions in Section 6.3 above are met or, (ii) if the conditions in Section 6.3 (other than 6.3.6) have not yet been met, for a period of ninety (90) days after receipt of written notice of such Material Adverse Event from any Party.

10.1.2 Termination At Any Time. Any affected Party may terminate, in its discretion, its obligations under the Agreement prior to the Combination Date or under any surviving provisions of the Agreement after the Combination Date upon the occurrence of any of the following at any time while any provisions of this Agreement remain in effect:

(a) *Material and Uncured Breach.* A material breach of this Agreement or any surviving provisions which has a material adverse effect on the affected Party and remains uncured or for which a cure has not been commenced within a period of ninety (90) days after the breaching Party's receipt of written notice of such default from an affected Party.

(b) *Material Change in Law or Regulation.* A subsequent and material change in applicable laws or regulations which prohibits, or substantially and materially impairs, the Parties' ability to operate the System as contemplated by this Agreement.

10.2 CONSEQUENCES OF TERMINATION

If the Agreement is terminated, then the Agreement will become void and have no further effect except for those provisions which expressly survive the termination of this Agreement. No Party will have any further obligations or liabilities under the Agreement following its termination; provided, however, that no Party will be relieved of liability for any damages arising out of its breach of the Agreement.

[The Remainder of this Page Intentionally is Left Blank]

ARTICLE 11. MISCELLANEOUS PROVISIONS

11.1 NO ASSIGNMENT.

The identity of each of the Parties is an essential element of the proposed Combination. Therefore, no Party may assign its rights or duties under this Agreement in whole or in part without the prior written consent of all of the other Parties.

11.2 GOVERNING LAW.

This Agreement and the obligations of the Parties under it will be governed by and interpreted under New Hampshire law.

11.3 APPLICATION OF LEGAL PRINCIPLES

11.3.1 Waiver. A waiver of any right under this Agreement will be effective only if it is written and signed by all of the Parties except the Party seeking the waiver. No waiver of any right will be deemed to be a waiver of any future right under this Agreement.

11.3.2 Integration. This Agreement represents the entire understanding and agreement among the Parties and supersedes all prior negotiations, representations and agreements, both written and oral, made by and among them, excluding the Confidentiality Agreements and Joint Defense Agreement, which remain in effect. This Agreement may be amended or modified only by a written document signed by all of the Parties.

11.3.3 No Third Party Beneficiaries. No person, organization or other party not a signatory to this Agreement will be regarded as a beneficiary of its terms or will have the standing or right to enforce any of the provisions of this Agreement.

11.3.4 Severability. If any particular provision of this Agreement is determined to be invalid or illegal, it will not affect the other provisions of this Agreement; instead, the Agreement will be construed as if the invalid or unenforceable provisions were limited to the fullest extent permitted by law and consistent with the spirit and intent of this Agreement.

11.3.5 Survival.

(a) The following provisions of this Agreement will survive for so long as any of CMC, the CMCHS Subsidiaries, HH or MCH remain in the System: Article 1; Article 2; Section 3.3.4; Section 3.4.3; Section 3.4.4; Sections 4.2.2(d) and (e); and Section 11.7;

(b) The following provisions of this Agreement will survive for so long as any of CMC, the CMCHS Subsidiaries, HH or MCH remain in the System unless a modification or termination is agreed upon in writing by all of the affected Parties: Section 3.3.3; Section 3.4.1(b); Section 3.4.2(b); Section 3.4.5; Section 5.3; Section 5.5; Section 10.1.2; Section 10.2; and Schedule 3.3.3;

(c) The following provisions of this Agreement will survive for so long as any of CMC, the CMCHS Subsidiaries, HH or MCH remain in the System unless modified or terminated by a vote of the System Board: Section 5.1; Section 5.2; Section 5.4; Section 5.6; and Schedule 5.5.2(a); and

(d) The following provisions of this Agreement will survive for a period of six (6) years following the Combination Date: Section 3.1; Sections 3.3.2(a), (b) and (c); Section 3.3.5; Section 4.1; Section 4.2.1; Section 4.2.2 (a), (b) and (c); Section 6.3.6; Section 7.1.6; Section 7.1.8; Section 7.1.10(a); Section 7.1.11; Section 7.2 (without altering the 2-year indemnification limit); Article 9; Section 11.1; Section 11.2; Section 11.3; Section 11.4; and Section 11.5.

