NOTICE OF MATERIAL CHANGE TRANSACTION
FILED BY ADVENTIST HEALTH SYSTEM/WEST
Supplemental Information Packet
January 18, 2023

Responses to Requests for Additional Documentation

1. Revised NPI List

Attached to this letter as **Exhibit A** is a revised NPI list that includes the NPIs associated with Adventist Health Portland and Adventist Health Tillamook, as well as the organizational and facility-level NPIs associated with Adventist's Oregon-based operations. The NPI list also includes the NPIs for MCMC's physicians and other providers.

2. Feasibility Study

Attached to this letter as **Exhibit B** is a copy of the feasibility study report referenced in subsection 2.6(d) of the letter of intent filed in connection with the Proposed Transaction. Because the report contains sensitive and confidential trade secrets, including, without limitation, financial and market share data, Adventist and MCMC have designated it as "CONFIDENTIAL", to be used by the OHA and the Department solely for purposes of evaluating the merits of the Proposed Transaction. It may not be shared publicly.

3. PowerPoint Presentation

Adventist and MCMC hereby grant permission for the OHA to post the full PowerPoint presentation, a copy of which is attached as **Exhibit C**, on the HCMO website along with the Notice of Material Change Transaction form.

Responses to Requests for Additional Information

1. Please provide an approximate date for when you expect the definitive agreement to be finalized and provided to OHA.

The parties expect to provide a finalized copy of the definitive agreement to the OHA on or about January 31, 2023.

2. Please provide additional information about how Adventist plans to spend the $100 million capital investment in MCMC. What specific projects are planned, how much will be allocated to each project, and what is their expected timing? Please describe the next steps in planning for these investments. How will decisions be made and how will community input be incorporated into these plans?

Adventist has agreed to invest $100 million in MCMC during the ten years immediately following the closing of the Proposed Transaction. The exact timing for allocation of this investment is subject to MCMC's economic performance and prevailing needs. However, up to $6 million of the investment will be spent in the first two years after closing on those capital needs deemed most urgent by the President of MCMC and the Oregon Network President of Adventist. These needs include urgently-needed major medical equipment to be put into service on MCMC's main campus.

A majority of the remaining portion of the investment—approximately, $94 million—will be used: (i) to revitalize and make long-term improvements to the facilities at MCMC's main healthcare campus in The Dalles, (ii) to finance strategic expansions for the benefit of MCMC, (iii) to purchase equipment and information technology software or systems, or finance capital projects costing $500,000 or more, or (iv) to develop new healthcare facilities for MCMC.

To identify specific projects on which the $100 million (or $94 million, as the case may be) will be spent, and to create a timeline for implementation of those projects, the parties have agreed to convene a capital committee. This committee, which will include representatives of the MCMC executive team, medical staff, and community board, is charged with devising a plan or budget for the allocation of the investment over the 10-year investment window. Adventist's corporate board will have the ability to modify this plan.

3. When will decisions be made about possibly building a new hospital versus refurbishing the existing one? It has been reported that in late 2021, MCMC had plans to build a new hospital financed through a loan. Why was this plan abandoned?

Several years ago, MCMC recognized the need to refurbish or replace its existing hospital, which was originally constructed in 1959. The organization's hope at the time was to be able to finance the needed construction through operating revenues, investment returns, and charitable contributions. MCMC initiated some preliminary planning and engagement with the community about the potential for a new hospital.

As it was considering its facility needs, MCMC's net cash from operating activities declined to a negative $5.73 million in 2021, from a positive $28.2 million in 2020. Net cash from investing activities fell to a negative $2.7 million in 2021, from a negative $2.46 million in 2020. These financial results did not support immediate, debt-financed construction of a new campus.

Confronting these access-to-capital and other financial challenges, MCMC concurrently evaluated whether to remain independent or to seek an affiliation with a large, stable, well-regarded, and like-minded corporate partner. After careful deliberation and consultation with affected constituencies, MCMC's process led to the proposed affiliation with Adventist.

Decisions about whether and when to build a new hospital facility will now be made jointly by MCMC and Adventist. The parties have sought to inform this decision by engaging an experienced consulting firm to provide recommendations. While it is premature to identify a specific date when the parties will make final decisions about which capital projects to undertake, existing agreements commit the MCMC capital committee to presenting an investment plan or budget to Adventist for approval within eight months after the closing of the Proposed Transaction.

4. How will MCMC slot into the organizational structure of Adventist Health following the transaction? A pre- and post-transaction organizational chart would be helpful.

Please see attached as **Exhibit D** the pre- and post-transaction organizational charts showing how MCMC will slot into the organizational structure of Adventist. To elaborate, Adventist currently owns and operates Adventist Health Portland and leases and operates Adventist Health Tillamook. The parties contemplate that MCMC will be positioned much like Adventist Health Portland within the Adventist organizational structure, with the primary difference being that the corporate

entity directly affiliated with Adventist Health Portland is Adventist Health System/West whereas the corporate entity slated to be directly affiliated with MCMC is Stone Point Health.

5. How will negotiations with payers will be managed post-transaction? Will Adventist Health negotiate on behalf of MCMC at the system level?

The majority of payments currently received by MCMC come from governmental payers with which the parties have little or no ability to negotiate prices and terms. The parties do not expect this dynamic to change appreciably after the closing of the Proposed Transaction. However, they do anticipate changes with respect to the way they negotiate with commercial payers.

Adventist provides centralized managed care and commercial payer negotiation services for its existing member hospitals. Adventist therefore contemplates providing such services for MCMC, subject to two caveats. First, the parties have not yet discussed negotiation approaches or strategies, pricing, or other topics that may raise antitrust or anti-competition concerns. All such discussions will occur only after (and if) the Proposed Transaction is consummated. Second, Adventist's payer negotiation approach is unique to each community its facilities and providers serve. One reason for this variation is that Adventist relies heavily on the input of local experts who have established relationships with relevant payers and an intimate knowledge of the community's health care needs. Accordingly, if Adventist takes a more substantial role in the negotiation of MCMC's commercial payer contracts after closing, then it will do so only with the support, guidance, and input of MCMC's existing leadership team.

It is important to add that the parties have a common goal of keeping post-closing price increases below Oregon's health care cost growth benchmark, as defined in ORS 442.385. They also have a commitment to deploy their resources (including the $100 million capital investment) in the manner deemed most beneficial and equitable to the community, regardless of whether such deployments inure primarily to the advantage of privately-insured patients, governmentally-insured patients, or uninsured patients.