NEW HAMPSHIRE
Department of Justice
Office of the Attorney General

Report of the Director of Charitable Trusts Regarding the Proposed Acquisition Transaction Between CMC Healthcare System and Dartmouth – Hitchcock Health

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I. INTRODUCTION

The Office of the Attorney General, through the Director of Charitable Trusts (the "Attorney General"), pursuant to New Hampshire RSA 7:19-b (the "Acquisition Act")[1] and under its common law and statutory duties, has reviewed the proposed acquisition transaction[2] between Dartmouth-Hitchcock Health ("DHH") and CMC Healthcare System ("CMCHS")[3] (the proposed acquisition transaction is referred to in this Report as the "Transaction"). At its essence, the Transaction reorganizes the corporate structures of CMCHS, and its affiliates, Catholic Medical Center ("CMC") and Alliance Health Services ("AHS"),[4] resulting in these organizations ceding control to DHH and becoming a part of a regional integrated health care delivery system overseen and controlled by DHH.[5]

The Attorney General's review has been performed in accordance with the Acquisition Act and the Attorney General's common law and statutory rights, duties, and powers in

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[1] Specifically, the Attorney General is directed to determine, within 120 days from the date of Parties filing if the Parties have complied with the minimum requirements set forth in RSA 7:19-b II or object to the Transaction on specified grounds. The requirements set forth in RSA 7:19-b II are as follows:

a) The proposed transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law;

b) Due diligence has been exercised in selecting the acquirer, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed transaction, and in determining that the transaction is in the best interest of the health care charitable trust and the community which it serves;

c) Any conflict of interest, or any pecuniary benefit transaction as defined in this chapter, has been disclosed and has not affected the decision to engage in the transaction;

d) The proceeds to be received on account of the transaction constitute fair value therefor;

e) The assets of the health care charitable trust and any proceeds to be received on account of the transaction shall continue to be devoted to charitable purposes consistent with the charitable objects of the health care charitable trust and the needs of the community which it serves;

f) If the acquirer is other than another New Hampshire health care charitable trust, control of the proceeds shall be independent of the acquirer; and

g) Reasonable public notice of the proposed transaction and its terms has been provided to the community served by the health care charitable trust, along with the reasonable and timely opportunity for such community, through public hearing or other similar methods, to inform the deliberations of the governing body of the health care charitable trust regarding the proposed transaction.

[2] "Acquisition transaction" is defined in RSA 7:19-b, I(a) as "transfer of control, direct or indirect, of a health care charitable trust, or of 25 percent or more of the assets thereof, including, but not limited to, purchases, mergers, leases, gifts, consolidations, exchanges, joint ventures, or other transactions involving transfer of control or of 25 percent or more of assets. However, changes in membership of the governing body of a health care charitable trust occurring through regular election or filling of vacancies in accordance with the bylaws thereof do not of themselves constitute acquisition transactions within the meaning of this section." The Parties refer to the Transaction as an "affiliation" in their documents. The Attorney General finds, as a matter of law, that the Transaction is an acquisition transaction as defined by RSA 7:19-b, I(a).

[3] DHH and CMCHS are sometimes referred to in this Report collectively as the "Parties."

[4] CMCHS, CMC, AHS and their affiliates are sometimes referred to in this Report collectively as the "CMC Charities."

[5] The resulting organizational chart and the current organizational charts of DHH and CMCHS are attached as Exhibits 1, 2, and 3.

connection with the supervision, administration and enforcement of charitable trusts pursuant to RSA 7:19 to 7:32-l

Based on the review of the Transaction completed by the Attorney General, the Attorney General objects under RSA 7:19-b, II(a) to the Transaction on the grounds that the Transaction is not permitted by applicable law. The Transaction will result in DHH obtaining control over core functions of the CMC Charities, which until this point have operated as an independent Catholic hospital. The Attorney General concludes that the Transaction will result in a profound change in the governance structure of the CMC Charities and diminish the fiduciary duties of the Boards of Directors of the CMC Charities which will inhibit the ability of the CMC Charities to carry out their charitable missions. The Attorney General also concludes that Probate Court approval of this transfer of control would be necessary in order to be permitted under New Hampshire law.

The Attorney General also objects to the Transaction in accordance with RSA 7:19-b, II(e). Based on the information provided by the Parties, the Attorney General concludes that the Parties have not provided adequate information upon which the Attorney General can determine whether it exercised due diligence in determining the effect of the Transaction on the cost of delivering health care. For that reason, the Attorney General objects.

Under RSA 7:19-b, II(d), the Attorney General has concluded that while the consideration exchanged in connection with the Transaction constitutes fair value, the Attorney General objects to the Transaction as there are insufficient safeguards in place to ensure that the calculation of the Post-Affiliation Surplus is not subject to manipulation or abuse by the Parties.

The Attorney General also reviewed the employment agreements for certain executives of DHH and CMC. RSA 7:19-b, II(c) to determine whether the Transaction would result in a pecuniary benefit. The compensation of the President and CEO of CMC, Alyson Pitman-Giles, when compared with the total compensation of other hospital presidents in the region, reveals that Ms. Pitman-Giles' compensation is significantly greater than her peers based on total compensation and as a percentage of operating revenue. Because the review under this Report is limited to the statutory factors listed in RSA 7:19-b, and the Transaction does not directly affect her salary, the Attorney General cannot conclude her salary is a basis for objecting to the Transaction. Her salary, however, will be separately reviewed under the statutory and common law authority of the Attorney General, and a separate determination will be made regarding the compensation paid to executives at CMC, as well as the executives of other hospitals in New Hampshire.

II. SUMMARY OF TRANSACTION

The Attorney General has engaged in an extensive review of the Transaction. This review included meeting with the senior executives of the Parties, meeting with those having an interest in the Transaction, meeting with interested citizens, reviewing the documents filed by the Parties, reviewing information provided by the Parties in response to detailed information requests issued by the Attorney General, and attending public hearings conducted by the Parties.

The Attorney General also retained legal counsel and an accountant to assist him with the review of the Transaction.

The Transaction is complex. First, the Transaction proposes the creation of a regional integrated health care delivery system comprised of: (1) an academic medical center and hospital based in Lebanon, New Hampshire, (2) an acute-care hospital based in Manchester, New Hampshire, and (3) a multi-specialty physician practice group located in Manchester, New Hampshire. It is anticipated that additional health care organizations will subsequently be added to the regional integrated health care delivery system created by this Transaction. In order to create the regional system, the governance structures of the organizations involved will be amended to ensure that DHH has control of the entities making up the regional system.

Second, the Transaction proposes an affiliation between secular and religious health care charitable trusts with the secular health care charitable trusts obtaining control of the religious health care charitable trusts. The Transaction has been structured in a manner that attempts to establish certain safeguards to preserve and protect the charitable missions of the health care charitable trusts involved, in particular the Roman Catholic mission of the CMC Charities. It should be noted that the Bishop of the Roman Catholic Diocese of Manchester (the "Bishop of Manchester") the authority to approve certain acts proposed by the Board of Trustees of CMCHS. The Bishop of Manchester has only conditionally approved the Transaction.

Third, the Transaction provides that most of the Dartmouth-Hitchcock Clinic Manchester ("DHC-M") physician practice group services will be combined with those services offered by AHS at CMC. This combination of services will be governed by an Amended and Restated Professional Services Agreement between DHC-M and AHS (the "PSA"). To comply with the Parties' stated goal of preserving the Roman Catholic aspects of the mission of the CMC Charities, as well as complying with the Ethical and Religious Directives for Catholic Health Care Services (the "ERDs"), the Parties have created three separate and distinct categories of medical procedures:

1. those medical procedures that are allowable at CMC or the DHC-M facilities leased by CMC (the DHC-M Facilities");

2. those medical procedures that may only be performed at DHC-M Facilities that are <u>not</u> leased by CMC and <u>not</u> under the PSA (e.g., direct sterilization and contraception related procedures); and

3. those medical procedures that may <u>not</u> be performed at CMC or at DHC-M Facilities (i.e., direct termination of pregnancy and in vitro fertilization).[6]

The Parties acknowledge that this three category approach has no precedent under the ERDs.

[6] The Parties have represented to the Attorney General that DHC-M does not currently provide services relating to the direct termination of pregnancy.

III. THE PARTIES

A. CMC Healthcare System

CMCHS is a New Hampshire voluntary, non-profit corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire 03102. It is the coordinating organization for, and the sole member of, CMC and AHS. CMCHS is a public juridic person of diocesan right under the Code of Canon Law of the Roman Catholic Church, subject to powers reserved to the Bishop of Manchester.

CMC is a New Hampshire voluntary, non-profit corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire. CMC operates an acute care hospital in Manchester, New Hampshire. CMC had its origins in 1892, when the Sisters of Mercy opened Sacred Heart Hospital. In 1894, the Sisters of Charity of Saint Hyacinthe opened Notre Dame Hospital. In 1974, Sacred Heart Hospital and Notre Dame Hospital merged to form CMC. Today, CMC is a 330-bed full-service hospital. CMC offers full medical-surgical care with more than 25 subspecialties. It is the home of the Poisson Dental Facility, a Healthcare for the Homeless Project, the Parish Nurse Program, and the Westside Neighborhood Health Center.[7]

AHS is a New Hampshire voluntary, non-profit corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire. AHS is a provider of health care services primarily through a professional services agreement and a facilities lease with Dartmouth-Hitchcock Clinic.

1. Dartmouth-Hitchcock Health

DHH is a New Hampshire voluntary, non-profit corporation with a principal place of business at One Medical Center Drive, Lebanon, New Hampshire. DHH was created on May 1, 2009 to be the coordinating organization for, and sole member of, Mary Hitchcock Memorial Hospital ("MHMH") and Dartmouth-Hitchcock Clinic ("DHC"). DHH has applied to the Internal Revenue Service (the "IRS") for recognition of its exemption from federal income tax as a charitable organization described under Section 501(c)(3) of the Internal Revenue Code.

MHMH is a New Hampshire voluntary, non-profit corporation with a principal place of business at One Medical Center Drive, Lebanon, New Hampshire. MHMH operates an academic medical center located in Lebanon, New Hampshire.

DHC is a New Hampshire voluntary, non-profit corporation with a principal place of business at One Medical Center Drive, Lebanon, New Hampshire. DHC is a provider of clinical services.[8] DHC-M was founded in 1984, when six physicians joined forces to create

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[7] Dorothy Bazos *et al*., *Believe in a Healthy Community*, app. at 54 (Greater Manchester Community Needs Assessment 2009).

[8] The DHC health care providers that provide services in Manchester, New Hampshire are referred to as Dartmouth-Hitchcock Clinic-Manchester ("DHC-M").

Manchester's first multi-specialty group practice. In 1998, DHC-M constructed a 120,000 square-foot ambulatory care facility to house its Manchester group practice. Today, DHC-M is a multi-specialty group practice with more than 125 physicians and associate providers. DHC-M's primary and specialty care departments offer a full range of health care services.[9]

IV. PROCEDURAL HISTORY

CMCHS and DHH jointly filed a notice pursuant to RSA 7:19-b III with the New Hampshire Director of Charitable Trusts on July 22, 2009 (the "July Notice"). The July Notice included the Dartmouth-Hitchcock Health – CMC Healthcare System Affiliation Agreement dated July 22, 2009 (the "Initial Affiliation Agreement"). Subsequent to the filing of the July Notice, CMCHS and DHH solicited public comment concerning the Transaction through three public hearings[10] and a website that the Parties established to provide the public with information regarding the Transaction, *www.ahealthiertomorrow.org*. As a result of the public commentary, the Parties amended the terms of the Initial Affiliation Agreement to address certain concerns raised during the public comment period. The First Amendment to Affiliation Agreement was adopted by the CMCHS and DHH Boards in January 2010 (the Initial Affiliation Agreement and the First Amendment to Affiliation Agreement are collectively referred to in this Report as the "Affiliation Agreement"). On January 21, 2010, the Parties filed the Supplemented and Restated Notice to the New Hampshire Director of Charitable Trusts Pursuant to RSA 7:19-b (the "Notice").[11]

V. METHODOLOGY

A. Review

Upon the filing of the July Notice, the Attorney General engaged in an extensive review of the Transaction. This review included an evaluation of: documents submitted to the Attorney General by the Parties with the July Notice, a revised set of documents with the First Amendment to Affiliation Request with the Notice, and responses provided by the Parties to two sets of information requests issued by the Attorney General. The Attorney General attended each of the public forums held by the Parties. Information submitted to the Attorney General by interested citizens was reviewed. The law firm of McLane, Graf, Raulerson & Middleton, Professional Association and the accounting firm of Carew & Wells, PLLC were retained to assist the Attorney General in connection with his review of the material and information obtained in this review.

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[9]Bazos, *supra*, app. at 56.

[10] Public forums were held in Manchester on September 15, 2009 and November 16, 2009, and in Lebanon on October 8, 2009.

[11] The Notice can be found at http://www.ahealthiertomorrow.org/affiliation html and a paper copy is available at the New Hampshire Department of Justice.

B. Interviews

In addition to attending hearings and receiving public comment, meetings regarding the Transaction were held with the following individuals:

- Timothy Soucy, Manchester Public Health Director
- Patrick Long, Manchester Alderman
  Edward George, Executive Director, Manchester Community Health Center

- Dr. James W. Squires, President, Endowment for Health
- John Friberg, Jr., Esq., Senior Vice President, General Counsel, Elliot Hospital
- Attorney Donald Crandlemire, legal counsel to Elliot Hospital
- Attorney James Bianco, legal counsel to Elliot Hospital
- Thomas Colacchio, M.D., President, Dartmouth-Hitchcock Health
- Steve LeBlanc, Chief Operating Officer at Dartmouth-Hitchcock Medical Center
- Steven Paris, M.D., Chief Physician Executive at Dartmouth Hitchcock Manchester
- Kevin Stone, Project Specialist, Dartmouth-Hitchcock Medical Center
- Alyson Pitman-Giles, Chief Executive Officer and President, Catholic Medical Center
- Kevin Kilday, Chief Financial Officer, Catholic Medical Center
- Peter Cataldo, Director of Mission Effectiveness, Catholic Medical Center
- Raymond Bonito, Executive Vice President, Chief Operating Officer, Catholic Medical Center
- Honorable Donald Welch, Former N.H. State Representative
- Honorable Andy Martel
- Barbara Hagan, New Hampshire Right to Life
- Kathleen Souza, New Hampshire Right to Life
- Lucy Hodder, Planned Parenthood of Northern New England
- Claire Ebel (New Hampshire Civil Liberties Union)
- Donald Shumway, -Former Commissioner, N.H. Department of Health and Human Services
- Marilee Nihan, New Hampshire Department of Health and Human Services
- Michael Quinlan
- Richard H. Girard
- Philip C.L. Gray, JCL
- Attorney Arpiar Saunders
- William G. Steele, Jr., CPA.

C. HCR-30

The New Hampshire General Court has passed House Concurrent Resolution 30, urging the Attorney General to bring the Transaction before the New Hampshire Probate Court in the event the Attorney General determines there are any unresolved legal questions within the jurisdiction of the Probate Court that relate to charitable missions and assets of DHH and CMCHS. A copy of the Resolution has been delivered to the Attorney General.

VI. THE PROPOSED TRANSACTION

A. Description Of The Transaction

The Transaction would result in: (i) the integration of the DHC Manchester-based physician practice group services with the services of CMC under its parent company, CMCHS (the "Manchester System"), and (ii) the integration of CMCHS into a regional health care delivery system overseen and controlled by DHH (the "Regional System").

The Parties have each operated in Manchester for many years. Over the past several years, DHC has collaborated with CMC on several patient-focused initiatives, including birthing support, pediatrics, cardiology, family medicine, intensivist services, hospitalist services, echocardiography and oncology. CMC and DHC also worked together in opening the Westside Neighborhood Health Center, which provides primary and pregnancy care to under-insured and uninsured children and adults in the Manchester area. The Parties represented that the programmatic success of DHC and CMC led the leadership of DHC and CMCHS to commence discussions that ultimately resulted in the Parties moving forward with the Transaction.

The general terms of the Transaction are set forth in the Affiliation Agreement. The Affiliation Agreement describes the purposes of the Transaction and the guiding principles of the Parties. The Affiliation Agreement also describes the rights and obligations of the Parties relating to the development and implementation of an integrated health care delivery system in Manchester, and includes the "Manchester System Financial Management: Dartmouth-Hitchcock Health (DHH) Financial Principles," which outlines the financial principles that are to be used to guide the Parties with regard to financial matters (Exhibit 4).

The Transaction includes an Amended and Restated DHC-AHS Professional Services Agreement which describes the employee leasing arrangements between DHC and AHS. The PSA replaces the existing Professional Services Agreement between AHS and DHC, and is intended to be broader and to cover almost all of the physician services offered by DHC-M in the Manchester area.

The Parties have also included a CMCHS Management Agreement with CMC for Management Services of the Chief Executive Officer and Chief Financial Officer, which describes the allocation of time and associated compensation expense of the CEO and CFO between CMCHS and CMC.

Upon the consummation of the Transaction, DHH will be the sole member[12] of CMCHS. In order to facilitate the operation of the Regional System, the Articles of Agreement and Bylaws

[12] In New Hampshire, the rights of members in a voluntary corporation are established and described in the corporation's Articles of Agreement and Bylaws. A voluntary corporation's "bylaws may contain any provisions for the regulation and management of the affairs of the corporation not inconsistent with the laws of the state or the articles of agreement…." (RSA 292:6). As a result, specific rights and roles of members in New Hampshire voluntary corporations can be varied and diverse. Unlike the shareholders of a business corporation, the members of a voluntary corporation are not "owners" of the voluntary corporation and have no rights other than those limited rights set forth in RSA 292 and those included in the Articles of Agreement and bylaws of the voluntary corporation.

of CMCHS will be amended to provide DHH with reserved powers over certain core functions and of CMCHS, many of which will be exercised concurrently with the reserved powers retained by the Bishop of Manchester (described further below).

CMCHS will continue to serve as the sole member of CMC and AHS. In conjunction with the development of the Regional System, certain powers have been reserved by CMC and AHS to CMCHS (Exhibit 5 and Exhibit 6, respectively). Under the regional health care delivery system established as part of the Transaction, CMCHS will coordinate the delivery of integrated health care services in the greater Manchester area. CMCHS will be responsible for creating and implementing a strategic plan for the Manchester System as well as coordinating and facilitating the implementation of the Regional System's strategic plan, financial guidelines and quality goals.