11.3.6 Availability of Rights and Remedies. Nothing in this Agreement is intended to limit the nature or extent of legal or equitable rights and remedies available to the Parties under New Hampshire law. The Parties agree that non-performance of this Agreement cannot be remedied by monetary damages, and that the equitable remedy of specific performance should be available to them as an appropriate remedy.

11.4 JOINT COMMUNICATIONS; PUBLIC STATEMENTS.

Each Party agrees not to make any public announcements or communications regarding the Combination unless the content has been shared in advance with the other Parties and is mutually acceptable. The Parties will develop and implement a joint communication plan and process for publicly announcing various milestones in the Combination process, communicating the terms and timing of the Combination to their respective medical staff, employees, donors and other stakeholders, and responding to any inquiries regarding the Combination. Any such communications regarding the Combination must be approved by all of the Parties prior to being released to ensure consistency and accuracy.

FINAL FOR SIGNATURE

11.5 NOTICES.

Any notice required to be given under this Agreement will be effective when it is deposited in first-class mail, overnight courier or certified mail, return receipt requested, or sent by 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 and 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 CMCHS, CMC and/or a CMCHS Subsidiary:

CMC Healthcare System
Catholic Medical Center
100 McGregor Street
Manchester, New Hampshire 03102
Attn: Jason E. Cole, Esq., Vice President and General Counsel
jcole@devinemillimet.com

If to MCH:

Monadnock Community Hospital
452 Old Street Road
Peterborough, New Hampshire 03458
Attn: Cynthia McGuire, President and CEO
Cynthia.McGuire@mchmail.org

With a simultaneous copy to:

Orr & Reno, P.A.
45 S. Main Street
Concord, New Hampshire 03301
Attn: John A. Malmberg, Esq.

FINAL FOR SIGNATURE

jmalmborg@orr-reno.com

If to HH:

Huggins Hospital
240 South Main Street
Wolfeboro, New Hampshire 03894
Attn: Jeremy S. Roberge, President and CEO
jroberge@HHhospital.org

With a simultaneous copy to:

Orr & Reno, P.A.
45 S. Main Street
Concord, New Hampshire 03301
Attn: John A. Malmberg, Esq.
jmalmborg@orr-reno.com

11.6 EXECUTION, DELIVERY AND COUNTERPARTS.

This Agreement and any amendments may be executed and delivered by facsimile or other electronic transmission, in any number of counterparts, each of which will be deemed to be an original and all of which will constitute one agreement that is binding upon each of the Parties. CMCHS and CMC are executing this Agreement subject to the provisions of Section 11.7 below.

11.7 INTERPRETATION OF STATEMENTS ABOUT CLOSING ACTIONS AND DELIVERABLES.

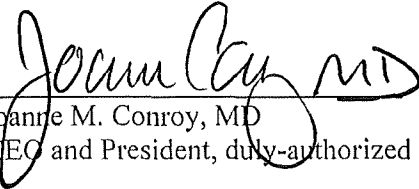
The requirements established by this Agreement for the delivery of certain documentation or the taking of certain actions on or prior to the Combination Date are intended to describe and prescribe the timing, occurrence and sequence of the steps required to implement the Combination. This Agreement purposefully excludes CMCHS, CMC and the CMCHS Subsidiaries from the reconstitution of D-HH into D-HH GO, its substitution as the sole member of HH and MCH, the powers reserved to the System Board by HH and MCH and other related actions. The Parties acknowledge that the execution of this Agreement by CMCHS, CMC and the CMCHS Subsidiaries may not be interpreted (a) to require CMCHS, CMC or any of the CMCHS Subsidiaries to participate in or to enforce any provisions of this Agreement regarding the implementation of the Combination that are inconsistent with Catholic moral teaching, the ERDs or Canon Law, or (b) as the agreement with or support of such provisions by CMCHS, CMC or any of the CMCHS Subsidiaries. The existence of such provisions, however, will not impair or excuse the performance of the express obligations of CMCHS, CMC and the CMCHS Subsidiaries under the terms of this Agreement.

