Schwabe

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VIA ELECTRONIC MAIL

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RE: Response to Your Letter of August 25, 2025; Petition for Modification of Order 006 Adventist-MCMC

Dear Sarah and Anna:

Thank you for laying out the steps that Adventist Health Columbia Gorge ("AHCG") will have to take to gain your agencies' approval for its proposed conversion to critical access hospital ("CAH") status. You have indicated that the first of these steps is for AHCG to: "Complete HCMO's petition process pursuant to Condition 2.h. of the Order and obtain HCMO's approval to 'significantly reduce, restrict or terminate the facilities, services, or programs' referenced in the Order, which includes reducing AHCG's bed count from 49 to 25." This letter is intended to serve as AHCG's petition.

Condition 2.h. states that, "MCMC and Adventist shall not significantly reduce, restrict or terminate the facilities, services, or programs contemplated by Sections c. through g. of these Conditions except for good cause shown as approved by OHA." As you correctly point in your letter of August 25, 2025, AHCG's initial petition to OHA was premised on the hope or assumption that the hospital could meet the technical requirements of the CAH regulations simply by

converting 24 of its existing 49 inpatient beds to swing beds. This follow-up petition concedes that these 24 beds will have to be decommissioned rather than reclassified. But AHCG maintains that its original arguments in favor of OHA allowing the CAH conversion remain as valid in the decommissioning context as they were in the reclassification context.[1]

"Good cause" is defined in the Order as follows:

> "Good cause" shall consist of one or more of the following circumstances or conditions:
>
> 1. the facility, service, or level of service is no longer needed in the community served by MCMC;
> 2. MCMC will incur substantial losses disproportionate to the losses historically incurred for such facility, service, or service level unless the facility, service, or service level is materially reduced, restricted, or terminated as proposed;
> 3. the facilities or services to be reduced, restricted, or eliminated have been or promptly will be replaced with facilities or services provided by other qualified health care providers in the communities served by MCMC; or
> 4. such other conditions or circumstances as OHA may deem to constitute "good cause" under the facts presented.

AHCG believes that it can satisfy the "good cause" showing under any or all of the listed circumstances or conditions.

"[T]he facility, service, or level of service is no longer needed in the community served by MCMC. . . ."

As noted in its initial petition, AHCG's census has not met or exceeded 25 inpatients on any day in the past two decades. The hospital is therefore in the enviable position of being able to eliminate or decommission inpatient beds with little or no adverse effect on patient care. For example, six

[1] Please note that AHCG is not (re)submitting with this petition the materials it attached to its earlier submission regarding its desire to transition to CAH status. Those materials included a letter from the Oregon Department of Transportation confirming that AHCG meets the critical access hospital location criteria in 42 CFR Sec. 485.610(c), since a 24.2-mile journey through "mountainous terrain" is required to travel from AHCG to the nearest hospital, Providence Hood River Memorial Hospital (the "ODOT Report"). The materials also included a financial analysis conducted by Wipfli, a consultancy whose nearest office is located in Spokane, Washington (the "Wipfli Analysis"). [redacted] AHCG has since confirmed with Wipfli that this estimate does not change based on the new understanding that the 24 inpatient beds will have to be decommissioned rather than transitioned to swing beds. AHCG is happy to resubmit the ODOT Report and/or the Wipfli Analysis, upon HCMO's or OHA's request.

(6) of the inpatient beds slated for elimination were being utilized by the hospital's rehabilitation unit, which closed in 2022. Another fifteen (15) inpatient beds are located either: (a) in semi-private, two-bed rooms that the hospital is actively working to convert to one-bed rooms; or (b) in areas of the hospital that make them difficult to attend to properly. The remaining three (3) beds are on the ob/labor and delivery unit, where demand for services has progressively waned to the point that such beds are no longer needed to serve the community. A chart showing the proposed inpatient bed reductions is attached as **Exhibit A**.

AHCG initially sought to keep all of its 49 beds, and to convert 24 of those beds to swing beds, as a precautionary measure. A major disaster can happen at any time and in any place. It is therefore theoretically possible that AHCG could be called upon to accommodate more than 25 inpatients at a time. But, again, this eventually has not come to pass in, at least, the last twenty years. Also, AHCG maintains effective transfer relationships and protocols with tertiary care centers in cities like Portland and Bend, as well as with smaller hospitals in towns like Hood River, Madras, Hermiston. The slight loss of AHCG's inpatient bed capacity is therefore extremely unlikely to leave community members without access to care, even if disaster strikes.