B. Role Of The Bishop

The Articles of Agreement of each of the CMC Charities provide that each of the CMC Charities are to be "operated in accordance with canon law of the Roman Catholic Church promulgated by the Supreme Roman Pontiff and the teachings of the Roman Catholic Church enunciated by the Holy See as well as with the Ethical and Religious Directives for Catholic Health Care Services issued by the United States Conference of Catholic Bishops, as amended from time to time." The CMC Charities' Articles of Agreement also provide that the Roman Catholic Bishop of Manchester shall monitor the implementation of and compliance with the ERDs. The Affiliation Agreement specifically provides that "[t]he Parties understand the need to preserve and respect the Catholic elements of the Manchester System and the charitable purposes for which they were established, as well as the ERDs and the Bishop's reserved powers . . ."

The ERDs are a set of directives and principles developed by the Committee on Doctrine of the United States Conference of Catholic Bishops. The ERDs provide that their purpose is twofold: "First, to reaffirm the ethical standards of behavior in health care that flow from the Church's teachings about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today."[13] The ERDs specifically address and provide guidance with regard to the formation of new partnerships with health care organizations and providers.[14]

Statutorily defined rights and roles of members of voluntary corporations are limited to the following: (1) a requirement that a voluntary corporation's Articles of Agreement contain provisions for (among other things) establishing membership and prioritizing the rights of members in an event of dissolution (RSA 292:2); (2) a reference that a voluntary corporation's Articles of Agreement may grant the corporation's members the right to amend the corporation's bylaws (otherwise this power vests in the corporation's board of directors, subject to repeal or change by a 2/3 majority action of the shareholders or holders of the membership certificates) (RSA 292:6); and 3) that a voluntary corporation may generate funds through its members, including the issuance of membership certificates, receipt of contributions to capital, and assessments of dues and fees on members (RSA 292:9).

[13] Comm. on Doctrine of the U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, preamble at 3-4 (United States Conference of Catholic Bishops, 5th ed. 2009).

[14] Directive 68: Any partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline. Diocesan bishops and other church authorities should be involved as such partnerships are developed, and the diocesan bishop should give the appropriate

The Transaction has been structured to include various safeguards that are intended to preserve the Bishop of Manchester's right to monitor the implementation of and compliance with the ERDs within the Manchester System. For example, CMCHS will remain a public juridic person of diocesan right under the Code of Canon Law of the Roman Catholic Church and it will be subject to certain powers reserved to the Bishop of Manchester. The Affiliation Agreement provides that if the Bishop determines that any of the Manchester System entities has failed to fulfill their obligations to comply with the ERDs, the Bishop will have the right to commence a civil proceeding to enjoin such violation and seek specific performance of the obligations to implement and abide by the ERDs. The Affiliation Agreement provides that if the Bishop is required to pursue enforcement of his rights and remedies under the Affiliation Agreement, then CMCHS will reimburse the Bishop for all of his reasonable costs, expenses and attorneys' fees arising from such enforcement. The inclusion of the Bishop's Health Care Delegate as an *ex-officio* member of the CMCHS Board serves as another safeguard of the Bishop of Manchester's oversight authority. CMC has also created the position of Director of Mission Effectiveness which will include the responsibility for monitoring and ensuring the ongoing compliance with the ERDs. This position will report to CMC's CEO.

The Affiliation Agreement states that the Parties understand the need to preserve and respect the Catholic elements of the Manchester System and the charitable purposes for which they were established. The Affiliation Agreement provides that CMC will remain a Catholic hospital and the care provided to CMC's patients will be administered in a manner that is consistent with the requirements of the ERDs. In order to facilitate compliance with the ERDs, the Parties have identified the procedures performed by the DHC-M and organized the procedures into three categories:[15]

1. those medical procedures that are allowable at CMC or the DHC-M Facilities leased by CMC;

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authorization before they are completed. The diocesan bishop's approval is required for partnerships sponsored by institutions subject to his governing authority; for partnerships sponsored by religious institutes of pontifical right, his *nihil obstat* should be obtained.

Directive 69: If a Catholic health care organization is considering entering into an arrangement with another organization that may be involved in activities judged morally wrong by the Church, participation in such activities must be limited to what is in accord with the moral principles governing cooperation.

Directive 70: Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.

Directive 71: The possibility of scandal must be considered when applying the principles governing cooperation. Cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused. Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the health care facility under Catholic auspices. The diocesan bishop has final responsibility for assessing and addressing issues of scandal, considering not only the circumstances in his local diocese but also the regional and national implications of his decision.

[15] Category 1 procedures are those that have no ethical or religious implications. Lists of Category 2 and Category 3 procedures are attached as Exhibit 7 and Exhibit 8, respectively.

2. those medical procedures that may only be performed at DHC-M Facilities that are not leased by CMC and not under the Amended and Restated Professional Services Agreement (e.g., direct sterilization and contraception related procedures); and

3. those medical procedures that may not be performed at CMC or at DHC-M Facilities (e.g., direct termination of pregnancy and in vitro fertilization).

In order to ensure compliance with the ERDs and the protocols established for the Manchester System, all DHC-M physicians and other appropriate personnel will participate in training regarding the application of the ERDs and will be required to complete continuing education programs regarding the ERDs conducted by CMCHS.

While the Category 3 procedures will not be performed at the DHC-M Facilities, Category 2 procedures may be performed at the DHC-M Facilities (which will be leased to AHS), provided such procedures are not performed under the PSA. The PSA provides that a portion of the facilities leased by DHC to AHS in Manchester and Bedford, and related furniture, fixtures and medical office supplies, will be excluded from the lease arrangement (the "Excluded Portion"). The Excluded Portion will be a percentage determined by dividing the amount currently billed by DHC for all services provided by it at the facilities in Manchester and Bedford by the current amount billed by DHC for only those services provided by it at the facilities in Manchester and Bedford that are not compliant with the ERDs. The Excluded Portion will not be physically segregated from the remainder of the facility. The PSA provides that the Category 2 procedures will be billed by DHC and no revenue from these procedures will be credited to or benefit any of the CMC Charities. In order to ensure that patients are aware of the segregation between services provided by the CMC Charities and DHC, the Parties intend to post a disclaimer statement at the DHC-M Facilities where the DHC physicians provide services, post the disclaimer on its website, and include the disclaimer in patient information packages.

The theoretical separation and segregation relating to the Category 2 procedures are intended to allow DHC to continue to perform the Category 2 procedures at the DHC-M Facilities in a manner that complies with the ERDs. This structure raises questions regarding its operational integrity given that the Category 2 procedures may not be performed at CMC. However, these same procedures may be performed at a facility leased by CMC, in a theoretically (but not physically) segregated area by physicians who at times may be leased to AHS, but for purposes of performing Category 2 procedures the physicians are not considered leased employees of AHS.

Whether the creation and implementation of the three categories of procedures developed by the Parties complies with the Code of Canon Law and the ERDs[16] is a matter of interpretation of Roman Catholic Doctrine. Pursuant to the Establishment and Free Exercise Clauses of the First Amendment of the United States, such interpretation and analysis are beyond the scope of the Attorney General's jurisdiction, because it would impermissibly entangle the Attorney

[16] Comm. on Doctrine of the U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, dir.71 at 37 (United States Conference of Catholic Bishops, 5th ed. 2009).

General "in matters of doctrine, discipline, faith, or internal organization of the Roman Catholic Church."[17] The Establishment Clause prohibits the government from taking action with respect to the establishment of religion, and the Free Exercise Clause prohibits the government from interfering with the free exercise of religion. Therefore, the Attorney General defers to the Bishop of Manchester with regard to whether this proposed structure complies with Canon Law.

C. Regional System

In their response to the Attorney General's information requests, the Parties state that one of the principal reasons for engaging in the Transaction is the desire of the Parties to expand the integrated health care delivery system that has been established by DHH. DHH was formed with the following stated purpose: to

> organize, operate, coordinate and govern a health care delivery system (the "System") in support, promotion and advancement of Mary Hitchcock Memorial Hospital, a New Hampshire voluntary corporation, Dartmouth-Hitchcock Clinic, a New Hampshire voluntary corporation, and such other not-for-profit, voluntary organizations that shall become members of the System . . .

DHH states as its goal "to establish, manage, govern, and fundraise for an integrated health care delivery system that best serves the purposes of preventing, diagnosing, treating and curing human illness within the Northern New England region." DHH's stated objectives are to manage a system that provides health care services to the public in a cost-effective manner; establish and maintain cooperative hospital and provider relationships throughout its system; achieve excellence in clinical innovations, service, quality cost and outcomes, supported by a strong academic program; and integrate research, training, information technology and academic medicine in the provider organizations throughout the system. DHH believes that the development of a regional integrated health care delivery system, which will be enhanced by the addition of the CMC Charities, will enable it to establish an accountable care organization[18] in the greater Manchester area. DHH believes that the development of a regional integrated health care delivery system will allow it to provide the highest quality and most effective health care services in an efficient manner.

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[17] *Berthiaume v. McCormack*, 153 N.H. 239, 245 (2006). *See also Reardon v. Lemoyne*, 122 N.H. 1402, 1048 (1982), citing *Jones v. Wolf*, 443 U.S. 595, 602 (1979); *Presbyterian Church v. Hull Church*, 393 U.S. 440, 449 (1969).

[18] An accountable care organization ("ACO") is a healthcare delivery model in which the ACO is responsible for managing the health of a population as efficiently as possible. The incentive will be to maintain health as opposed to provide treatment. While the structure of this healthcare delivery model is continuing to evolve, it is expected that an ACO will be reimbursed on a global or bundled payment basis. This payment will be expected to cover physician services as well as hospital services and primary care as well as tertiary care. An ACO can only function if it is an integrated system that can deliver all aspects of the care continuum. This healthcare delivery model is a significant departure from the fee for service based system that currently dominates healthcare.

The entities comprising the Regional System would be DHH, MHMH, DHC, Cheshire Medical Center,[19] CMCHS, CMC and AHS, with additional organizations subsequently being added. DHH's role in the Regional System will be: (1) exercising long-term oversight and planning for the provider organizations, (2) approving operating and capital budgets for the provider organizations, (3) approving the appointment or removal of members of the provider organizations' governing boards, (4) approving the level of debt allowed by the members of the system, (5) designing and implementing strategic plans for the provider organizations, and (6) approving any participation in any key strategic relationship by any of the provider organizations with an organization not within the integrated health care system. DHH will serve as the overall authority for the development of health care delivery policies for provider organizations and will develop strategic plans for the expansion and direction of health care services within the system. DHH will also oversee the financial condition of the Regional System, approve policies for, and oversee the management and investment of, all funds within the Regional System, and approve the decisions of the provider organizations with respect to the selection, evaluation, compensation, and discharge of their presidents or chief executive officers. In general, DHH will oversee all of the strategic operations of the provider organizations within the Regional System.

VII. ATTORNEY GENERAL'S REVIEW CRITERIA

New Hampshire RSA 7:19-b IV provides that within 120 days from the Parties' notice of the proposed transaction to the Attorney General, the Attorney General shall determine whether the health care charitable trusts' boards of trustees have fulfilled their fiduciary standards.[20] Within the stated 120 days, the Attorney General shall notify the Parties that either the Attorney General will take no further action with respect to the Transaction, or the Attorney General objects to the Transaction on specified grounds. The Acquisition Act sets forth the following minimum standards to be considered by the Attorney General in his review:

1. The governing body has acted in good faith and in a manner consistent with its fiduciary duties to the health care charitable trust, and unless the following minimum standards are met: (a) The proposed transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law. RSA 7:19-b, II(a).

2. Due diligence has been exercised in selecting the acquirer, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed transaction, and in determining that the transaction is in the best interest of the health care charitable trust and the community which it serves. RSA 7:19-b(II)(b).

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[19] Chesire Medical Center, a New Hampshire voluntary, non-profit corporation with a principal place of business at 580 Court Street, Keene, New Hampshire, 03431. Cheshire Medical Center operates a medical center located in Keene, New Hampshire.

[20] RSA 7:19-b, IV makes it clear that this section does not derogate from the authority of the Attorney General provided by common law or other statutes.

3. Any conflict of interest, or any pecuniary benefit transaction has been disclosed and has not affected the decision to engage in the transaction. RSA 7:19-b, II(c).

4. The proceeds to be received on account of the transaction constitute fair value therefor. RSA 7:19-b, II(d).

5. The assets of the health care charitable trust and any proceeds to be received on account of the transaction shall continue to be devoted to charitable purposes consistent with the charitable objects of the health care charitable trust and the needs of the community which it serves. RSA 7:19-b, II(e).

6. Reasonable public notice of the proposed transaction and its terms has been provided to the community served by the health care charitable trust along with reasonable and timely opportunity for such community, through public hearing or other similar methods, to inform the deliberations of the governing body of the health care charitable trust regarding the proposed transaction. RSA 7:19-b, II(g).

It should be noted that under the First Amendment of the United States Constitution, the Attorney General must defer to the interpretation by a religious organization of its theology. *See, e.g., Berthiaume*,153 N.H. at 245 (citing *Jones*, 443 U.S. at 603). The Attorney General acknowledges that ethicists engaged by the CMC Charities and the Bishop of Manchester have opined that the Transaction conforms with the ERDs.[21] The Attorney General expresses no opinion on such findings made from a theological perspective. The Attorney General does, however, have the right and duty to analyze the Transaction in light of the "neutral principles" of charitable trust law. *See Berthiaume v. McCormack*, 153 N.H. 239, 249 (2006) (citing *Jones v. Wolf*, 443 U.S. 595, 602 (1979) and *Presbyterian Church v. Hull Church*, 393 U.S. 440, 449 (1969) (adjudication of religious property dispute to be determined in accordance with "neutral principles" of governing law)). *See also Reardon v. Lemoyne*, 122 N.H. 1402, 1048 (1982).

VIII. RSA 7:19-B, II (a) – IS THE TRANSACTION PERMITTED BY APPLICABLE LAW

The first statutory standard that must be evaluated by the Attorney General is whether the governing body has acted in good faith and in a manner consistent with its fiduciary duties to the health care charitable trust, and unless the following minimum standards are met: (a) The proposed transaction is permitted by applicable law, including, but not limited to, RSA 7:19-32, RSA 292, and other applicable statutes and common law.

This standard is the broadest of the six standards to be considered, in that it incorporates the broad statutory authority of the Director of Charitable Trusts. For the reasons discussed in detail below, the Attorney General has concluded that the Transaction will result in a profound

[21] For example, Roland P. Hamel, Ph.D., who is the Senior Director for Ethics with the Catholic Health Association, as a consultant for the CMC Charities, has reviewed the Affiliation and concluded that it "is in accord with the Catholic Church's moral teaching and with the ERDs." Roland P. Hamel, *Moral Analysis of the Affiliation Agreement between CMC Healthcare System and Dartmouth-Hitchcock Health Executive Summary*, 3 (Jan. 19, 2010), http://www.ahealthiertomorrow.org/docs/MoralAnalysis_Hamel_Jan2010.pdf.

change in the governance structure of the CMC Charities and diminish the fiduciary duties of the Boards of the CMC Charities which will inhibit the ability of the CMC Charities to carry out their charitable missions.

A. Change Of Control Over Core Functions Of CMC Charities

The Transaction will result in DHH being granted control over core functions of the CMC Charities (which until this point have operated as an independent Catholic hospital). For the reasons discussed below, the Attorney General concludes that the Transaction will result in a profound change in the governance structure of the CMC Charities and diminishment of fiduciary duties of the Boards of the CMC Charities. This deviation will result in such a significant change of control, that the charitable mission of CMC cannot be adequately protected by the restructured Board of Directors. The Attorney General also concludes that Probate Court approval of this transfer of control would be required in order to be permitted under New Hampshire law.

The Transaction will cause DHH to become the sole member of CMCHS. The Board of CMCHS would be composed of the following individuals:

- the President/CEO of CMCHS;
- the President/CEO of DHH;
- the Bishop's Health Care Delegate;
- seven (7) members selected by the CMC Board of Directors[22]; and
- five (5) members selected by those AHS Trustees selected, directly or indirectly, by DHH.

Pursuant to the terms of its Bylaws, all actions that come before the CMCHS Board would be determined by a majority vote of the members of the Board present at the meeting subject to the reserved powers of DHH and the Bishop of Manchester.

The Affiliation Agreement grants to DHH ten significant reserved powers that directly impact the mission, governance and operation of CMCHS. Four of these reserved powers would be exercised exclusively by DHH and six would be exercised on a shared basis with the Bishop of Manchester.[23] The powers reserved exclusively to DHH are:

1) The DHH Board must approve the final adoption of the entirety of each annual and any revised operating and capital budgets of CMCHS approved by the CMCHS Board, and any proposed action which may result in a deviation

[22] These members selected by the CMC Board of Directors, however, would be subject to DHH's approval of CMC Healthcare System, Article VIII.

[23] Proposed CMCHS Affidavit of Amendment, Article VIII.

in a "Material Amount" (which is defined as a dollar amount equal to or greater than the capital expenditure threshold for acute care facilities set forth in New Hampshire RSA 151-C:5(II)(a) as adjusted for inflation from time to time by the Health Services Planning and Review Board) from such budgets. If the DHH Board does not approve any annual or revised operating or capital budgets, the entire such budget will be returned for reconsideration and resubmission by the CMCHS Board. It is the Parties' understanding that the DHH Board will not have a "line item veto" over any annual or revised operating or capital budgets of CMCHS. The DHH Board also must approve the final adoption of, and any approval of a deviation in a Material Amount from, only those components of the annual and any revised operating and capital budgets of CMC and AHS, respectively, that constitute a Material Amount and have strategic implications for the Regional System;

2) The DHH Board must approve any unbudgeted transfer by CMCHS, CMC and/or AHS to any person or organization, with or without consideration, during any twelve (12) month period of tangible, intangible or mixed assets with a value of a Material Amount (which amount need not be equal among Regional Provider Organizations);

3) The DHH Board must approve any unbudgeted single occurrence, or unbudgeted cumulative occurrences in any twelve (12) month period, of debt by CMCHS, CMC and/or AHS in a Material Amount, which amount need not be equal among Regional Provider Organizations (the term "debt" is defined as short-term and long-term indebtedness and financial obligations of all types, including, but not limited to, capitalized leases, notional principal contracts, and guarantees, except "debt" shall not include loans or guarantees incurred to facilitate routine business transactions, not to exceed a Material Amount, or accounts payable incurred in the ordinary course of business); and

4) The DHH Board must approve the elimination or addition of any material health care service or program by CMCHS, CMC and/or AHS, with the understanding that any such new health care service or program by CMCHS, CMC and/or AHS must be in accordance with the ERDs.