FINAL FOR SIGNATURE

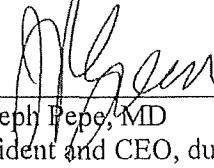
Execution by the Parties:

Each of the Parties indicates its understanding and acceptance of the terms described above as of the Agreement Date by signing below through its duly-authorized representative.

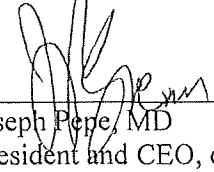
DARTMOUTH-HITCHCOCK HEALTH

By: 
Name: Joanne M. Conroy, MD
Title: CEO and President, duly-authorized

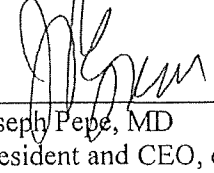
GRANITEONE HEALTH

By: 
Name: Joseph Pepe, MD
Title: President and CEO, duly-authorized

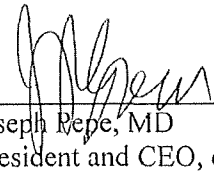
CMC HEALTHCARE SYSTEM

By: 
Name: Joseph Pepe, MD
Title: President and CEO, duly-authorized

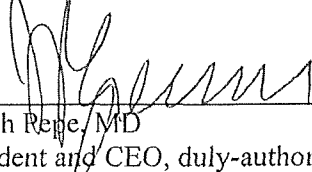
CATHOLIC MEDICAL CENTER

By: 
Name: Joseph Pepe, MD
Title: President and CEO, duly-authorized

ALLIANCE AMBULATORY SERVICES

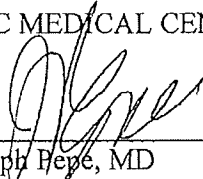
By: 
Name: Joseph Pepe, MD
Title: President and CEO, duly-authorized

ALLIANCE HEALTH SERVICES

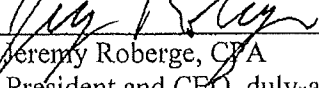
By: 
Name: Joseph Pepe, MD
Title: President and CEO, duly-authorized

FINAL FOR SIGNATURE

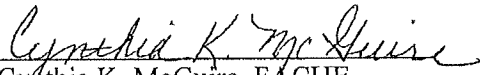
CATHOLIC MEDICAL CENTER PHYSICIAN PRACTICE ASSOCIATES

By: 
Name: Joseph Pepe, MD
Title: President and CEO, duly-authorized

HUGGINS HOSPITAL

By: 
Name: Jeremy Roberge, CPA
Title: President and CEO, duly-authorized

MONADNOCK COMMUNITY HOSPITAL

By: 
Name: Cynthia K. McGuire, FACHE
Title: President and CEO, duly-authorized

INDEX OF SCHEDULES AND APPENDICES

[NOTE: Schedules 5.5.2(a) through 7.1.14 are Confidential and will not be posted publicly. The Appendices will be posted separately when completed.]