"MCMC will incur substantial losses disproportionate to the losses historically incurred for such facility, service, or service level unless the facility, service, or service level is materially reduced, restricted, or terminated as proposed. . . ."
As a 49-bed facility, AHCG has struggled to remain profitable. Indeed, its financial woes were one of the main reasons it sought out a corporate partner like Adventist Health System/West ("Adventist Health") in the first place. [redacted] Impending Medicaid cuts and other government financial austerity initiatives seem likely only to worsen matters.

Meanwhile, Adventist Health has remained steadfast in its commitment to strengthen and grow AHCG. It continues to invest millions of dollars, as well as innumerable other resources, in the hospital each year. [redacted] Conversion to CAH status is, perhaps, the single most significant change the hospital can make to realize this critical improvement.

"[T]he facilities or services to be reduced, restricted, or eliminated have been or promptly will be replaced with facilities or services provided by other qualified health care providers in the communities served by MCMC. . . ."
There are, at least, two ways of addressing this clause of the "good cause" definition. One is to reiterate that AHCG does not anticipate its proposed reduction of bed count will cause services

materially to be reduced, restricted, or eliminated. The hospital must concede that its "facilities" will be reduced or eliminated, to the extent that a loss of inpatient beds can be said to constitute a loss of "facilities." It also wants to acknowledge that it transitioned from Trauma Status III to Trauma Status IV on June 1, 2025.[2, 3] But it has no reason to believe that this loss of beds or change in trauma status will translate into a significant deterioration of healthcare access, quality, or equity, or a significant increase in healthcare costs.

Another way to address this third clause of the "good cause" definition is to note again that AHCG has effective transfer arrangements in place with other hospitals in Oregon. It also happens to be located within about 24 miles from both Providence Hood River Memorial Hospital in Hood River, Oregon, and Skyline Health, in White Salmon, Washington. Both of these critical access hospitals provide service offerings and levels that are similar to the offerings of AHCG. Moreover, Providence Hood River Memorial Hospital operates a women's clinic and a family birth center that help serve the community's need for ob/gyn services, which could theoretically be affected by AHCG's proposed elimination of three ob/gyn inpatient beds. Skyline Health provides both inpatient and outpatient rehabilitation and therapy services like the ones previously offered by AHCG's rehabilitation unit.

"[S]uch other conditions or circumstances as OHA may deem to constitute 'good cause' under the facts presented. . . ."

Oregon hospitals are struggling. The Hospital Association of Oregon warns that:

> Around half of the state's hospitals are losing money on operations. More than two thirds of hospitals aren't making enough money to do things that patients expect, like updating facilities and replacing outdated equipment. Expenses have soared while payments from both private insurers and government programs have not kept pace.[4]

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[2] *See generally* American Trauma Society, "Trauma Center Levels Explained," *accessed on* August 27, 2025, at https://www.amtrauma.org/page/traumalevels. It is important to note that AHCG's change in trauma status was not precipitated by a decrease in emergency medicine coverage levels. Those levels will remain the same. Instead, the change was precipitated by a potential decrease in general surgery and orthopedic surgery levels. [redacted]

[3] AHCG will be submitting an updated/amended CAH application that acknowledges its transition from Trauma III status to Trauma IV status. This application is currently in the process of being completed, signed, and submitted. AHCG is happy to provide a copy of the final, signed version of the revised application, upon HCMO's or OHA's request.

[4] Hospital Association of Oregon, "Oregon Hospitals on the Brink," (April 25, 2025), *accessed on* August 26, 2025, at https://oregonhospitals.org/wp-content/uploads/2025/04/2025.04.25_Report_Oregon-Hospitals-on-the-Brink_FINAL.pdf.

These financial headwinds are particularly challenging to overcome for rural hospitals. It therefore is not surprising that these hospitals are considering all reasonable options for keeping their doors open. Some have proposed closing unprofitable units.[5] Some, like MCMC, have entered into partnership arrangements with large, nonprofit health systems. Some have even entertained affiliations with out-of-state, private-equity-backed, for-profit health systems.[6] Time and again, the leaders of these hospitals have justified painful cuts and corporate changes by pointing out that the alternative—closing their doors—is simply unacceptable.

Because it has the solid backing of Adventist Health, AHCG is not facing imminent closure if its application for CAH status is delayed or denied. But it would be facing a number of unpleasant options for returning to financial viability. All of these options are certain to have much more negative consequences for the community than allowing AHCG to transition to CAH status. Indeed, as has been pointed out in this letter several times already, AHCG believes that it can make the necessary bed count reductions and other changes needed to qualify for CAH status with few or no adverse consequences for healthcare access, quality, cost, or equity.