Consistent with the fourth reserved power listed above, the proposed Bylaws of CMCHS include a provision that DHH will have the right to approve significant clinical and other programmatic initiatives and development in the Manchester System identified by the CMCHS Board and the CMCHS management.[24]

The six powers reserved jointly to DHH and the Bishop of Manchester are:

1) The DHH Board of Trustees (the "DHH Board") must approve the appointment or removal of a member of CMCHS's Board, provided that if

[24] Proposed CMCHS Bylaws, Article III, Section 19.

new members are appointed as a slate, the DHH Board will exercise its approval with respect to the entire slate;

2) The DHH Board must approve the creation of any affiliate or subsidiary of CMCHS or any merger with or consolidation of CMCHS, CMC and/or AHS into another entity, or the acquisition by the CMCHS, CMC and/or AHS of substantially all of the assets of another entity which acquisition may have a material effect on the Manchester System and/or the Regional System;

3) The DHH Board must approve the corporate division, dissolution, or liquidation of CMCHS, CMC and/or AHS;

4) The DHH Board must approve the participation by CMCHS, CMC and/or AHS in a "Key Strategic Relationship" defined as the ownership of, or contractual participation in, a network, system, affiliation, joint venture, alliance or similar arrangement (not including ordinary academic programs, managed care contracts, or other payment arrangement with third party payors), entered into with another organization that is not a Manchester Provider Organization;

5) The DHH Board must approve the appointment and termination of the CMCHS's President and CEO; and

6) The DHH Board must approve the amendment of the Articles of Agreement and/or Bylaws of CMCHS, CMC and/or AHS where such proposed amendment would (i) impact the powers reserved to DHH, or (ii) reasonably be expected to have any material strategic, competitive or financial impact on one or more Regional Provider Organizations or on the Regional System and Manchester System as a whole.

Both AHS and CMC are subject to reserved powers similar to those reserved by CMCHS to DHH and the Bishop of Manchester.[25]

With regard to AHS, the Parties state that one of the purposes of the Transaction is to "provide DHC with a more significant role in AHS' governance."[26] Accordingly, the AHS Board would be reconstituted to allow eleven (11) of the seventeen (17) members—sixty-five percent (65%) — to be selected, directly or indirectly, by DHH.[27] (Thus, control over AHS will be

[25] Proposed AHS Bylaws, Article II, Section 2 and Proposed CMC Affidavit of Amendment, Article VI.

[26] The Notice at 3–4.

[27] Restated Affiliation Agreement at Sec. 3.1.1.

changed to DHH regardless of its reserved powers.) Specifically, the AHS Board of Trustees would be composed as follows:[28]

1) The CMCHS Chief Physician Executive, ex officio;

2) The AHS Medical Director, ex officio, provided that if the same individual holds the office of CMCHS Chief Physician Executive and the AHS Medical Director, then the AHS Associate Medical Director will serve on the AHS Board of Trustees, ex officio;

3) The DHC President, ex officio;

4) The Dartmouth-Hitchcock Vice President of Community Group Practices, ex officio;

5) The CMCHS CEO, ex officio;

6) The CMC Physician Practice Associates Medical Director, ex officio;

7) Two (2) members nominated by the DHC-M Board of Governors (defined below);

8) Five (5) members nominated by the DHC Board of Trustees; and

9) Four (4) members nominated by the Board of Directors of CMC.

Further, the Board of Governors of AHS, which is responsible for advising and implementing the policy and programmatic decisions of the AHS Board, will have eighteen (18) of its twenty (20) members selected directly or indirectly by DHH. The AHS Board of Governors will be comprised of the following individuals:

- CMCHS President and CEO;
- Medical Director of CMC Physician Practice Associates;
- Chief Physician Executive (Elected by Board of Trustees, initially will be the current Medical Director of DHC-Manchester);
- AHS' Medical Director or Associate Medical Director (Appointed by Chief Physician Executive after consultation with Board of Governors and DHC President, and subject to the approval of the Board of Trustees);
- Associate Medical Director of Dartmouth-Hitchcock Clinic;
- Chairs DHC-Manchester: Pediatrics;
- Chairs DHC-Manchester: Adult Medicine;
- Chairs DHC-Manchester: Obstetrics and Gynecology;
- Chairs DHC-Manchester: Surgery and Gastroenterology;

[28] The members identified in 1, 2, 3, 4, 7 and 8 are referred to in the Affiliation Agreement as the "D-H Members" of the AHS Board because all will have been selected directly or indirectly by Dartmouth-Hitchcock.

- Chairs DHC-Manchester: Medical Specialties;
- Chairs DHC-Manchester: Pediatric Specialties (ChaD);
- 3 physicians elected by DHC-Manchester;
- 1 associate provide elected by DHC-Manchester;
- 1 staff member elected by DHC-Manchester;
- Dartmouth-Hitchcock Vice President of Community Group Practices;
- 3 representatives of other clinical specialties appointed by the Chief Physician Officer; and
- Such other members as are recommended by the Chief Physician Executive, subject to Board of Trustee approval.

In summary, the Transaction will result in the CMC Charities ceding significant control over their mission, governance and operations to DHH. DHH will become the sole member of CMCHS and will be granted "reserved powers" over the CMC Charities which eliminate the ability of the Boards of CMC Charities to exercise their fiduciary duty in many areas. The "reserved powers" granted to DHH relate to the CMC Charities' core organizational and board functions, including, changes to the entity's Articles of Agreement and Bylaws, appointment and removal of board members, appointment and removal of the Chief Executive Officer, approval of annual budgets, transfer of assets, incurrence of debt, liquidation, dissolution, as well as how to implement its mission such as changes in the charitable purposes, affiliations with other entities, and changes in the services and programs provided.

While DHH will have significant involvement in the oversight and strategic direction of the CMC Charities, the CMC Charities will have no countervailing or equivalent control over the DHH Charities. The rights of the CMC Charities to be involved in the governance of the Regional System are limited to CMCHS having the ability to nominate three (3) of the eighteen (18) members of DHH's Board and the CMCHS President/CEO would have a seat on the DHH Leadership Council.[29] While these rights allow CMCHS to remain informed about the actions taken by the DHH Board or the DHH Leadership Council, but they do not provide CMCHS with any ability to control or limit DHH's authority over the CMC Charities.

B. Discussion Of Applicable Law

The members of the board of directors of a charitable corporation have two distinct fundamental fiduciary duties: the duty of care and the duty of loyalty. In addition, the boards

[29] The Leadership Council will be composed of the President of DHH and the provider organizations (currently, MHMH, DHC and CMCHS). The responsibilities of the Leadership Council include: (1) developing and recommending DHH strategic plans for review and approval by the DHH Board of Trustees; (2) developing and recommending strategic plans to the Boards of Trustees of the regional provider organizations which plans are aligned with DHH strategic plans; (3) coordinating the development of Five-year Capital Plans and Annual Operating and Capital Budgets that support DHH and regional provider organization strategic plans, including but not limited to the use of Regional System resources; (4) developing and coordinating quality improvement plans among the regional provider organizations; (5) overseeing the coordination and integration of clinical and administrative services and processes to advance the goals of DHH and the regional provider organizations in a manner consistent with their respective charitable missions and, where applicable, the ERDs; (6) monitoring the performance of DHH and the regional provider organizations, including but not limited to their commitment to their community benefit, educational and research programs; and (7) resolving conflicts that may arise.

also have a derivative duty, the duty of obedience to the mission of the organization.[30] The duty of care requires directors to make a reasonable attempt at obtaining all relevant information before taking action and then requires the director to take prudent action.[31] The duty of loyalty requires directors to disclose actual and potential conflicts of interest in transactions involving the director and the charity as well as acting in the best interest of the charity.[32] The duty of obedience requires directors to be faithful to the mission and not allow the charity to violate the organizational documents (i.e., a faithfulness to the charity's purpose).[33]

In a charitable corporation, the board of directors is vested with the right to authorize action to be taken by the corporation.[34] The duty of care owed by the members of a board of directors of a charitable corporation (*i.e.* one of the CMC Charities) includes the duty to oversee and supervise all of the core functions of the charitable enterprise.[35] It is acceptable for board members to delegate certain tasks, provided the board retains the right to oversee the execution of such task. However, a delegation of core responsibilities of the board where the right to oversee the execution of such task has not been retained by the board is an abdication of the board's duty[36] and constitutes a breach of the board's duty of care.[37]

A distinction needs to be drawn between delegation of functions and management on the one hand and the transfer of the fiduciary duty itself. A director cannot give a proxy to another person: the fiduciary duty is personal and nontransferable. If there is such a transfer, the courts characterize the action as an "abdication", an improper shedding of the director's core

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[30] It should be noted charitable corporations should be held to the same rules and principles as charitable trusts. Restatement (Second.) of Trusts § 348 cmt. f (1959).

[31] "The duty of care requires each governing board member –

(a) to become appropriately informed about issues requiring consideration, and to devote appropriate attention to oversight; and

(b) to act with the care that an ordinary prudent person would reasonably exercise in a like position and under similar circumstances."

Amer. Law. Inst., *The Law of Nonprofit Organizations,* A.L.I. Nonprofit § 315 (T.D. No. 1, 2007).

[32] Phil Kline *et al*., *Protecting Charitable Assets in Hospital Conversion: An Important Role for the Attorney General*, 13 Kan. J.L. & Pub. Pol'y 351, 360 (Spring 2004).

[33] Peregrine, "Coalition For Nonprofit Healthcare, Overview of State Law Challenges to Nonprofits" 3 (2001); *See also* Amer. Law Inst., *The Law of Nonprofit Organizations*, § 320 cmt. e (T.D. No. 1, 2007) (providing that the duty of obedience may in appropriate circumstances determine that the organization's purposes be modified).

[34] Rev. Model Nonprofit Corp. Act § 8.01(b) (1987), available at http://www muridae.com/nporegulation/documents/model/_npo_corp_act html.

[35] Amer. Law. Inst., *Principles of the Law of Nonprofit Organizations,* A.L.I. Nonprofit § 325 (T.D. No. 1, 2007).

[36] An abdication is a delegation where the right to oversee the execution of such task has not been retained by the board.

[37] Amer. Law Inst., *The Law of Nonprofit Organizations,* A.L.I. Nonprofit, § 325, comment a.(1) (while delegation of certain functions is permitted, abdication of responsibility is not).

responsibilities.[38] When an agreement substantially limits the freedom of a director to take action on matters of management policy, such agreement violates the duty of care that requires each director to exercise his own best judgment on matters coming before the board.[39]

This concept of supervision over delegated actions is incorporated into New Hampshire's laws under the Uniform Trust Code. The Uniform Trust Code states that trustees in noncharitable trusts may delegate duties, powers and management functions to a person with appropriate skills.[40] However, the trustee must periodically review the agent's actions to monitor performance.[41] Under New Hampshire's business corporation law (which is frequently referred to in the voluntary corporation context) there are similar provisions that all corporate powers must be exercised by or under the authority of its board of directors.[42]

C. Application Of Applicable Law To Voting Structure And Reserved Powers In The Transaction

The Attorney General objects to the proposed structure due to the substantial impact it would have on the fiduciary duties owed by the CMC Charities' directors. Due to the profound change in the governance structure of the CMC Charities and the diminishment of the board's fiduciary duties a Petition for Deviation to the Probate Court is required in order to effectuate such significant changes to a charitable trust.

In the Transaction, the voting power and reserved powers granted to DHH impact core functions of the Boards of the CMC Charities. While the board members of each of the CMC Charities will continue to owe fiduciary duties to their respective organizations to act in a manner that is in the best interest of these organizations, the DHH and reserved powers will significantly limit the CMC Charities' directors' ability to implement their decisions. This is not a situation in which the documents provide DHH with merely a consulting role with regard to

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[38] *Id. See also, Ray v. Homewood Hospital, Inc.*, 27 N.W.2d 409, 411 (Minn. 1947), *Chapin v. Benwood Foundation, Inc.*, 402A.2d 1205, 1210 (Del. Ch. 1979), *Grimes v. Donald*, 673 A.2d 1207, 1214 (Del. 1996), *Vt Dept. of Pub. Serv. v. Mass. Mun. Wholesale Elec.*, 151 Vt. 73, 89 (1988).

[39] *Abercrombie v. Davis*, 123 A.2d 893, 899 (Del. 1957); *see Ray v. Homewood Hospital, Inc., et al.*, 27 N.W.2d 409, 411 (1947) (board of directors of non-profit corporation is "vested with a fiduciary responsibility to administer its affairs. As such, they are charged with the duty to act for the corporation according to their best judgment, and in so doing they cannot be controlled in the reasonable exercise and performance of such duty . . . and an agreement by which individual directors, or the entire board, abdicate or bargain away in advance the judgment which the law contemplates they shall exercise over the affairs of the corporation is contrary to public policy and void. . . . They may not agree to abstain from discharging their fiduciary duty to participate actively and fully in the management of corporate affairs. The law does not permit the creation of a sterilized board of directors." (Internal citations omitted)).

[40] RSA 564-B:8-807. In contrast, it is recognized that a founder of a charitable corporation can design a governance structure where certain individuals have limited fiduciary duties.[40] This option is not available to directors after the initial formation.[40] Therefore, after the initial creation of the entity, all board members retain the same duty of care as originally bestowed on them.

[41] RSA 564-B:8-807(a)(3).

[42] RSA 293-A:8.01.

these core functions; rather, DHH reserves an actual veto power over many strategic, operational and clinical decisions by the Boards of the CMC Charities.[43] The DHH reserved powers effectively result in the Boards of the CMC Charities being relegated to an advisory role on issues where DHH holds a reserved power, and puts the Boards of the CMC Charities in a position where they must compromise their decisions to accord with DHH goals (or risk the denial of required approval).[44]

Unlike with delegated powers, the Boards of the CMC Charities do not have the ability to withdraw the reserved powers from DHH if those Boards determine its mission or implementation is at risk.

Although the Affiliation Agreement includes dispute resolution and termination mechanisms, these mechanisms do not serve to counterbalance the reserved powers granted to DHH. The Affiliation Agreement provides that if a matter is not approved after two attempts, is not considered in a timely manner, or if the Parties agree, that the matter may be addressed through the dispute resolution mechanism described in the Affiliation Agreement.[45]

While the dispute resolution mechanisms and termination provisions provide the Parties with a way to address disputes that may arise or changes that undermine the fundamental assumptions of the Parties, these mechanisms do not in any way ameliorate the impact of the transfer of the reserved powers to DHH. The availability of non-binding mediation and binding arbitration for dispute resolution does not alleviate the problem with improper delegation of authority; it simply shifts the potential decision-maker from DHH to another third party – an arbitrator.[46]

The Affiliation Agreement also includes a series of events that, if any were to occur, would result in the termination of the relationship of the Parties under the Affiliation

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[43] *See Taylor v. Baldwin*, 247 S.W.2d 741, 748-9 and 752-3 (both lower and appellate courts found that Barnard Hospital board had not violated its fiduciary duties by merely agreeing to *consult* with another hospital (with which it was affiliating) regarding appointment of medical staff and the hospital director; while court stated that an agreement that would preclude a board from appointing the officers of the corporation, it found that a mere agreement to consult with another entity did not constitute a delegation of the authority where the Barnard board retained the final decision-making authority).

[44] It should be noted that, in general, when authority is delegated to a third party by a non-profit board of directors (for example, to an investment advisor), no fiduciary duty arises in that third party toward the non-profit corporation. Instead, the fiduciary duty remains with the board of directors of the non-profit corporation to supervise the actions of the delegee. In this situation, the delegation of authority by its nature would not allow for supervision by the CMC Charities.

[45] Affiliation Agreement, Section 5.4.2. The Affiliation Agreement provides that a dispute will first be submitted to non-binding mediation. If mediation fails to achieve a mutually agreeable resolution, the matter will be submitted to binding arbitration.

[46] *See Abercrombie v. Davies*, 123 A.2d 893 (Del. 1956) (improper delegation of authority occurred when directors shifted their ability to govern to a minority of the board which, if unable to come to unanimous decision, would submit relevant board decision to arbitrator for determination).

Agreement.[47] Upon the occurrence of a termination event, the Parties would proceed to terminate the Affiliation Agreement and dissolve and unwind the Transaction as described in the Affiliation Agreement.[48] Providing the Board of the CMC Charities with the extraordinarily burdensome option of withdrawing from the Affiliation Agreement does not constitute an appropriate or effective mechanism through which the CMC Charities' Boards may exercise their fiduciary duties.

Courts have recognized that, over time, certain charitable purposes and the means of carrying out these charitable purposes may become obsolete. Thus, under certain circumstances, in order for a charitable trust to remain viable in a changing society, it may need to alter its course.

In New Hampshire, there are two mechanisms available for such course alterations, both of which require the approval of the Probate Court. One course, *cy pres*, applies to the purpose of the charitable trust; the other course, deviation, applies to the administration of this purpose. While these two concepts are closely linked, there are distinctions between them; further, a change to the purpose of a charitable trust requires a more substantial showing than does a change to the administration of the charitable trust.