Schedules:

- 3.3.2(c) -- Terms of D-HH Nominees and GOH Nominees to System Board
- 3.3.3 -- Trustee Criteria for System Board Appointees/Nominees and Member Board Nominees
- 5.5.2(a) -- Dartmouth-Hitchcock Health GraniteOne (D-HH GO) Financial Management Principles
- 7.1.5 -- Required Consents, Approvals, Licenses or Permits
- 7.1.7 -- Undisclosed Liabilities
- 7.10 -- Noncompliance of Welfare Benefit Plan/Pension Benefit Plan with ERISA
- 7.1.11 -- Noncompliance with Laws, Regulations, Rules, Orders and Legal Requirements
- 7.1.12 -- Material Legal Proceedings or Claims
- 7.1.14 -- Material Adverse Circumstances

Appendices:

- 6.2.1(a) -- Amended D-HH Articles of Agreement
- 6.2.1(b) -- Amended D-HH Bylaws
- 6.2.1(c) -- Vote of D-HH Board of Trustees
- 6.2.3(a)-1 -- Amended HH Articles of Constitution
- 6.2.3(a)-2 -- Amended MCH Articles of Agreement
- 6.2.3(b)-1 -- Amended HH Bylaws
- 6.2.3(b)-2 -- Amended MCH Bylaws
- 6.2.4(a)-1 -- Amended CMC Articles of Agreement
- 6.2.4(a)-2 -- Amended AAS Articles of Agreement
- 6.2.4(a)-3 -- Amended AHS Articles of Agreement
- 6.2.4(a)-4 -- Amended CMCPA Articles of Agreement
- 6.2.4(b)-1 -- Amended CMC Bylaws
- 6.2.4(b)-2 -- Amended AAS Bylaws
- 6.2.4(b)-3 -- Amended AHS Bylaws
- 6.2.4(b)-4 -- Amended CMCPA Bylaws

SCHEDULE 3.3.2(c)
Terms of D-HH Nominees and GOH Nominees to System Board

D-HH Designees	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
#1	Original Term			Auto Renew			Renew or Replace		
#2	Original Term			Auto Renew			Renew or Replace		
#3	Original Term		Auto Renew			Renew or Replace			
#4	Original Term		Auto Renew			Renew or Replace			
#5	Original Term	Auto Renew			Renew or Replace				
#6	Original Term	Auto Renew			Renew or Replace				
#7	Original Term	Auto Renew			Renew or Replace				
GOH Designees									
#1	Original Term			Auto Renew			Renew or Replace		
#2	Original Term			Auto Renew			Renew or Replace		
#3	Original Term		Auto Renew			Renew or Replace			
#4	Original Term		Auto Renew			Renew or Replace			
#5	Original Term	Auto Renew			Renew or Replace				
EX OFFICIO									
System Parent CEO									
Region 1 President									
Region 2 President									
TOTAL	15	15	15	15	15	15	15	15	15

COLOR CODE:

Green	D-HH Designee and Auto Renew Term; D-HH Ex Officio	Orange	First Renewal Election by Reconstituted Board or Officer Appointment
Blue	GOH Designee and Auto Renew Term; GOH Ex Officio		

SCHEDULE 3.3.3

Trustee Criteria for System Board Appointees/Nominees and Member Board Nominees

1. Employment or personal experience, and/or professional status, that reflect a record of accomplishment or reveals expertise that will help the Member Board fulfill its duties.
2. Possesses a long-term, positive reputation for high ethical standards.
3. Demonstrates an understanding of the Member's mission including, in the case of a nominee to the CMC Board of Trustees, the Catholic moral teachings, the ERDs and Canon Law, as well as the mission, vision and principles of the System.¹
4. Demonstrates a strategic perspective, an awareness of the dynamics of the complex and ever-changing healthcare environment and the need to anticipate and capitalize on opportunities that enhance the vision and principles of the Member as well as the System.
5. Service and experience with other non-profit or healthcare boards with a record of preparation, attendance, participation, interest and initiative.
6. Willing and enthusiastic promoter of the Member as well as the System.
7. Connections with public and influential community organizations and stakeholders important to Member.
8. Willingness and availability to contribute time and energy to the Members Board and its committees.

¹ Pursuant to Article III, Section 3(b) of the Amended and Restated Bylaws of CMC, Trustees shall attest on an annual basis, in their capacity as a Trustee of CMC, that they will comply with and respect the ERDs and the moral teachings of the Catholic Church and that their activities outside of CMC shall not mislead or confuse the Christian faithful about the moral teachings of the Catholic Church.