It must also be acknowledged that other communities in Oregon of similar size to The Dalles are currently being served effectively by CAHs. A chart showing listing Oregon's CAHs, along with the populations of the cities and towns in which they are located, is attached as **Exhibit B**. The success of these 25 hospitals helps validate AHCG's argument that it, too, can effectively serve its community's needs as a CAH. In fact, to the extent that converting to CAH status allows it to reduce or, even, reverse its operational losses, AHCG should be better positioned in the future to invest in facility, service, personnel, and other improvements that ultimately inure to the benefit of its community.

For all the reasons set forth above, AHCG respectfully requests that HCMO approves its petition to modify the Order pursuant to Condition 2.h. While it acknowledges that this conversion will result in a loss of inpatient bed capacity, AHCG is confident that converting to CAH status will improve its financial wherewithal and position it better for long-term success. AHCG does not have specific language to propose for its requested amendment of the Order, nor does it have suggestions as to which provisions of the Order should be modified. Instead, it defers to the discretion of HCMO, asking only that the division works collaboratively with the hospital to come up with language that makes practical sense and helps the parties accomplish their common goal of strengthening the health care infrastructure in the Columbia River Gorge and beyond.

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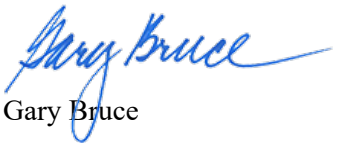
[5] *See, e.g.*, Amelia Templeton, "Providence's Hospital in Seaside, Oregon to Close Maternity Unit," OPB (Aug. 19, 2025), *accessed on* August 27, 2025, at https://www.opb.org/article/2025/08/19/providence-seaside-hospital-closes-maternity-unit/.

[6] *See, e.g.*, Justin Higginbottom, "No Quorum: Coos County Hospital Deal With Tennessee-Based Quorum Health Falls Apart," OPB (Aug. 13, 2025), *accessed on* August 27, 2025, at https://www.opb.org/article/2025/08/13/no-quorum-coos-county-hospital-deal-with-tennessee-based-quorum-health-falls-apart/

Sincerely,



Gary Bruce

GTB

cc: Kyle King, Adventist Health System/West (kingk2@ah.org)
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EXHIBIT A

Chart of Proposed Inpatient Bed Reductions

Bed Tracking- Adventist Health Columbia Gorge d/b/a

Mid-Columbia Medical Center

EXHIBIT B

Critical Access Hospitals in Oregon and the Communities They Serve

Hospital[7]	Town/Location	Population of Town/Location[8]
Pioneer Memorial Hospital & Nursing Facility	Heppner	1,119
Blue Mountain Hospital	John Day	1,641
Wallowa Memorial Hospital	Enterprise	2,083
Curry General Hospital	Gold Beach	2,272
Lake District Hospital	Lakeview	2,418
Harney District Hospital	Burns	2,689
Southern Coos Hospital & Health Center	Bandon	3,311
Coquille Valley Hospital	Coquille	3,972
Lower Umpqua Hospital	Reedsport	4,299
Adventist Health Tillamook	Tillamook	5,157
Providence Seaside Hospital	Seaside	7,110
St. Charles Madras	Madras	7,764
Providence Hood River Memorial Hospital	Hood River	8,350
PeaceHealth Peace Harbor Medical Center	Florence	9,504
Columbia Memorial Hospital	Astoria	9,906
Samaritan North Lincoln Hospital	Lincoln City	10,034
St. Alphonsus Medical Center—Baker City	Baker City	10,135
PeaceHealth Cottage Grove Community Medical Center	Cottage Grove	10,690
Samaritan Pacific Communities Hospital	Newport	10,833
St. Charles Prineville	Prineville	11,917
Grande Ronde Hospital	La Grande	13,058
Adventist Health Columbia Gorge	***The Dalles***	***15,884***
CHI St. Anthony Hospital	Pendleton	17,026
West Valley Hospital	Dallas	17,911
Good Shepherd Health Care System	Hermiston	19,746
Samaritan Lebanon Community Hospital	Lebanon	19,950

[7] Oregon Office of Rural Health, "Oregon Critical Access Hospitals," *accessed on* August 27, 2025, at https://www.ohsu.edu/media/1666.

[8] Kristen Carney, "Oregon Cities By Population (2025)," Oregon Demographics by Cubit (Aug. 7, 2025), *accessed on* August 27, 2025, at https://www.oregon-demographics.com/cities_by_population