Cy pres is a traditional equitable power exercised by the Probate Court. When property is given in trust for a charitable purpose, New Hampshire law allows the Probate Court to approve a change to the purpose of a charitable trust where its purpose "is or becomes impossible or impracticable or illegal or obsolete or ineffective or prejudicial to the public interest to carry out."[49] The Court may permit the trustees to redirect the assets of the charitable trust to some other charitable purpose which "fulfills as nearly as possible the general intent of the settlor or

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[47] The written consent of the Parties upon a determination by their respective Boards of Trustees that the mutual vision and purpose of their affiliation, is unlikely to be furthered or achieved;

A material breach of this Agreement which 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;

A subsequent and material change in applicable laws or regulations which prohibit, or substantially impair the Parties' abilities to effect, the affiliation contemplated by this Agreement;

A subsequent and material change in the ERDs, or a binding interpretation thereof by the Bishop resulting from new procedures or treatments arising after the Closing Date and which interpretation is a material change, in either case which is incompatible with the goals and purposes of the Manchester System and/or the Regional System, or which substantially impairs the Parties' abilities to effect the affiliation contemplated by this Agreement, or which materially and adversely affect any clinical services permitted under the ERDs in effect on the Effective Date; and

A subsequent circumstance which prevents Dartmouth-Hitchcock Medical Center from continuing to operate as an academic medical center and which circumstance: (1) is not satisfactorily addressed within nine (9) months; and (2) has a material adverse effect on the Regional System and/or the Manchester System.

[48] Affiliation Agreement Section 5.5.1.

[49] RSA 547:3-d; *see, e.g., In re Certain Scholarship Funds*, 133 N.H. 227, 233-34 (1990) (*cy pres* is appropriate relief to alter purposes of scholarship fund with impermissibly restrictive class of beneficiaries).

testator."[50] Thus, the purpose of a *cy pres* petition is to allow the Probate Court to determine the original purposes of the charitable trust, to determine whether a change to that purpose is allowable under the criteria set forth above.

While *cy pres* may be applied to allow for changes in purpose, there are situations in which the charitable purpose need not change, but rather, there must be a significant alteration to the administrative structure of the charitable trust. Under the doctrine of deviation, the Court may alter the administrative provisions of a charitable trust, if an unanticipated change in circumstances has made strict compliance with the "administrative machinery"[51] of a charitable trust would "substantially impair the accomplishment of the purposes of the trust," the court may permit the trustees of the charitable trust to deviate from these administrative provisions.[52] Thus, if the purpose of a charitable trust (or charitable corporation) will remain the same, but a substantial change in the administrative or governance mechanism is required to allow the effective accomplishment of the purposes, the Probate Court may allow this change under the doctrine of deviation.

Courts have allowed for the restructuring and enlarging of charitable boards under the doctrine of deviation.[53] Chief Justice Brock of the New Hampshire Supreme Court described the doctrine of deviation as follows:

> Where the dominant objective of a trust remains capable of fulfillment, but its method of accomplishment has been stalled due to a hitch in the administrative machinery, the doctrine of deviation permits a reworking or repair of the administrative mechanism so that the trust purposes may be accomplished effectively. The doctrine of deviation permits changes in the management of all trusts, and in the case of charitable trusts, may be employed to substitute trustees as well as to alter trust conditions.[54]

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[50] RSA 547:3-d.

[51] *In re Certain Scholarship Funds*, 133 N.H. at 240 (Chief Justice Brock, dissenting), *citing Jacobs v. Bean*, 99 N.H. 239, 241-42 (1954).

[52] RSA 547:3-c.

[53] *See, e.g., The Barnes Foundation, a Corporation*, No. 58,788, Memorandum Opinion and Order Sur Second Amended Petition to Amend Charter and Bylaws, Court of Common Pleas of Montgomery County, Pennsylvania Orphans' Court Division (Jan. 29, 2004), slip op. at 12 ("With this authority in mind, we believe it appropriate to permit deviation on this issue. We determine that the provisions in the indenture concerning the structure of the Board of Trustees of The Foundation are administrative in nature. We agree that Dr. Barnes could have foreseen neither the complicated, competitive, and sophisticated world in which non-profits now operate, nor the range of expertise and influence the members of their governing bodies must now possess. We conclude that maintaining the status quo in this regard would substantially impair the accomplishment of the Foundation's charitable purposes, and that approving the expansion of its Board of Trustees is therefore necessary.").

[54] *In Re Certain Scholarship Funds*, 133 N.H. 227, 240 (1990) (Brock, C.J., dissenting) (citing *Jacobs v. Bean*, 99 N.H. 239, 241-42 (1954)).

The precise procedure for seeking deviation from the terms of a charitable trust are set forth in RSA 547:3-c.[55]

The Attorney General recognizes that as part of the Transaction the CMC Charities provide the Bishop of Manchester with a series of reserved powers (Exhibit 9).[56] Based on the history of the Bishop's involvement with the CMC Charities and the predecessor governing instruments, these reserved powers do not create the same issues as do the newly created reserved powers flowing to DHH. The original Articles of Agreement of each of the CMC Charities specifically reference operating each entity consistent with the teachings of the Roman Catholic Church as enunciated by the Holy See and the ERDs. Those Articles and subsequent amendments have acknowledged the Bishop's oversight and reserved powers.[57] Hence, the doctrine of deviation is not needed to create or expand the Bishop's reserved powers.

Based on the foregoing, the Attorney General objects to the Transaction and in order for the Transaction to be in compliance with all applicable laws the Board of the CMC Charities must obtain the approval of the Probate Court under the doctrine of deviation prior to ceding control over core aspects of their mission, governance and operations to DHH through the reserved powers.

D. Expansion of Charitable Mission.

The Transaction will result in the CMC moving from an independent hospital to part of a regional integrated health care delivery system controlled by DHH. In connection with the Transaction, each of the CMC Charities' "Purposes" as set forth in their Articles of Agreement will be modified. The changes to the charitable purposes of CMCHS will be expanded to include additional purposes relating to the Regional System. The change to the charitable purposes of CMC and AHS will be modest. The Attorney General believes that although the expansion of CMCHS' charitable purposes does not require Probate Court approval, the integration of CMCHS into the Regional System and the actions required to carry out these

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[55] RSA 547:3-c Deviation From Terms of Trust – In all cases where by reason of a change of circumstances which has occurred, shall occur, or is reasonably foreseeable, subsequent to the creation, heretofore or hereafter, of a trust by any deed, will or other instrument, compliance by the trustee or trustees with the terms of the trust relating to the property or the kinds of classes of property which may be held under the trust would defeat or substantially impair the accomplishment of the purposes of the trust, the court may, upon the filing by the trustee of a bill in equity for instructions and upon notice to all parties in interest, enter a decree permitting the trustee to deviate from such terms of the trust and directing the trustee, if necessary to carry out the purposes of the trust, to sell all or any part of the property held under the trust and to invest the proceeds of such sale in kinds or classes of property which are lawful investments for trustees of estates. No such decree, after its entry, shall thereafter operate to relieve any trustee of any duty imposed by law relating to the investment of trust funds and the exercise of reasonable care for the preservation thereof. This section shall not be construed to limit or restrict the general equitable jurisdiction of the court over the trustees, trusts or trust funds.

[56] *See* Proposed CMCHS Affidavit of Amendment, Article IX; Proposed CMC Affidavit of Amendment, Article VI; Proposed AHS Affidavit of Amendment, Article II, Section 2.

[57] CMCHS Articles of Agreement (filed 12/28/01); CMC Articles of Agreement (filed 11/7/74); CMC Affidavit of Amendment and Restatement (filed 12/31/01); AHS Articles of Agreement (filed 6/12/07).

purposes presents potentially challenging issues for board members who sit on the Boards of both DHH and any of the CMC Charities.

1. Discussion of Changes to Charitable Purposes

CMCHS currently acts as a supporting organization for CMC and its affiliated entities, and has as its primary focus upholding and promoting the charitable missions of CMC and its affiliates. As a result of the Transaction, CMCHS's purposes will be expanded to include:

- Serve as a public juridic person of diocesan right under the canon law of the Roman Catholic Church responsible for assuring that CMC, AHS and their subsidiaries operate in adherence to the ERDs and subject to the reserved powers of the Bishop of Manchester;

- Initiate, develop and conduct programs to further (i) the quality and accessibility of health services, particularly in the Greater Manchester community and throughout the State of New Hampshire (when acting in conjunction with DHH) now referred to as the "Regional System," (ii) the efficiency of utilization of health care facilities, particularly in the Regional System, and (iii) the reasonable containment of the cost of health care to the public; and

- Develop a strategic plan for the Manchester System that is compatible with the Regional System plan and account for adherence within the Manchester System of overall quality goals established for the Regional System.[58]

The core purpose of CMC will not change; it will remain an entity focused on operating an acute care hospital in Manchester, New Hampshire in compliance with the ERDs and the teachings of the Roman Catholic Bishops of the United States and the Holy See, as interpreted by the Bishop of Manchester[59]. AHS' fundamental purpose will continue to be to provide services through a multi-specialty group of physicians in collaboration with CMC and CMCHS.[60]

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[58] Proposed CMCHS Affidavit of Amendment, Article II.

[59] The dissolution provisions will be changed to eliminate the Bishop as the automatic recipient of any funds in the event that CMC is dissolved and CMCHS no longer exists. Under the proposed By-Laws, DHH and the Bishop would both have to agree to CMC's decision regarding the distribution of the remaining assets to another 501(c)(3) organization. The Bishop's consent would be required only with respect to "stable patrimony" which is undefined in the documents.

[60] *See* Proposed AHS Affidavit of Amendment, Article II. The purposes of AHS will be amended to add an additional purpose which is possibly allowed by the current Articles: The current Articles provide that AHS' purpose is "To promote and generate health care for a broad cross section of the Greater Manchester, New Hampshire community in general and to own interests in entities which accomplish such purposes." These very broad purposes will be amended to include that the promotion and generation of health care will be "through a multi-specialty group practice model" (which it is already doing prior to the proposed affiliation) and that AHS will "participate in an integrated health care delivery system with" as well as own entities which accomplish such purposes.

2. Discussion of Applicable Law

As discussed above, under common law, the directors of a charitable corporation are subject to two fundamental fiduciary duties: the duty of loyalty and the duty of care, and subsumed within these duties is the duty of obedience.[61] Where directors are voting to change the purposes of the voluntary corporation, the issue involved is the duty of obedience.

> The duty of obedience requires corporate directors to be faithful to the corporation's mission. Although board members may exercise their own reasonable judgment concerning how the organization should best meet its mission, they are not permitted to act in a way that is inconsistent with the central goals of the organization.[62]

While no New Hampshire courts have provided direct guidance on the duty of obedience,[63] courts in other jurisdictions have addressed this issue. In California, a court found that while a charitable corporation may do things other than its primary purpose, it cannot abandon this primary purpose.[64] In New York, a court found that a merger between two non-profit hospitals (one Catholic, one not) was acceptable and did not require court review even under New York's fairly rigorous amendment statute because the amendments did not alter the core purpose of the two hospital corporations – which was to operate hospitals.[65]

The right to alter the purpose of a charitable corporation does not correspondingly grant the board the right use the assets of the organization in a manner other than in accordance with the purposes for which they were given. In order to ensure that a charity's funds are used in a

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The only material change to the purpose is in the language relating to the participation in the integrated health care delivery system. However, this participation may well be within the ambit of the already broad purposes of the organization which include the promotion and generation of health care in the Manchester area.

Another change in the proposed Articles involves the distribution of assets upon dissolution. Under the current Articles, remaining assets would be distributed first to CMC, then if CMC is not in existence to CMCHS and then to the Bishop. Under the proposed Articles, this change to have the assets distributed first to CMCHS, then if CMCHS is not in existence, to another 501(c)(3) organization to be chosen by AHS, but which must be approved by DHH and the Bishop (the Bishop's approval is required with respect to "stable patrimony" which may refer only to ecclesiastical resources, but is undefined).

[61] See, e.g., Huberfeld, N. "Tackling the 'Evils' of Interlocking Directorates in Healthcare Nonprofits," 85 Neb. L. Rev. 681701-02 (2007).

[62] Kline, *supra*, at 360. *See also* Amer. Law. Inst., *supra*, § 310 cmt. a(1) (the duty of fiduciaries is to the charitable mission, not to a particular entity); *Id*. § 310 cmt. e (it is possible for a board to determine that the organization undergo an extraordinary change such as a merger).

[63] New Hampshire law does address the application of the doctrines of *cy pres* and deviation to change the charitable purpose or administration of a charitable trust. *E.g. Portsmouth Hospital v. Attorney General*, 104 N.H. 51 (1962).

[64] *See Queen of Angels Hospital v. Younger*, 66 Cal. App. 3d 359, 368 -71 (Cal. Ct. App. 1977).

[65] *Nathan Littauer Hospital Association v. Spitzer*, 287 A.D.2d 202 (NY. App. Div. 2001).

manner that is consistent with the purpose for which they were given, some courts have restricted the ability of a charitable corporation from using its existing funds to further its changed purpose. In such cases, funds already held by the charity must be used for the purposes of the charitable corporation's original mission. In Massachusetts, a court found that the charitable corporation could change its charitable purpose and did not have to restrict these changes to purposes that would be in support of the original, dominant, purpose of the charitable corporation. However, the court also found that the assets of the charitable corporation were held in charitable trust, and that the change to the corporation's purpose could not impact the assets held by the charitable corporation prior to the change to the corporate purpose.[66] In South Dakota, a court similarly held that a voluntary corporation could not amend its Articles of Agreement with respect to the use of assets received in advance of the amendment to its purposes.[67]

3. Application of Applicable Law to the Transaction

The Transaction includes a provision that states that the assets of the CMC Charities will be valued as of the date of the Transaction, and these assets will be safeguarded and used exclusively to support the CMC Charities' original purposes.[68] By employing this structure, the Parties have addressed the issue of the Charities' funds being used in a manner that is consistent with the purpose for which they were given.

As noted above, the Transaction will result in the expansion of CMCHS' purposes[69] CMCHS will continue as a supporting organization of CMC and AHS. Following the Transaction, CMCHS will gain two additional functions.

First, the expansion will result in CMCHS being charged with the responsibility to ensure that the other CMC Charities adhere to the ERDs and to certain quality guidelines put into place in the Regional System. Second, CMCHS will also support the efforts of the CMC Charities to integrate into the Regional System through strategic planning and accounting for the adherence by the CMC Charities with the Regional System quality guidelines. The expansion of CMCHS' purposes proposed by the Transaction does not constitute an improper expansion of its purposes.

It should be noted that DHH as the sole member overseeing the Regional System becomes a new benefactor of the services of CMCHS. With these expanded purposes, CMCHS may be subject to a possible conflict of interest between supporting CMC and AHS and

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[66] *See also Attorney General v. Hahnemann Hospital*, 494 N.E.2d 1011 (Mass. 1986).

[67] *Banner Health System v. Long*, 663 N.W.2d 242 (S.D. 2003).

[68] Not only are said assets protected, but so are the future earnings derived from those assets. Section 3.9.3.1 of the Affiliation Agreement states in part: "After the Effective Date, the Parties will track changes in such net asset values annually and attribute those changes to either non-Affiliation matters . . . and [to] Affiliation related matters. . . . The positive changes in the net asset value attributable to Affiliation related matters will be referred to in this Agreement as the "Post-Affiliation Surplus."

[69] Some commentators believe that a board has the obligation to keep the purpose of the charity current and useful. To that end, the board must amend the stated purposes when necessary and appropriate to do so. Amer. Law Inst:, *Principles of Law of Nonprofit Organizations*, *supra*, § 300 cmt. g(3).

overseeing the integration of the Manchester System into the Regional System (whose goals CMCHS does not define). While these purposes are not necessarily in conflict, the CMCHS Board will need to have a heightened sensitivity to balancing these purposes.

4. Duality of Board Loyalty

In the corporate setting, it is possible for an individual to serve on more than one board of directors. This does not change the fiduciary duties owed to each organization. Similarly, the fact that a board member is nominated by one organization to serve on the board of another organization is irrelevant: "[t]he rule that the fiduciary duties run to the organization is true for every board member, regardless of how that board member obtained his or her seat."[70] When individuals serve on the boards of more than one organization, the possibility of "duality of loyalties" arises and can result in conflicts of interest.

It is recognized that in the Transaction, a Regional System organization board member could be elected to one of the CMC Charities' boards. In such case, issues will arise (*e.g.*, how to deploy an organization's assets, how to determine the Post-Affiliation Surplus, whether to expand or contract along geographic or medical services lines, etc.) that may place a board member in a conflict. While this issue is not unique to the Transaction, the Attorney General notes that this issue warrants continued vigilance by the Parties. The Director of Charitable Trusts will continue to review the exercise of the Board members' duties to ensure compliance with applicable law.

IX. RSA 7:19-B, II(b) EXERCISE OF DUE DILIGENCE

The Acquisition Act provides that,

> [t]he governing body of a health care charitable trust, or any person having authority to direct the affairs of a health care charitable trust, shall not approve the acquisition thereof unless the governing body has acted in good faith and in a manner consistent with its fiduciary duties to the health care charitable trust, and unless the following minimum standards are met: due diligence has been exercised in selecting the acquirer, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the Transaction, and in determining that the transaction is in the best interest of the health care charitable trust and the community which it serves;

RSA 7:19-b, II (b).

[70] Amer. Law. Inst., Principles of the Law of Nonprofit Organizations, A.L.I. Nonprofit § 310 cmt. a(1) (T.D. No. 1, 2007).

A. Selection Of Acquirer

The Transaction is viewed by the Parties as an expansion the existing relationship between CMC and DHC. This relationship developed over the past several years through the successful collaboration of DHC with CMC on various patient-focused initiatives, including birthing support, pediatrics, cardiology, family medicine, intensivist services, hospitalist services, echocardiography and oncology. Each organization also has its own reasons to participate in the Transaction.

According to DHH, in connection with the development of the MHMH and DHC strategic plans, MHMH and DHC determined that they could best achieve their missions through collaborations with health care providers throughout New Hampshire via an integrated health care delivery system. The MHMH and DHC Trustees recognized that they needed to bring their services to New Hampshire's most populous area, the Southern region, and they could accomplish this goal by affiliating with one of the two hospitals located in Manchester.[71] MHMH and DHC recognized that an affiliation with an organization such as CMCHS would allow MHMH and DHC to bring specialty services to more people and would better position MHMH and DHC to develop an accountable care organization for the delivery of health care services.

The Board and senior management of CMCHS recognize that in the current health care environment stand-alone community hospitals, such as CMC, face many challenges. These challenges include: (1) recruiting and retaining physicians, medical staff and related health care providers; and (2) accessing the capital necessary to allow for the investment in essential equipment, such as computerized physician order entry systems and electronic medical records.[72] In addition, as a stand-alone community hospital, CMC believes that it will be difficult to adapt to and take advantage of future payment models, such as those offered by accountable care organizations. Given these challenges, CMCHS concluded that the best way of continuing the long-term viability of CMC, and preserve its Catholic mission, is to integrate into a broader health care delivery system, such as proposed by the Transaction.

Based on the information provided to the Attorney General, the Attorney General concludes that due diligence was exercised by the Parties in selecting the acquirer.

B. Engaging And Considering The Advice Of Expert Assistance

Throughout the process of structuring and negotiating the Transaction the Boards of DHH and CMC engaged the following consultants to assist them with the evaluation of the Transaction:

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[71] DHH Noted that it had discussions with Elliot Hospital about a possible collaboration, however, DHH concluded that the parties did not share a common vision for the nature or scope of an affiliation and discontinued discussions with Elliot Hospital.

[72] It should be noted that Catholic Medical Center's income from operations based on its IRS Forms 990 has decreased in the years 2005-2007 from $12,649,735 dollars to $3,489,095 to $699,332.

CMCHS

- PriceWaterhouseCoopers, LLC, certified public accountants;
- Kaufman, Hall & Associates, Inc., consulting services;
- Peter J. Cataldo, Ph.D., ethicist;
- Father Francis G. Morissey, O.M.I., canon lawyer;
- Ronald Hamel, Ph.D., Senior Director, Ethics of The Catholic Health Association, ethicist; and
- Walter Maroney, Esq.

DHH

- KPMG LLP, certified public accountants; tax and advisory services;
- Watson Wyatt & Company, actuarial consultants;
- InterContinental Risk Management Consulting, insurance and risk consultants;
- The Chartis Group, health care consultants;
- Foley & Lardner, LLP, Stark, Anti-Kickback, Medicare and Medicaid;
- Hinckley, Allen, Snyder, LLP, antitrust legal counsel; and
- Sutherland, Asbill & Brennan, LLP, tax and ERISA legal counsel.

The reports issued by the consultants were used by the Parties to provide them with guidance regarding the Transaction. The Parties also engaged in a thorough due diligence process. The due diligence review conducted by the Parties included a review of legal, financial, employee benefits and insurance coverage issues.

Based on the information provided to the Attorney General, the Attorney General concludes that the Parties exercised due diligence in selecting the consultants who assisted them and in considering the advice of the experts retained in connection with the evaluation of the Transaction.

C. Negotiating The Terms And Conditions Of The Proposed Transaction

The Parties initiated the evaluation of the Transaction in December, 2007. Following a December, 2007 meeting of key executives of CMCHS and DHC, the senior leaders from both organizations conducted joint meetings to determine whether mutual interest existed in pursuing an affiliation. A meeting of representatives of the Boards of both organizations (the "Joint Trustee Committee") was held on May 1, 2008, where the Parties agreed to explore a formal affiliation between CMCHS and DHC. After consideration by each organization's Board, the Parties entered into a confidentiality agreement in June, 2008 and commenced formal discussions regarding the structure of the affiliation. Over the next twelve months, the Parties used a combination of meetings among senior management (the "Senior Leadership Group"), legal counsel, and the Joint Trustee Committee to negotiate the terms of the Transaction.[73] The effort concluded with a letter of intent being signed in February, 2009, following which, the Parties negotiated and entered into an Affiliation Agreement in July, 2009. Subsequent to

[73] The Joint Trustee Committee met nine times between May 1, 2008 and May 29, 2009. The Senior Leadership Group met eleven times between June 16, 2008 and May 22, 2009.

receiving feedback via its internet website, http://www.ahealthiertomorrow.org, and at three public forums, the Parties amended the Affiliation Agreement in January, 2010.

Based on the information provided to the Attorney General, the Attorney General concludes that the Parties exercised due diligence in negotiating the terms of the Transaction.

X. RSA 7:19-b, II(c) DETERMINING THAT THE TRANSACTION IS IN THE BEST INTEREST OF THE HEALTH CARE CHARITABLE TRUST AND THE COMMUNITY WHICH IT SERVES:

RSA 7:19-b directs the Attorney General to determine if the health care charitable trusts exercised due diligence in determining that the Transaction is in the best interest of the health care charitable trusts and the communities they serve. MHMH and CMC have enjoyed longstanding relationships with the communities where they are located; therefore, any change to either organization will impact the communities they serve. However, given the dynamic nature of health care and health care policy, health care providers are forced to continually evolve. The Transaction represents an evolution for the Parties and for the communities they serve.

A. Best Interest Of Health Care Charitable Trusts

As discussed above, in the current health care environment stand-alone community hospitals face many challenges. Given these challenges, CMCHS has concluded that the best way of continuing the long-term viability of CMC, and preserve its Catholic mission, would be to integrate into a broader health care delivery system.

With regard to DHH, the Boards of MHMH and DHC recognized that MHMH and DHC needed to bring its services to New Hampshire's most populous area, the Southern region, and to establish a relationship with a hospital in the State's largest city, Manchester. MHMH's and DHC's realizations developed out of their belief that communities are better served when services provided by physicians and hospitals are more fully integrated, thereby enhancing care coordination and facilitating joint decisions on how best to allocate their resources to meet patients' health care needs. Through an integrated health care delivery model, DHH believes that it can offer the community the best care, in a coordinated and efficient manner. DHH believes that in order for its plan for an integrated health care delivery system to be effective that a financial alignment with a hospital is needed.

B. Best Interest Of Communities Served

With regard to the assessment that due diligence was exercised by the Parties to determine that the Transaction is in the best interest of the communities served by the health care charitable trusts, the Attorney General has focused his review on the impact of the Transaction on the greater Manchester community. The Attorney General made this decision based on the conclusion that the Transaction will have limited impact on the current operations of MHMH and the Lebanon, New Hampshire community.

1. Community

According to CMCHS, the community that it serves is the citizens residing in the municipalities within CMC's primary and secondary service areas.[74] CMCHS recognizes that the communities served by certain specialty programs, such as the New England Heart Institute, is broader, and may encompass the State of New Hampshire. This description of the community served by CMCHS is consistent with its Articles of Agreement, which suggest that CMCHS' primary focus is on the greater Manchester area, but recognizes that part of its purpose is to serve the State of New Hampshire.

2. Access to Specialist and Additional Services

Among the benefits that the Transaction offers to the communities served by MHMH and CMC is greater access to specialists through an integrated health care delivery system. In spite of Manchester being the largest city in New Hampshire, CMC's management has concluded that it has historically lacked access in certain key clinical areas. As is discussed above, CMC and DHC have collaborated on several patient-focused initiatives

In connection with its preliminary evaluation of the Transaction, the Parties identified the following as clinical services and programs that may be added to or improved in the greater Manchester service area following the consummation of the Transaction:

- Critical Care: the addition of another intensivist physician;
- Neurosurgery/neurosciences development;
- CHad specialties: increase presence and physician depth to improve access. The following new community services may be added:
  - pediatric pulmonary
  - behavioral pediatrics
  - Epilepsy and Multiple Sclerosis specialty programs
  - Swedish model neonatal program
- Cancer specialty treatment programs: expand presence of comprehensive breast cancer program (including surgery at CMC both therapeutic and reconstructive);
- Lung Cancer; Colon Cancer; Bone Marrow Transplantation;
- Expand presence of organ transplant services (liver; kidney);
- Digestive Health Program: continue development just started to create a multi-disciplinary digestive health program;

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[74] Primary Service Area: Allenstown, Auburn, Bedford, Candia, Deerfield, Goffstown, Dunbarton, Hooksett, Manchester, New Boston.

Secondary Service Area: Amherst, Bow, Chester, Derry, Londonderry, Raymond, Weare.

The Manchester Health Service Area as of 2010 is estimated to be 191,150 persons. The primary and secondary service areas include approximately 350,000 people. Dorothy A. Bazos and Anna Thomas, *Manchester's Primary Care Safety Net "Intact but Endangered": A Call to Action*, 5 (Manchester Sustainable Access Project, City of Manchester Dept. of Health, June 2008).

- Vascular Services: create linkages between DHMC and local vascular surgeons to expand local care in the greater Manchester area.

3. Benefits of Integrated Health Care Delivery System

According to the Parties, the creation of an integrated health care delivery system that integrates health care facilities and various providers along the continuum of care has the following benefits: (1) allows for the management and coordination of the utilization of all patient services; (2) overcomes regulatory restrictions on the sharing of information and the alignment of incentives between facilities and providers; and (3) establishes a framework by which accountability for quality and efficient care can be established. While it is assumed that certain administrative savings will be achieved, the Parties' main focus has been on clinical improvements and larger system efficiencies, which can only occur through clinical integration. With regard to the Manchester community, the Parties believe that the development of an integrated health care delivery system will provide the Parties with the ability to: (1) avoid or minimize the duplication of clinical services; (2) allow for the development of additional specialty care, primary care and tertiary care services for greater Manchester; (3) position both organizations to compete in the highly competitive health care environment of greater Manchester and southern New Hampshire; and (4) enhance the financial positions and future prospects of both organizations. The Parties also expect that the Transaction will lead to the development of an accountable care organization which will allow the organizations to participate in the Dartmouth-Hitchcock CMS project titled "Physician Group Practice Demonstration Project" that was mandated by the "Benefits Improvement and Protection Act" of 2000, and has shown substantial savings for the Medicare program. The development of an accountable care organization will also allow DHH to contract with third party payors in creative fashions.

The case for the need to develop an integrated health care delivery system is made more compelling if one assumes that the current method of health care reimbursement will undergo significant changes in the near future. The Parties believe that federal review of insurance premium increases will quickly lead to a change to the way that health care providers are paid. According to the Parties, the Transaction puts the Parties in a better position to adapt to this evolution in health care.

As discussed above, the Parties believe that the challenges facing stand-alone community hospitals place them at risk. While it is not possible to predict with any degree of certainty what impact these challenges will have on the long-term viability of CMC, the senior management of CMCHS believe that the affiliation with DHH, and the creation of an integrated health care delivery system in Manchester, New Hampshire, will enhance CMCHS' ability to maintain a Roman Catholic hospital in Manchester, New Hampshire.

4. Cost of Care

Another factor to consider when assessing the impact of the Transaction on the community is the impact that the Transaction will have on the cost of delivering health care. Multiple factors affect overall health care costs associated with consolidation of health care

providers. When physicians perform services in hospital settings, both the hospital and the physicians may bill for the services. Medicare reimburses physicians less when the services are rendered in a hospital setting as opposed to a private office setting. This is known as the "site of service differential." However, because the hospital will also bill for an outpatient facility fee, there is a possibility of additional revenue flowing into the system, this method of billing is referred to as hospital-based billing. In addition, costs of services to Medicare could increase as clinics can receive higher Medicare payments for services if located within thirty-five miles of an affiliated hospital under the "Provider-based Rule."

CMCHS and DHH stated in response to information requests that they do not "envision any change in their respective charge structures *solely* due to the affiliation." Emphasis added. The Parties further stated that

> [a]lthough there have been no final determinations made as to whether or not CMCHS through AHS would implement hospital based billing for professional services or hospital based billing for technical services, it has been calculated by independent consultants that revenue opportunities exist in the approximate amount of $6.2 million. Hospital based professional services could generate $1.9 million through Medicare and technical services could generate $4.3 million through commercial payors. This revenue would be derived from service volumes being paid under existing payor contracts and would not be the result of any new negotiations on the part of either party.

Based on the information provided by the Parties, the Attorney General concludes that the Parties have not provided adequate information upon which the Attorney General can determine whether it exercised due diligence in determining the effect of the Transaction on the cost of delivering health care. For that reason, the Attorney General objects.[75]

XI. RSA 7:19-B II(c) DISCLOSURE OF CONFLICT OF INTEREST AND PECUNIARY BENEFIT TRANSACTIONS

A. Conflict of Interest

The Acquisition Act permits the Attorney General to consider whether all conflict of interest and pecuniary benefit transactions have been disclosed and evaluate if any such transactions have affected the decision to engage in the Transaction. New Hampshire RSA 7:19-a defines "pecuniary benefit transaction" as "a transaction with a charitable trust in which a director, officer, or trustee of the charitable trust has a financial interest, direct or indirect." 7:19-a(I)(c). This statute exempts from the definition of pecuniary benefit transaction reasonable compensation for services of an executive director, and expenses incurred in connection with official duties of a director, officer, or trustee, and a continuing transaction entered into by a charitable trust, merely because a person with a financial interest therein subsequently becomes a

[75] As is referenced in Section XIV (Other Approvals), a separate antitrust evaluation is being performed, and the effect on health care costs in the community is subject to review and analysis within the context of the antitrust review.

director, officer, or trustee of the charitable trust. RSA 7:19-a defines "financial interest" as "an interest in a transaction exceeding $500 in value for any officer, director, or trustee on an annual aggregate basis.[76] An "indirect" financial interest arises where the transaction involves a person or entity of which a director, officer, or trustee, or a member of the immediate family of a director, officer, or trustee, is a proprietor, partner, employee, or officer."[77]

All directors, officers, or trustees of the Parties must act in the best interest of each respective party, and avoid conflicts of interests or pecuniary benefit transactions. In connection with the Transaction, each member of the Boards of DHH and CMCHS delivered to the Attorney General certifications that any conflicts of interest or any pecuniary benefit transactions have been disclosed and have not affected the Parties' decision to engage in the Transaction ("Conflict Certificates"). The Attorney General reviewed the Conflict Certificates to determine whether the affiants acted in the best interest of the health care charitable trusts, engaged in any conflict of interest or pecuniary benefit transaction or anticipated receiving any benefit for supporting the Transaction.

In connection with his review of the Transaction, the Attorney General reviewed a transaction involving Jeff Eisenberg, former Chairman of the Board of Directors of CMC. Mr. Eisenberg served on the Board of Directors of CMC for two consecutive terms commencing January, 2004 and concluding January, 2010. Mr. Eisenberg participated in three actions of the Board of Directors of CMC to conditionally approve the Transaction. On December 23, 2009, Mr. Eisenberg acquired an ownership interest in Vital & Ryze Advertising, Inc. ("Vital"). Vital includes among its clients DHH. DHH was a client of Vital prior December 23, 2009.

The Attorney General has concluded that the transaction involving Mr. Eisenberg's acquisition of an ownership interest in Vital is not a pecuniary benefit transaction as defined by RSA 7:19-a. In addition, the Transaction was disclosed to legal counsel for CMC and its President prior to the time that the January, 2010 vote was taken and all actions taken were approved by a majority of disinterested board members. The Attorney General concluded that Mr. Eisenberg's acquisition of an ownership interest in Vital does not constitute a pecuniary benefit transaction or a conflict transaction that affected the decision to engage in the Transaction.

B. Excessive Compensation

The Attorney General also reviewed the employment agreements for certain executives of DHH and CMC. Salaries are disclosed annually to the Attorney General with the filing of IRS Form 990. The Parties have represented that there will be no changes to the compensation paid to any executive of DHH or any of the CMC Charities as a result of the Transaction. In addition, the Affiliation Agreement provides that after the consummation of the Transaction, CMCHS will utilize certain services of Alyson Pitman-Giles, CEO and President of CMC. The Affiliation Agreement provides that a Management Services Agreement be entered into by CMC and

[76] 7:19-a(I)(b).

[77] 7:19-a(I)(b)

CMCHS and that CMC be reimbursed for the portion of time Ms. Pitman-Giles devotes to CMCHS's operations. The Management Services Agreement does not change the terms of the employment relationship between CMC and Ms. Pitman-Giles set forth in her existing Employment Agreements.

CMC's Form 990 was due to the Attorney General on November 15, 2009 for the fiscal year ending June 30, 2009. CMC sought an automatic extension, and its Form 990 was not delivered until May 17, 2010. Based on the IRS Form 990s filed by CMC, the compensation of the President and CEO of CMC was as follows:

Fiscal Year	Compensation Alyson Pitman-Giles	Compensation as a % of Operating Revenue
2006	$540,736	0.28%
2007	$695,803	0.33%
2008	$907,604	0.38%
2009	$1,359,848	0.51%

A comparison of Ms. Pitman-Giles' total compensation with other hospital presidents in the region reveals that Ms. Pitman-Giles' compensation is significantly greater than her peers based on total compensation and as a percentage of operating revenue (See Exhibit 10 and Exhibit 11). The reasonableness of the compensation paid to Ms. Pitman-Giles is an area of significant concern to the Attorney General.

XII. RSA 7:19-B II(d) THE PROCEEDS TO BE RECEIVED ON ACCOUNT OF THE TRANSACTION CONSTITUTE FAIR VALUE THEREFORE

The Acquisition Act permits the Attorney General to consider whether the proceeds to be received on account of the Transaction constitute fair value. The Affiliation Agreement provides that no payment is being made by either Party in connection with the Transaction. Although no cash is being paid, consideration is being exchanged by CMCHS and DHH in connection with the Transaction. For example, as a result of the Transaction, CMCHS will gain access to a broader integrated health care delivery system. As discussed above, CMCHS' management views this access to be essential because of the challenges facing CMC. With regard to DHH, the Transaction allows DHH to bring its specialty services to more of New Hampshire's population and allows it to be better positioned to develop an accountable care organization. Without a hospital partner, DHH does not believe that it could economically afford to transition care from its Lebanon integrated delivery system to a non-integrated system in the greater Manchester area.

The Transaction will also result in DHH having direct and indirect access to certain CMCHS assets. As part of the Regional System, CMCHS will pay an annual assessment fee to DHH. The assessment fee will be a prorated amount equal to the expenses incurred by DHH to oversee the Regional System. DHH will also have access to the positive changes in net asset value attributable to the Transaction, referred to in the Affiliation Agreement as "Post-Affiliation Surplus." The Affiliation Agreement provides that as of the effective date of the Transaction, the Parties will determine the value of the consolidated net assets of CMCHS. After the effective

date, the Parties will track changes in the net asset value annually and attribute those changes to either non-affiliation related matters, such as investment return and mark-to-market adjustments on swap agreements, and matters related to the Transaction, such as the benefit which may be derived from hospital-based physician services or from administrative cost efficiencies (the "CMCHS Assets"). The positive changes in net asset value attributable to the transaction are referred to as "Post-Affiliation Surplus." The Parties have represented to the Attorney General that the CMCHS Assets will continue to be used to support the mission of the Manchester System. The Parties agree that DHH will only have the right to allocate Post-Affiliation Surplus within the Regional System through the annual budget or five-year capital plan provided such allocation is consistent with the Manchester System Financial Management, DHH Financial Principals and with the ERDs.

The Affiliation Agreement provides that the Parties will determine the value of the consolidated net assets of CMCHS as reported on its financial statement and track changes in net asset value annually and attribute those changes to either non-Affiliation related matters or Affiliation related matters. The annual calculation of Post-Affiliation Surplus is an area that affords the Parties a degree of discretion. The Affiliation Agreement does not include any oversight mechanism or audit mechanism to ensure that the discretion exercised by the Parties is reasonable. The Attorney General believes that the Parties must include additional protective measures to ensure that the Parties do not have the ability to abuse or manipulate the discretion afforded to them under the Affiliation Agreement with regard to calculation of the Post-Affiliation Surplus.

Based on the information provided to the Attorney General, the Attorney General has concluded that while the consideration exchanged in connection with the Transaction constitutes fair value, the Attorney General objects to the Transaction as there are insufficient safeguards in place to ensure that the calculation of the Post-Affiliation Surplus is not subject to manipulation or abuse by the Parties.

XIII. RSA 7:19-B II(e) ASSETS AND PROCEEDS SHALL BE DEVOTED TO CHARITABLE PURPOSES

The Acquisition Act permits the Attorney General to consider whether the assets of the health care charitable trusts and any proceeds to be received on account of the Transaction will continue to be devoted to charitable purposes consistent with the charitable objective of the charitable trust and the needs of the community which it serves. RSA 7:19-b, II(e). The analysis under RSA 7:19-b II(e) of the Acquisition Act requires the Attorney General to assess the deployment of the proceeds from the Transaction with regard to the health care charitable trust and the community.

A. Health Care Charitable Trusts

As discussed above, the Transaction will result in DHH becoming the sole member of the CMCHS and having control over certain aspects of the operations of CMCHS and its affiliates. In the Affiliation Agreement, the Parties have established certain mechanisms that are intended to allow CMCHS, CMC and AHS to retain the ability to oversee and manage the assets

generated by the Manchester System. These mechanisms include adherence to guidelines set forth in the Manchester System Financial Management, DHH Financial Principles (Exhibit 4), the segregation of the consolidated net assets of CMCHS as of the effective date of the Transaction from the Post-Affiliation Surplus, requirements set forth in the Affiliation Agreement that provide that the development of clinical and programmatic initiatives will be identified by the CMCHS management and Board, a reporting structure that provides that the CEO of CMCHS will report directly to the CMCHS Board, statements that the operating and capital budgets of CMCHS will be developed by the CMCHS Board subject to the approval by DHH (however, DHH will not have a "line item" veto over any annual or revised operating or capital budgets of CMCHS) and the restriction in the Affiliation Agreement that provides that DHH may not allocate the Post-Affiliation Surplus in a manner that is not consistent with the ERDs.

CMC and MHMH both have significant endowment funds and restricted institutional funds that are used to support the missions of their respective organizations. In addition, several of the organizations involved in the Transaction, including CMC, have other significant assets, including real estate and equipment. While DHH will gain some limited ability to influence the manner in which CMCHS' funds are expended, as described above, DHH does not have any right to direct how the CMC Charities' assets are allocated. The Affiliation Agreement specifically provides for the segregation of the assets of CMCHS as of the date the Transaction is consummated. The Parties have represented that there will be no changes to how they use their endowment and institutional funds, and that these funds will continue to be held in separate accounts controlled by the respective entities.

B. Community

The City of Manchester, is the largest urban community in northern New England, and has a diverse health care system that is comprised of both public and private health institutions.[78] The charity care provided by health and social service agencies is a critical component of this system. In 2009, the Healthy Manchester Leadership Council, a partnership chaired by the Manchester Health Department and composed of a number of Manchester area health and social service agencies (including CMC and DHC-M), prepared a community assessment titled "Believe in a Healthy Community" (the "Community Health Assessment").[79] The Community Health Assessment states:

> "The Manchester Health Service Area has the largest population and number of jobs, but also has the lowest average income levels in the State. …. Residents experience discrepancies in health and health care access there associated with their age, income, educational attainment and neighborhood."[80]

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[78] Bazos, *Believe in a Healthy Community, supra*, at 11.

[79] Pg. 1 Executive Summary

[80] *Id.*

The Community Health Assessment identifies many health related challenges facing the people of Manchester, including high rates of hospitalization of young children for acute Ambulatory Care Sensitive Conditions, obesity, increasing rates of mental health concerns, aging population, higher rates of heart disease, and disparity with regard to access to health care across income levels.[81] The Community Health Assessment also noted that poverty is greater in Manchester than in the rest of New Hampshire and that childhood poverty is growing[82]. The Community Health Assessment concludes that certain poor health outcomes and risk factors appear to have ties to income and that service providers in Manchester have seen increasing requests for assistance.[83]

CMC and DHC-M each provide a significant amount of health care services to the indigent, underserved and uninsured population of greater Manchester. CMC and DHC-M are each an essential part of the web of service providers that serve this population and any change to the scope or degree of charity care provided by CMC or DHC-M could have a dramatic impact on the overall Manchester health care system.[84]

CMCHS and DHH have represented that they are committed to continuing to provide health care services to all regardless of ability to pay or insurance coverage. The Parties believe that the proposed Transaction will put CMC and DHC-M in a better position to continue to serve the varied needs of the indigent and underserved in greater Manchester. The Transaction will allow DHH to continue to develop ways of serving patients that will allow the Parties to better coordinate out-patient and in-patient needs and allow for these services to be delivered more efficiently and effectively. CMCHS and DHH have represented to the Attorney General that they expect the creation of an integrated health care delivery system will provide the underserved with greater access to specialty care. The Parties also believe that the Transaction will allow for the development of more innovative health care delivery models, such as accountable care organizations which the Parties believe will enhance the delivery of health care.

Several organizations have expressed concern that certain DHC-M physicians will no longer provide women's health services at Elliot Hospital and the Manchester Community Health Center following the Transaction. DHC-M is the largest outpatient provider of women's health services in the greater Manchester area. In addition to obstetrics and gynecology services, DHC-M's connection to New Hampshire's only academic health system has provided Manchester with sub-specialists in the areas of urogynecology, gynecologic oncology, maternal fetal medicine, reproductive endocrinology, and genetic counseling. In connection with the Attorney General's review process, DHH has represented that it will continue to expand its women's health services in Manchester. Because the PSA has been revised to exclude those DHC-M services that do not comply with the ERDs, but specifically allows DHC-M physicians

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[81] *Id.* at 129-131.

[82] *Id.*

[83] *Id.*

[84] For fiscal years 2004 – 2006, the Manchester Community Health Center (MCHC), Dartmouth-Hitchcock Manchester, Child Health Services, The Mental Health Center of Greater Manchester, and the CMC and Elliot Hospital contributed a total of $133,023,926 in uncompensated care to the community.

to continue to provide these services (albeit outside the Manchester System) the Transaction will not cause a reduction in the availability of women's health services at DMC-M.[85]

Subject to the concerns raised earlier in this Report, the Attorney General believes that the safeguards and firewalls provided for in the Affiliation Agreement are sufficient to ensure that the assets that are currently held by the charitable trusts will continue to be devoted to the charitable purposes consistent with the charitable objectives of the health care charitable trust and the needs of the community which they serve.

C. Reasonable Public Notice Of The Transaction (RSA 7:19-b II(g))

The Acquisition Act permits the Attorney General to consider whether reasonable notice of the Transaction and its terms has been provided to the community served by the health care charitable trusts, along with reasonable and timely opportunity for such community, through public hearings or similar methods, to inform the deliberations of the governing bodies of the health care charitable trusts. The Parties have utilized various methods to provide the public with notice of the Transaction. RSA 7:19-b, II(g). The Parties established an internet website, http://www.ahealthiertomorrow.org, where Transaction documents were made available for review. The website allowed visitors to provide written comments regarding the Transaction. Three public forums were held, two in Manchester, on September 15, 2009 and November 16, 2009, and one in Lebanon, on October 8, 2009. The public forums were recorded and copies of the recordings were provided to each of the members of the Board of DHH and CMCHS for their consideration. The Parties also made copies of the transaction documents available at various locations in Manchester, Lebanon and Hanover. The Parties compiled the public commentary and posted responses to many of the issues raised by the public on the http://www.ahealthiertomorrow.org website. As a result of the comments received by the Parties, several amendments were made to the Affiliation Agreement and the PSA.

Based on the steps taken by the Parties to solicit and respond to public commentary regarding the Transaction, the Attorney General has concluded that the Parties have provided reasonable public notice of the Transaction to the communities served by the health care charitable trusts and reasonable and timely opportunity for interested members of the community, through public hearing or other methods, to inform the deliberations of the governing bodies of the health care charitable trusts regarding the Transaction.

XIV. OTHER APPROVALS PENDING OR REQUIRED

A. Approval Of The Roman Catholic Church

The Parties have sought the approval of the Transaction from the Bishop of Manchester. In a statement dated July 22, 2009, the Bishop of Manchester states that "he has begun to review the documents submitted to him concerning the Transaction and has given his conditional approval to move forward with the transaction." The Parties have certified to the Attorney General that the Transaction is consistent with Canon Law and provides the Bishop of

[85] It should be noted that termination of pregnancy services have never been provided by DHC-M.

Manchester with sufficient reserved powers to maintain the Catholic identity and fidelity to Catholic teaching and practice of the CMC Charities. The Parties have also certified that the Bishop of Manchester possesses the legal authority under Canon Law to approve the Transaction.

Based on the certification provided by the Parties, the Attorney General concludes that in order for the Transaction to comply with applicable law that the approval of the Bishop of Manchester is required.

B. Federal Trade Commission

The Parties filed a Notification and Report Form with the Federal Trade Commission ("FTC") under the Hart-Scott-Rodino Antitrust Improvement Act[86] on August 28, 2009.[87] On October 1, 2009, the FTC issued a "second request" to the Parties which required the Parties to produce a considerable amount of data and documents for the FTC's review. The Parties completed the submission of the response to the FTC "second request" on May 7, 2010. Unless extended by the parties, the FTC has thirty (30) days from May 7 to determine whether to contest the transaction. If the FTC fails to object or intervene on or before the expiration of the 30-day period, the Transaction may be consummated by the Parties.

Based on the information provided to the Attorney General, in order for the Transaction to comply with applicable law, the 30-day period following the completed submission by the Parties of the response to the FTC "second request" must lapse with no objection or intervention by the FTC or extension by the parties during this 30-day period, or such other final resolution that must be reached between the Parties and the FTC regarding the issues reviewed by the FTC.

C. New Hampshire Consumer Protection And Antitrust Bureau Of The Attorney General's Office.

The New Hampshire Consumer Protection and Antitrust Bureau of the Attorney General's Office (the "Antitrust Bureau") is obligated to engage in a review of the Transaction as it relates to RSA 356, the New Hampshire Combinations and Monopolies Act (the "Combinations Act"). Pursuant to RSA 356:14, the Combinations Act is to be interpreted in a manner consonant with the federal antitrust laws. Accordingly, the Antitrust Bureau has undertaken its review of this matter jointly with the FTC. Despite its joint review of the Transaction with the FTC, the Antitrust Bureau will make an independent determination of whether the Transaction is in accord with New Hampshire's antitrust laws.

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[86] The Hart-Scott-Rodino Antitrust Improvement Act of 1976 provides that parties to certain mergers or acquisitions notify the Federal Trade Commission and the Department of Justice before consummating the transaction. The parties must wait a specific period of time while the FTC reviews the transaction. The purpose of the review is to ensure that the proposed transaction complies with federal antitrust laws. If the FTC believes that a proposed transaction may violate the federal antitrust laws, it may seek an injunction in federal district court to prohibit consummation of the transaction.

[87] The FTC acknowledged receipt of a completed Notification and Report Forms on September 1, 2009.

Based on the information provided to the Attorney General, in order for the Transaction to comply with applicable law the Antitrust Bureau must determine that the Transaction is in accord with New Hampshire's antitrust laws.

D. Internal Revenue Service

On May 7, 2009, DHH submitted an Application for Exemption, Form 1023, and Private Letter Ruling request to the Internal Revenue Service ("IRS"). The private letter ruling requests that the IRS rule that: (1) the restructuring of the relationship among MHMH, DHC and CMC, including the formation of DHH, the addition of CMC to the system, and the potential future additions of other tax-exempt health care organizations will not adversely affect the continued tax-exempt status of DHC, MHMH or any other organization that may become a member of the system, (2) the proposed restructuring and the transfer of authority, responsibility and assets to it by MHMH, DHC, and CMC will not adversely affect the continued non-private-foundation status of MHMH, DHC, or CMC, and (3) the proposed restructuring will not give rise to the use of the proceeds of any outstanding tax-exempt bond issue for the benefit of MHMH, DHC or CMC by any person other than an organization described in Internal Revenue Code ("IRC") Section 501(c)(3) or for any purpose other than an exempt purpose, and will not cause any of the facilities financed by such tax-exempt bonds to be treated as used for any private business use within the meaning of IRC Sections 141(b) and 145(a). On October 13, 2009 DHH added the following additional requests to its private letter ruling request: (1) that the proposed restructuring will not adversely affect CMCHS's ability to continue to be listed in The Official Catholic Directory and will not adversely affect the continued tax-exempt status of CMCHS, (2) the proposed restructuring, including the appointment of DHH as the sole member of CMCHS with certain retained powers and the granting of certain retained powers over AHS to DHH will not adversely affect the continued tax-exempt status of CMC and AHS, (3) the proposed restructuring, including the appointment of DHH as the sole member of CMCHS with certain retained powers and the granting of certain retained powers over AHS to DHH will not adversely affect the continued non-private-foundation status (under IRC Sections 509(a) and 170(b)(1)(A)(iii)) of CMC and AHS, and (4) the proposed restructuring, including the appoint of DHH as the sole member of CMCHS with certain retained powers will not give rise to the use of the proceeds of any outstanding tax-exempt bond issue for the benefit of CMC by any person other than an organization described in IRC Section 501(c)(3) or for any purpose other than an exempt purpose, and will not cause any of the facilities financed by such tax exempt bonds to be treated as used for any private business use within the meaning of IRC Sections141(b) and 145(a).

Based on DHH's submission of an Application for Exemption and Private Letter Ruling request with the IRS, in order for the Transaction to comply with applicable law, DHH must receive a favorable ruling from the IRS determining that the creation of the Regional System and the affiliation of CMCHS with DHH will not jeopardize the tax-exempt status of CMCHS or the Manchester System members.

XV. CONCLUSION

In accordance with RSA 7:19-b, IV, the Attorney General must, "[w]ithin a reasonable time, not to exceed 120 days after receipt of the notice specified in the preceding paragraph...determine compliance with the standards set forth in paragraph II of this section and ... notify the parties either that [he] will take no further action with respect thereto, or that [he] objects to the transaction on specified grounds." The Attorney General makes the following findings:

1. The Attorney General objects under RSA 7:19-b, II(a) to the Transaction on the grounds the Transaction is not permitted by applicable law. The Transaction will result in DHH obtaining control over core functions of the CMC Charities, which until this point have operated as an independent Catholic hospital. The Attorney General concludes that the Transaction will result in a profound change in the governance structure of the CMC Charities and diminish the fiduciary duties of the Boards of Directors of the CMC Charities which will inhibit the ability of the CMC Charities to carry out their charitable missions. The Attorney General also concludes that Probate Court approval of this transfer of control would be necessary in order to be permitted under New Hampshire law. .

2. Based on the information provided by the Parties, the Attorney General concludes that the Parties have not provided adequate information upon which the Attorney General can determine whether it exercised due diligence in determining the effect of the Transaction on the cost of delivering care. For that reason, the Attorney General objects.[88]

3. Under RSA 7:19-b, II(d), the Attorney General has concluded that while the consideration exchanged in connection with the Transaction constitutes fair value, the Attorney General objects to the Transaction as there are insufficient safeguards in place to ensure that the calculation of the Post-Affiliation Surplus is not subject to manipulation or abuse by the Parties.

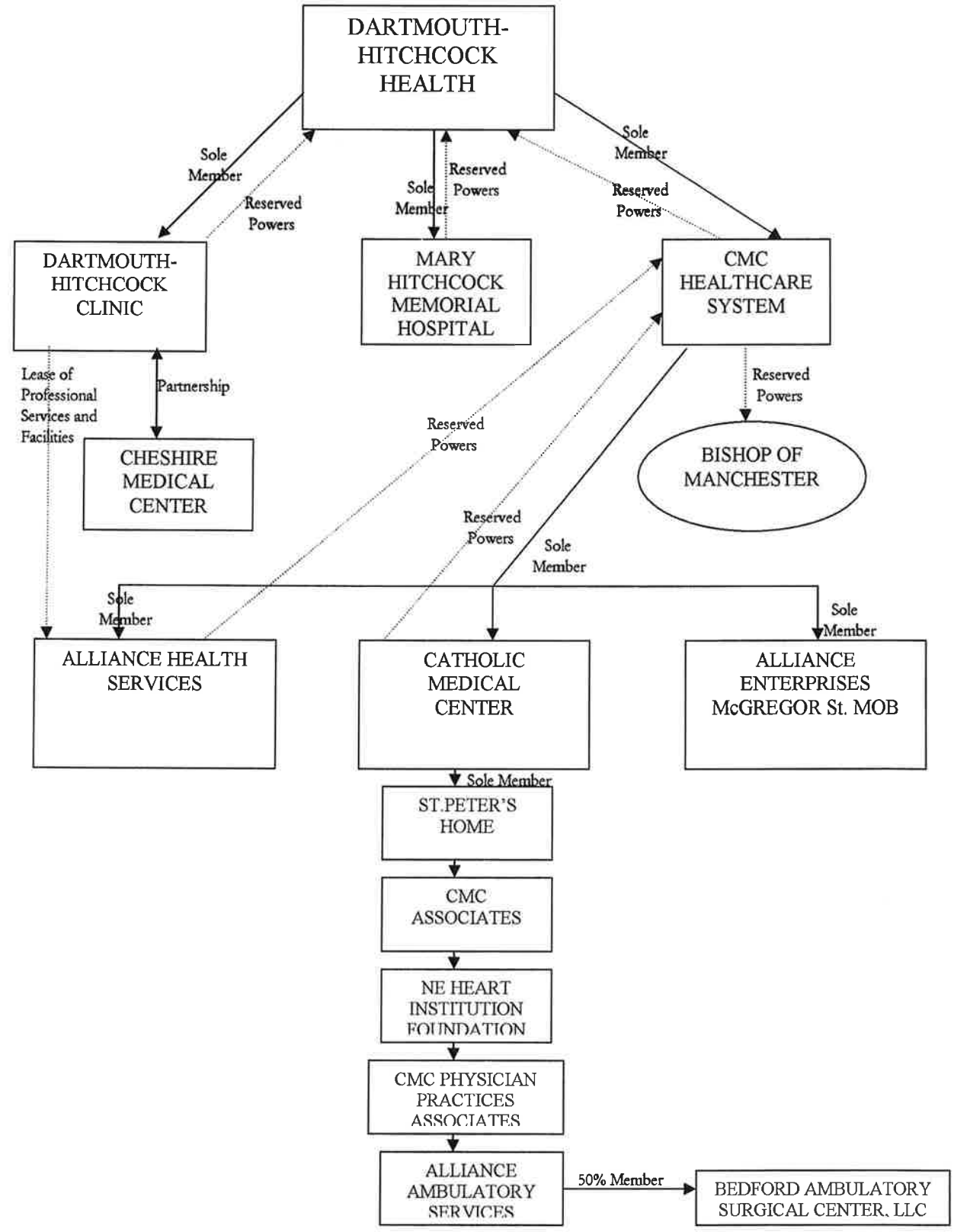
4. The Transaction remains subject to approval of the Bishop of Manchester, Federal Trade Commission, the Consumer Protection and Antitrust Bureau and Internal Revenue Service. To the extent those approvals are not obtained, the Attorney General objects in accordance with RSA 7:19-b, II(a) on the grounds the Transaction is not permitted by applicable law.

In addition to the Parties, copies of this Report will be delivered to the Governor, Speaker of the House and the Senate President.

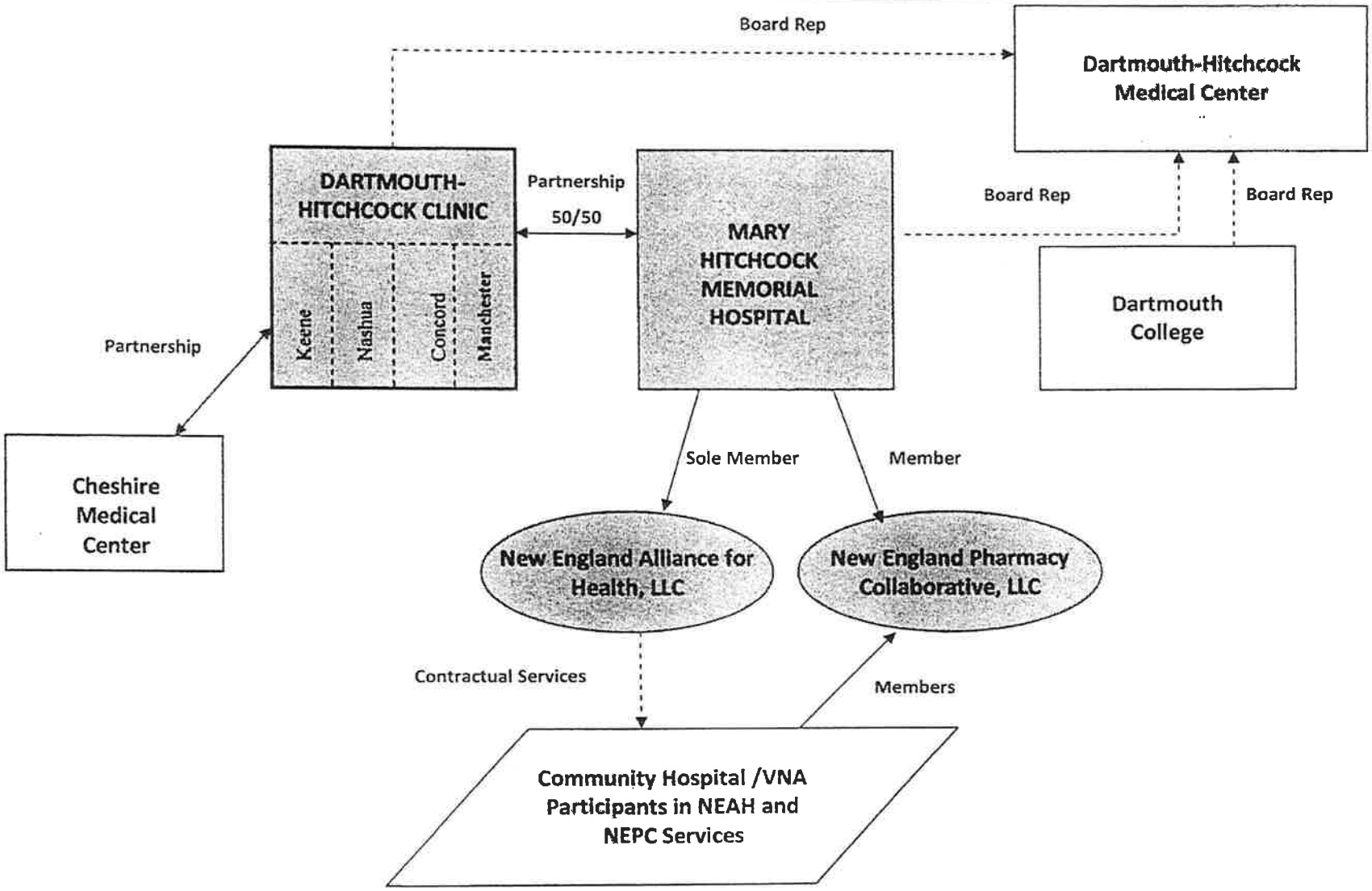
[88] As is referenced in Section XIV (Other Approvals), a separate antitrust evaluation is being performed, and the effect on health care costs in the community is subject to review and analysis within the context of the antitrust review.

EXHIBITS

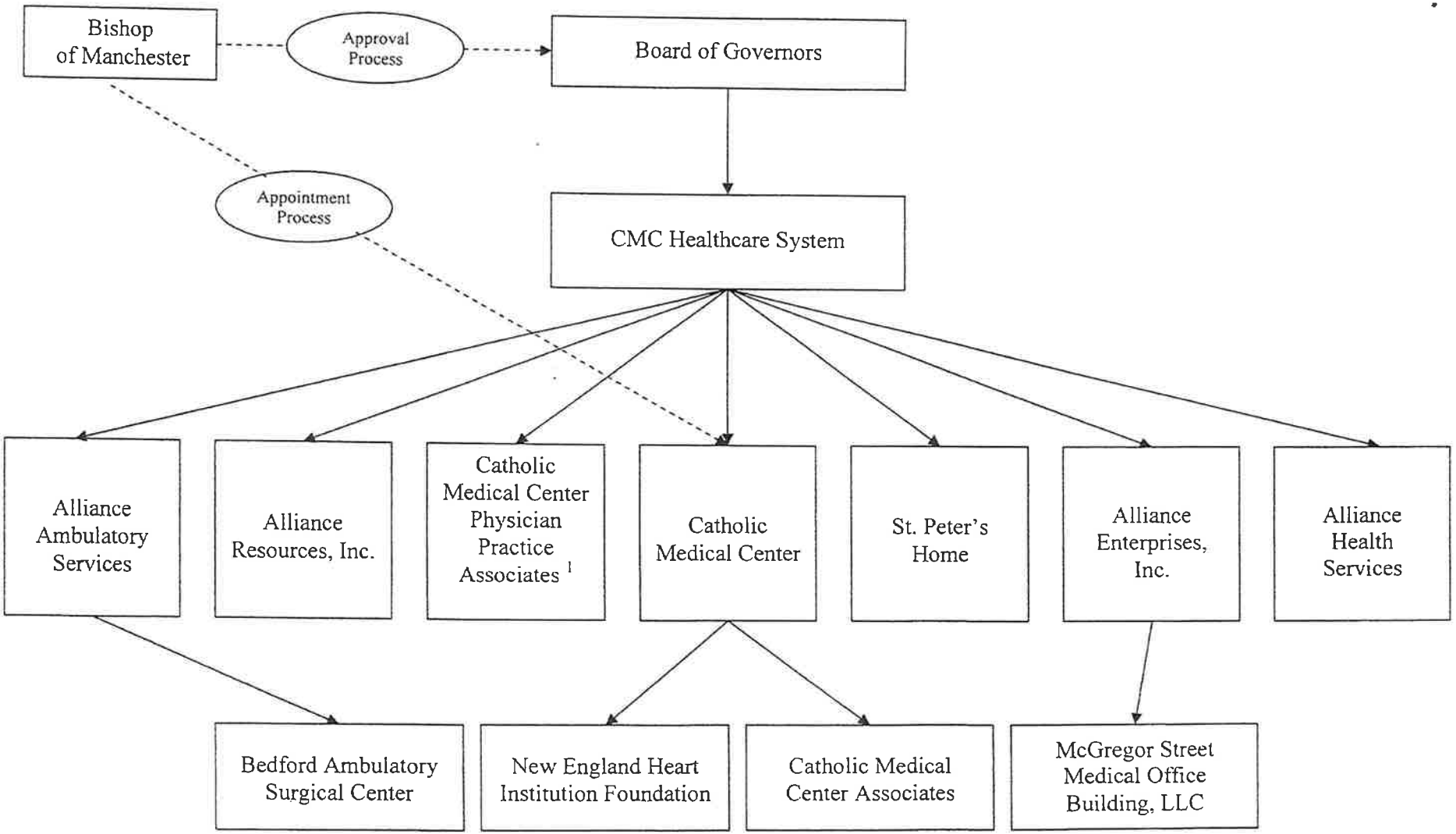
DHH-CMCHS Proposed Affiliation Structure



Basic Dartmouth-Hitchcock Structure (as of 1/1/09)



CMC HEALTHCARE SYSTEM
CURRENT CORPORATE STRUCTURE



1 - NEHI is a division of CMC PPA

EXHIBIT 3.8
Manchester System Financial Management

DARTMOUTH-HITCHCOCK HEALTH
(DHH)

Financial Principles

INTRODUCTION

Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital have a 75 year history of working collaboratively to optimize each other's ability to meet the needs of the population which they serve. In recent years, this relationship has evolved into Dartmouth-Hitchcock, two legal entities working together as one economic unit to fulfill a single mission and, most recently, to achieve a vision of the healthiest population possible. Recognizing that forging substantive relationships with other health care providers is a requirement to fully realizing this vision, DHH was formed to support the creation of a regional integrated health care delivery system.

It is important to note that optimizing the population's health within a given region is not necessarily the same as maintaining or expanding the existing health care delivery system. DHH is committed to improving the health of the population; to being a good steward of its resources and those within the community; and to ensuring the optimal deployment of those collective resources to achieve the greatest value for the community. These financial principles have been developed to guide the DHH Leadership in achieving these goals.

PURPOSE

This document sets forth financial principles to be generally utilized by DHH organizations in developing long-term financial plans, annual operating and capital budgets and in conducting their financial affairs.

These financial principles have been developed to provide a basis for the DHH organizations to evaluate their financial position, establish financial objectives, and create financial plans that provide for future operating and capital needs and achieve financial objectives. In short, following these principles will help to ensure the long-term financial health of DHH and the Regional Provider Organizations.

DHH recognizes that these financial principles reflect its understanding of financial planning and operating practices which should be utilized. It also understands that regulators and others may have differing views. It is DHH's responsibility to communicate the logic and rationale of these concepts to other parties and in the case that DHH does not follow them, to analyze the impact of those decisions on DHH's future financial position.

The DHH Board of Trustees (or appropriate Committee) will employ these principles in the review and approval of Regional Provider Organization annual budgets and long-term financial plans and projects. These principles will also be helpful in presenting and explaining our financial plans to regulators, bond holders, rating agencies and others.

I. GENERAL FINANCIAL PRINCIPLES

A. DHH will strive to maintain an actual (if applicable) or a shadow credit rating equivalent to Standard & Poor's A+ rating or higher as reflected by financial ratios and credit market analysis. Individual Regional Provider Organizations will establish a goal of achieving and maintaining the following targets for their overall financial condition:

1. D-H will strive to achieve and maintain an "A+" actual (if applicable) or shadow rating; and

2. Other Regional Provider Organizations will strive to achieve and maintain an "A-" actual (if applicable) or shadow rating.

B. DHH organizations should maintain working capital reserves rather than relying on external lines of credit or Regional System support to finance operations.

C. Debt should be issued when it is most economical to borrow and with consideration for future capital project needs over time.

1. Tax-exempt debt generally remains the least costly means to finance capital expenditures. The establishment of an Obligated Group (or Groups) will be utilized as appropriate to maximize access to capital markets at the lowest cost possible.

2. Borrowings through a DHH Revolving Loan Program (should one be developed) will require a financial analysis which reflects reasonable assumptions and an ability of the borrower to repay the loan according to the original terms.

3. Equipment leases should only be used when they result in lower financing costs compared to other alternatives or when they improve the ability to manage technological obsolescence.

4. Operating leases should be considered for financing real estate that is used for non-core purposes or programs with unpredictable long-term funding sources.

D. Significant new program, facility and equipment investments proposed by Regional Provider Organizations will be reviewed to ensure a full understanding of the immediate and long-term financial impacts of the proposal.

II. PRINCIPLES FOR LONG-TERM FINANCIAL PLANNING

A. Organizations should periodically assess the adequacy of their financial position. They should calculate financial indicators and compare them to minimum acceptable levels and target levels. Minimum or maximum acceptable levels have been established for five key ratios as follows:

Ratio	Capital Intensive	Non- Capital Intensive
▪ Debt Service Coverage - Annual	Minimum of 2x	(same)
▪ Days Cash on Hand	Minimum of 100	Minimum of 45
▪ Debt-to-capitalization	Maximum of 50%	(same)
▪ Days in A/R, net	Maximum of 70	(same)
▪ Average Age of Fixed Assets	Maximum of 12	(same)

B. Financial objectives should be established by the Regional Provider Organization Boards based on their evaluation of the adequacy of current financial position and projected financial requirements.

1. Minimum and maximum levels of liquid and unencumbered assets ("reserves") should be established by the Board. Appropriate levels of conservatism should be considered when establishing reserves, or committing funds to various operating and strategic purposes. Specific financial objectives should be established if any reserves are not minimally adequate.

2. Organizations should maintain reserves sufficient to maintain their facilities and equipment and to handle unanticipated cash flow requirements. Reserve levels should be based on the following:

   a) Equipment replacement reserves should be at least equal to 100% of accumulated equipment depreciation.

   b) Plant replacement reserves should be at least equal to 40% of accumulated facility depreciation.

   c) Other specific reserves should be identified where appropriate.

   d) The adequacy of general undesignated reserves should be based on the evaluation of funds for general purposes and the evaluation of contingencies and provisions for uncertainties.

C. A Five Year Financial Plan should be prepared and/or updated annually and projections compared to financial objectives.

1. Cash provided from operations reflected in the Five Year Plan should be adequate to cover the following:

   - Equipment and plant replacement and/or reserve funding
   - New technology
   - Debt retirement, including funding of sinking funds for the retirement of debt
   - Working capital needs
   - Provision for certain strategic initiatives
   - Funding requirements for defined benefit plans

2. If capital and strategic reserves are inadequate, non-operating income should be added to reserves until adequate levels are reached.

3. If capital and strategic reserves are adequate, consideration should be given to using non-operating income (including unrestricted income earned on permanently restricted funds via an endowment spending policy) for investing in mission related objectives.

III. PRINCIPLES FOR ANNUAL OPERATING AND CAPITAL BUDGETS

A. Each year, the budgeted operating margin will approximate the operating margin projected in the current Five Year Financial Plan.

B. A level of conservatism sufficient to accommodate normal variation in market conditions and errors in estimates shall be incorporated into the annual operating budget in order to achieve financial objectives in normal situations. Organizations with a less than desired financial position should incorporate additional levels of conservatism to increase the probability of attaining their financial goals. All organizations should meet their budgeted operating margins at least 75% of the time (i.e. 3 out of 4 years).

C. Impacts of current budgeting decisions on future periods must be considered.

   a) Pricing of products and services should be consistent with the organization's overarching strategy and be based on an understanding of costs, competition, and consumer expectations.

   b) Employee compensation should be set at levels appropriate to attract and retain skilled personnel.

   c) The organization should annually and systematically replace equipment and maintain facilities.

D. Non operating income should generally not be used to support operations unless specifically justified.

AFFIDAVIT OF AMENDMENT OF
CATHOLIC MEDICAL CENTER
A NEW HAMPSHIRE NONPROFIT CORPORATION

Form No. NP 3
RSA 292:5 & 7

ARTICLE VI

Each of the following actions of the Corporation must be approved by the Board of Trustees of its Sole Member (as defined in Article VIII (the "CMCHS Board") and, where applicable and as set forth in the Sole Member's Articles of Agreement and Bylaws, by either or both Dartmouth-Hitchcock Health ("DHH") and/or the Bishop of the Roman Catholic Diocese of Manchester (the "Bishop"):

1. *Amendments of Articles of Agreement.* Any proposed amendment or repeal of the Articles of Agreement of the Corporation which proposed amendment or repeal would (i) impact the powers reserved to the Sole Member in this Article VI, or (ii) reasonably be expected to have any material strategic, competitive or financial impact on one or more of the provider organizations in the Manchester System (of which CMCHS is the sole member) or in the Manchester System as a whole;

2. *Changes to Mission or Ethical and Religious Standards of the Corporation.* Any change in the mission, objectives or purposes of the Corporation or its ethical and religious standards;

3. *Appointment or Removal of Directors.* The appointment or removal of each Director of the Corporation;

4. *Appointment of President and Chief Executive Officer.* The appointment and termination of the Corporation's President and Chief Executive Officer;

5. *Operating and Capital Budgets.* The final adoption of, and any deviation in a Material Amount from, the annual and any revised operating and capital budgets of the Corporation. For purposes of these Articles, the term "Material Amount" will mean a dollar amount equal to or greater than the capital expenditure threshold for acute care facilities set forth in New Hampshire RSA 151-C:5(II)(a) as adjusted for inflation from time to time by the Health Services Planning and Review Board;

6. *Conveyance of Assets; Indebtedness.* Any conveyance, purchase, sale or lease of, or grant of mortgages, trust deeds or creation of other liens or encumbrances on, real property assets of the Corporation in excess of a material amount or any conveyance of any assets of the Corporation (other than real property assets) or the incurring of any indebtedness (other than any such indebtedness secured by real property assets) which exceeds a material amount;

7. *Clinical Service or Programs.* Any elimination or addition of any material health care service or program proposed by the Corporation;

8. *Merger or Acquisition.* Any merger with or consolidation of the Corporation into

another entity, or the acquisition by the Corporation of substantially all of the assets of another entity which may have a material effect on the Manchester System, or the sale or lease of substantially all of the assets of the Corporation to any person or entity;

9. *New Affiliations*. Any creation of an affiliate or subsidiary organization, or any affiliation of the Corporation with any other entity for the purpose of the joint conduct of business or other programs, whether in the form or participation in a corporation (either through the holding of stock or membership), partnership, joint venture, co-tenancy or any other form of ownership or control; and

10. *Dissolution*. The dissolution or liquidation of the Corporation.

11. *Information to be Furnished to the Member*. The Corporation will provide the Sole Member with such information as the Sole Member may reasonably request to fulfill its role as the integrator of the Manchester System, including without limitation financial statements, budgets, strategic plans and quality improvement plans.

ARTICLE VII

1. These Articles of Agreement may be amended or repealed by a two-thirds vote of the members of the Corporation's Board of Directors. Any such amendment or appeal which may (a) impact the powers reserved to the Sole Member in the Corporation's Articles, or (b) reasonably be expected to have any material strategic, competitive or financial impact on one or more entities of which the Sole Member is the sole member or on the integrated health care delivery system managed by the Sole Member as a whole, must be approved by a majority vote of the CMCHS Board.

2. At all times this Corporation shall be operated in accordance with the canon law of the Roman Catholic Church promulgated by the Supreme Roman Pontiff and the teachings of the Roman Catholic Church enunciated by the Holy See as well as with the Ethical and Religious Directives for Catholic Health Care Services promulgated by the United States Conference of Catholic Bishops, as amended from time to time. In regard to the foregoing, the Corporation shall, in all such matters, rely upon and defer to the teaching, ruling and sanctifying authority of the Roman Catholic Bishop of Manchester who shall monitor the implementation of and compliance with the Ethical and Religious Directives for Catholic Health Care Services, whether directly or by delegation of authority, in such manner as he deems appropriate.

CONFIDENTIAL AND PRIVILEGED COMMON INTEREST MATERIALS
Final Draft: *To Be Executed at Closing*

SECOND AMENDED AND RESTATED BYLAWS

OF

ALLIANCE HEALTH SERVICES

ARTICLE I
NAME, BUSINESS ADDRESS AND PURPOSES

The name of the corporation is Alliance Health Services (the "Corporation"). The business address and purposes of the Corporation are as set forth in the Articles of Agreement as amended from time to time.

ARTICLE II
MEMBER AND RESERVED POWERS

Section 1. Member. The sole Member of the Corporation is CMC Healthcare System, a tax-exempt New Hampshire voluntary corporation with a principal place of business in Manchester, New Hampshire ("CMCHS"). CMCHS also is the sole member of Catholic Medical Center and manages and operates an integrated health care delivery system in the Greater Manchester, New Hampshire service area (the "Manchester System"), in which the Corporation is a participant. The sole member of CMCHS is Dartmouth-Hitchcock Health, a tax-exempt New Hampshire voluntary corporation ("DHH"), which manages and operates a regional integrated health care delivery system in the Northern New England service area (the "Regional System"), in which CMCHS is a participant.

Section 2. Powers Reserved to CMCHS. Each of the following actions of the Corporation must be approved by the CMCHS Board of Trustees (the "CMCHS Board") and, where applicable and as set forth in the CMCHS Articles and Bylaws, by either or both DHH and/or the Bishop of the Roman Catholic Diocese of Manchester (the "Bishop"):

2.1. *Amendments of Articles of Agreement and Bylaws.* Any proposed amendment or repeal of the Articles of Agreement or Bylaws of the Corporation which proposed amendment or repeal would (i) impact the powers reserved to CMCHS in this Article II, Section 2, or (ii) reasonably be expected to have any material strategic, competitive or financial impact on one or more of the provider organizations in the Manchester System (of

which CMCHS is the sole member) or in the Manchester System as a whole;

2.2. *Changes to Mission or Ethical and Religious Standards of the Corporation.* Any change in the mission, objectives or purposes of the Corporation or its ethical and religious standards;

2.3. *Appointment or Removal of Trustees.* The appointment or removal of each trustee of the Corporation;

2.4. *Appointment of Chief Physician Executive.* The appointment and termination of the Corporation's Chief Physician Executive;

2.5. *Operating and Capital Budgets.* The final adoption of, and any deviation in a Material Amount from, the annual and any revised operating and capital budgets of the Corporation. For purposes of these Bylaws, the term "Material Amount" will mean a dollar amount equal to or greater than the capital expenditure threshold for acute care facilities set forth in New Hampshire RSA 151-C:5(II)(a) as adjusted for inflation from time to time by the Health Services Planning and Review Board;

2.6. *Conveyance of Assets; Indebtedness.* Any conveyance, purchase, sale or lease of, or grant of mortgages, trust deeds or creation of other liens or encumbrances on, real property assets of the Corporation in excess of $1 million or any conveyance of any assets of the Corporation (other than real property assets) or the incurring of any indebtedness (other than any such indebtedness secured by real property assets) which exceeds $1 million;

2.7. *Clinical Service or Programs.* Any elimination or addition of any material health care service or program proposed by the Corporation;

2.8. *Merger or Acquisition.* Any merger with or consolidation of the Corporation into another entity, or the acquisition by the Corporation of substantially all of the assets of another entity which may have a material effect on the Manchester System, or the sale or lease of substantially all of the assets of the Corporation to any person or entity;

2.9. *New Affiliations.* Any creation of an affiliate or subsidiary organization, or any affiliation of the Corporation with any other entity for the purpose of the joint conduct of business or other programs, whether in the form or participation in a corporation (either through the

holding of stock or membership), partnership, joint venture, co-tenancy or any other form of ownership or control; and

2.10. *Dissolution.* The dissolution or liquidation of the Corporation.

Section 3. Information to be Furnished to the Member. The Corporation will provide CMCHS with such information as CMCHS may reasonably request to fulfill its role as the integrator of the Manchester System, including without limitation financial statements, budgets, strategic plans and quality improvement plans.

ARTICLE III
BOARD OF TRUSTEES

Section 1. Number and Composition. The Board of Trustees will be responsible for governing the Corporation, and will be comprised of seventeen (17) seats. To ensure that the Board of Trustees is representative of and responsive to its role within the Manchester System, the Board of Trustees will be composed as follows:

1.1 *Ex Officio Members.* The following individuals will serve on the Corporation's Board of Trustees *ex officio*, with full voting rights: (a) the CMCHS Chief Physician Executive; (b) the Medical Director of the Corporation or, if the same individual holds the office of CMCHS Chief Physician Executive and the Corporation's Medical Director, then the Associate Medical Director of the Corporation; (c) the Dartmouth-Hitchcock Vice President of Community Group Practices; (d) the CMCHS President and Chief Executive Officer; (e) the Dartmouth-Hitchcock Clinic President; and (f) the Catholic Medical Center Physician Practice Associates Medical Director. If any of the above offices are renamed or reorganized, the holder of the successor office will serve on the Corporation's Board of Trustees.

1.2 *Elected Members.* The remaining members of the Board of Trustees will be elected by the Corporation's Board of Trustees from a slate of candidates determined as follows:

(a) Two (2) members will be nominated by the Dartmouth-Hitchcock Manchester Board of Governors;

(b) Five (5) members will be nominated by the Dartmouth-Hitchcock Clinic Board of Trustees; and

Category 2 Procedures

2.1 With respect to the procedures and activities performed in this Category 2, it must be made clear to patients the DHM health care provider is not acting as an agent of Catholic Medical Center or the Manchester System. A mutually agreed upon disclaimer will be created by CMCHS and DHM. This disclaimer will be published electronically on websites, displayed at appropriate DHM locations and be included in any general information packets given to all patients and especially obstetrical patients.

2.2 No referral for abortions are allowed. Any counseling that mentions abortion may only be in response to a request from a patient and can only give general contact information pursuant to the Preamble.

2.3 The listing of the procedures and activities in this Category 2 is simply a recognition of procedures and activities that preexisted the Manchester System and continue to be offered at DHM facilities but outside of the Manchester System. The listing is a current complete list of Category 2 procedures done at DHM facilities. A procedure will be adopted to review any contemplated new procedures to determine what category it would belong to pursuant to Exhibit A of the Restated Professional Services Agreement.

2.4 Direct sterilization procedures (tubal ligation, vasectomy).

2.5 Semen analysis.

2.6 Intrauterine Insemination (IUI).

2.7 Non directive genetic counseling to discuss with couples diagnostic tests available to identify syndromes/conditions in affected fetuses. If and when syndromes/conditions are identified, nondirective counseling about options available including treatment in utero or after birth if possible, care of an affected child after birth, termination of pregnancy (only if requested by patient/couple and subject to the Preamble), use of donor sperm or eggs, or the choice not to have children.

2.8 Counseling families about management of pregnancy at the lower limit of viability and acceding to family wishes for no obstetrical intervention and no neonatal resuscitation acceding to family decisions of nonintervention for severe fetal abnormalities consistent with federal law and/or regulations and when treatment offers no reasonable hope of benefit or poses and excessive burden.

2.9 Counseling about sterilization procedures.

2.10 Counseling about all methods of contraception including emergency contraception.

2.11 Contraception: placing intrauterine or implantable devices, providing prescriptions for medical contraception, emergency contraception, use of barrier methods for all ages regardless of marital status, permanent sterilization.

2.12 Fertility sparing or fertility preserving procedures for patients with cancer including ART for patients completing cancer therapy other the IVF or any IVF-based procedures.

2.13 Counseling leading to, but not the performance of, In Vitro Fertilization, Itra-Cytoplasmic-Sperm injection (ICSI), Embryo freezing (FET), Donor oocytes, Donor embryo, Gestational carrier, and subsequent pregnancy care.

Category 3 Procedures

3.1 The listing of the procedures and activities in this Category 3 is simply recognition of procedures and activities that have not and will not be performed at the DHM facilities. The listing does not in any way establish them. It is understood and agreed by the Parties that the procedures identified in this Category 3 will not be offered at the DHM Facilities even outside of the Affiliation.

3.2 Prescriptions for drugs such as RU-486 (Mifepristone) for medical abortions.

3.3 Performing any direct termination of pregnancy.

3.4 In Vitro Fertilization (with cryopreservation, embryo discarding, donation and research on excess embryos, Intra-Cytoplasmic-Sperm Injection (ISCI), Embryo freezing (FET), Donor oocytes, Donor embryo, Gestational carriers.

3.5 Research on donated sperm, eggs, embryos.

EXHIBIT 3.5

Reserved Powers of the Roman Catholic Bishop of Manchester Over CMCHS

Although many of the reserved powers of the person who holds the office of the Bishop of the Roman Catholic Diocese of Manchester are delegated to the Board of Trustees of CMC Healthcare System ("CMCHS"), the following actions require the express approval of the Bishop of the Roman Catholic Diocese of Manchester before they can be effective and implemented:

1. Any repeal, alteration or amendment of the Articles of Agreement or Bylaws of CMCHS;

2. Any change in the philosophy, objectives or purposes of CMCHS or its ethical or religious standards;

3. Any conveyance, purchase, sale or lease of, or grant of mortgages, trust deeds or creation of other liens or encumbrances on, real property assets of CMCHS or those of its Subsidiaries[1] with a fair market value in excess of the maximum amount approved by the Holy See for the United States of America[2] or any conveyance of any non-real property assets of CMCHS or those of its Subsidiaries or the incurring of any general indebtedness by CMCHS or those of its Subsidiaries which exceeds the same maximum amount;

4. The appointment of each elected trustee of CMCHS as described in section 3.6.4 of the Affiliation Agreement between CMCHS and DHH dated July 22, 2009, as amended by the First Amendment to Affiliation Agreement dated January 20, 2010 (the "Affiliation Agreement");

5. The removal of any elected trustee of CMCHS;

6. The appointment of the President and Chief Executive Officer of CMCHS as described in section 3.7.1 of the Affiliation Agreement;

7. The removal of the President and Chief Executive Officer of the CMCHS;

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[1] The term "Subsidiary" means any voluntary corporation over which either CMCHS or Catholic Medical Center serves as sole member or in the case of other forms of entities, where either CMCHS or Catholic Medical Center exercises control over the organization.

[2] The approved amount is $5,000,000, indexed according to the cost-of-living index. For 2008-2009, the maximum amount is fixed at $5,699,000.

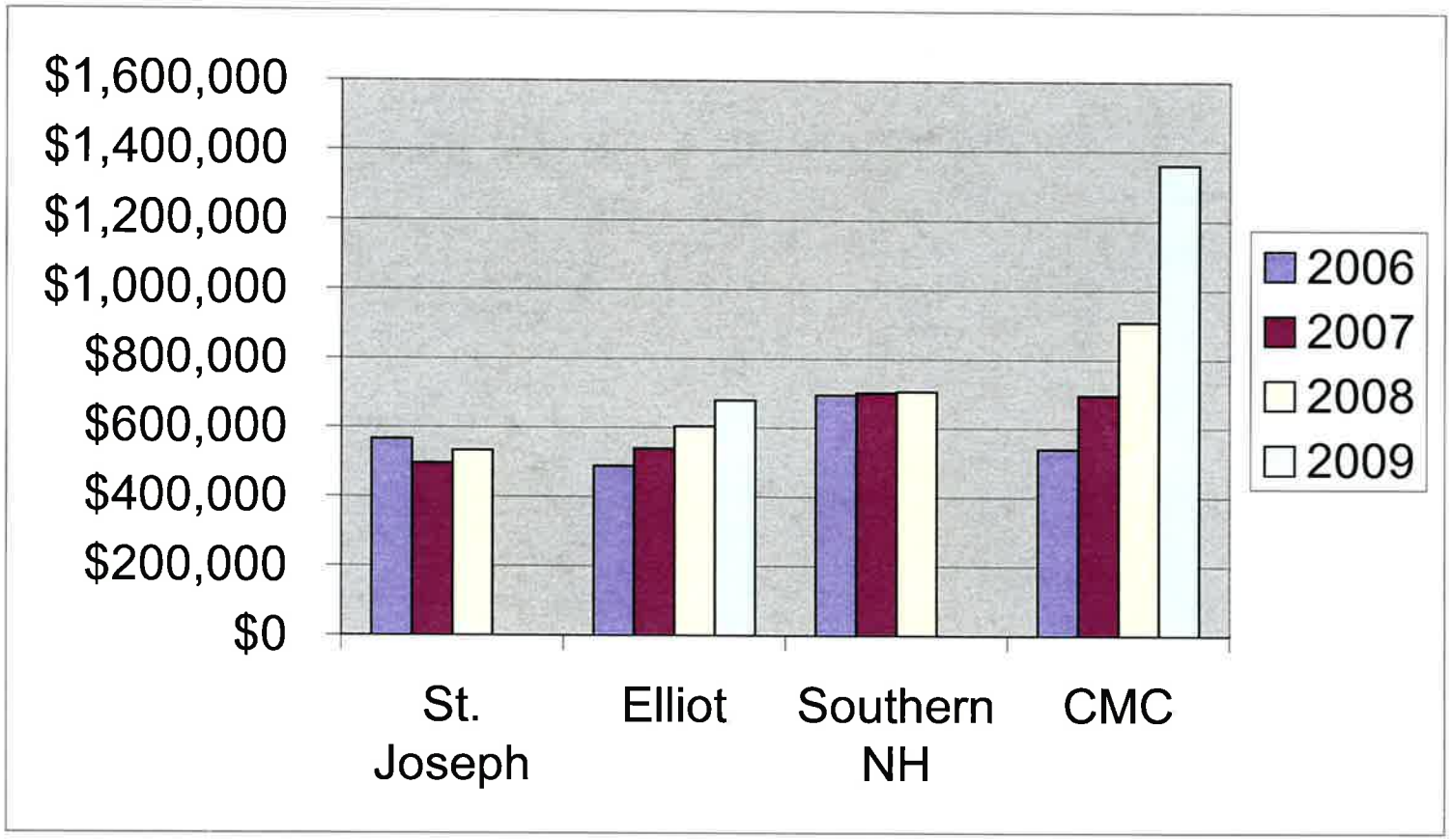
8. Any merger with or consolidation of CMCHS or any of its Subsidiaries into another entity, or the acquisition by CMCHS or any of its Subsidiaries of substantially all of the assets of another entity or the sale or lease of substantially all of the assets of CMCHS or any of its Subsidiaries to any person or entity;

9. Any creation by CMCHS or one of its Subsidiary organizations of an affiliate or subsidiary organization, or any affiliation of CMCHS or any of its Subsidiaries with any other entity for the purpose of the joint conduct of business or other programs, whether in the form of or participation in a corporation (either through the holding of stock or membership), partnership, joint venture, co-tenancy or any other form of ownership or control; and

10. The dissolution or liquidation of CMCHS.

At all times, CMCHS and its Subsidiaries shall be operated in accordance with the Canon Law and teachings of the Roman Catholic Church as well as with the *Ethical and Religious Directives for Catholic Health Care Services*, issued by the United States Conference of Catholic Bishops, as amended from time to time. In regard to the foregoing, CMCHS shall, in all such matters, rely upon and defer to the authority of the Bishop of the Roman Catholic Diocese of Manchester who, in such manner as he deems appropriate -- whether directly or by delegation of authority -- shall monitor CMCHS' implementation of and compliance with the *Ethical and Religious Directives for Catholic Health Care Services*.

CEO Compensation



CEO Compensation as % of Operating Revenue