Health Care Market Oversight (HCMO) Program
HCMO-1: Notice of Material Change Transaction

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact us by email at hcmo.info@oha.oregon.gov or by phone at 503-945-6161. We accept all relay calls.

General Instructions

Pursuant to Oregon Revised Statute (ORS) 415.501, an entity to a material change transaction must submit a Notice to the Oregon Health Authority (OHA) notifying OHA of such transaction. This HCMO-1 Notice form must be used to comply with this statutory mandate.

You must file this HCMO-1 Notice form electronically with OHA, in a portable document form (pdf), by email to hcmo.info@oha.oregon.gov **no less than 180 days** before the expected closing date of your material change transaction. Please submit the completed HCMO-1 Notice form, other relevant HCMO forms, and any supplemental documents as separate files.

To avoid delays in OHA's review of your proposed transaction, due diligence is required to complete this HCMO-1 Notice form correctly. Please provide a public-facing response to each item. Pursuant to the requirements of OAR 409-070-0070(1), this form should not contain any information you intend to designate as confidential. All information you designate as confidential must be provided separately as one or more supplemental attachments to this form. To avoid unnecessary delays, do not redact content that is publicly available or without grounds for a claim of confidentiality under Oregon law. Please consistently apply Bates numbering to all documents submitted with this form and include the applicable Bates number sequence on all redaction logs.

The Notice is not complete until all required information is satisfactorily provided, and the review period will not run until OHA deems the Notice complete.

This HCMO-1 Notice form, along with any public supporting documents, will be published and serve as notice to the public. Contact program staff with any questions or to request technical assistance at hcmo.info@oha.oregon.gov.

Who must file a Notice

Under ORS 415.501, an entity entering into a transaction that constitutes a material change must submit written notice to OHA of such material change.

A material change transaction includes:

A. A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:

"**Merger**" means a consolidation between two or more organizations, including two or more organizations joining through a common parent organization or two or more organizations forming a new organization.

"**NPI**" means 10-digit National Provider Identification number issued by the Centers for Medicare and Medicaid Services (CMS).

"**Tax ID**" means 9-digit federal tax identification number also known as an employer identification number (EIN) assigned by the Internal Revenue Service.

"**Transaction**" means:

a) A merger of a health care entity with another entity;
b) An acquisition of one or more health care entities by another entity;
c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services (see Essential Services and Significant Reduction guidance);
d) A corporate affiliation involving at least one health care entity; or
e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization.

Additional defined terms can be found at ORS 415.500 et seq. and OAR 409-070-0000 to -0085.

I. Parties to the proposed transaction

List the entity names for all parties to the proposed transaction. Add extra rows as needed for additional parties.

Party A:	Bay Area Hospital District
Party B:	Blue Mountain Hospital District
Party C:	Cascades Rural High Value Network
Party D:	Coquille Valley Hospital District
Party E:	Curry Health District
Party F:	Grande Ronde Hospital, Inc.
Party G:	Harney District Hospital
Party H:	Lake Health District
Party I:	Lower Umpqua Hospital District
Party J:	Morrow County Health District
Party K:	Southern Coos Health District
Party L:	Wallowa County Health Care District

In this application, each of the health districts or hospitals named above may be referred to as a "Participating Entity," and all of the health districts or hospitals may be referred to collectively as the "Participating Entities." Cascades Rural High Value Network ("Cascades Network") is the nonprofit corporation that the Participating Entities have formed to carry out the goals set forth in this application.

II. Contact information for the parties

Provide contact information for the proposed transaction, as requested below.

1. Provide information for the parties.

Legal entity name	Bay Area Hospital District
Assumed name	Bay Area Hospital
Tax ID	93-0593249
Mailing address	1775 Thompson Road, Coos Bay, OR 97420
Website	https://bayareahospital.org/
Contact Name	Gretchen Nichols
Title	President and CEO
Phone	(541) 269-8111
Cell Phone	Click or tap here to enter text.
Email	Gretchen.nichols@bayareahospital.org

Legal entity name	Blue Mountain Hospital District A Municipal Corporation
Assumed name	Blue Mountain Hospital District
Tax ID	93-6002615
Mailing address	170 Ford Road, John Day, OR 97845
Website	https://bluemountainhospital.org
Contact Name	Misty Robertson
Title	Chief Executive Officer
Phone	(541) 575-4151
Cell Phone	Click or tap here to enter text.

Email	mrobertson@bluemountainhospital.org

Legal entity name	Cascades Rural High Value Network
Assumed name	NA
Tax ID	42-3090886
Mailing address	707 SW Washington Street, Suite 1500
Website	NA
Contact Name	Landon Dybdal
Title	Chair of the Board
Phone	(541) 947-2114
Cell Phone	Click or tap here to enter text.
Email	ldybdal@lakehealthdistrict.org

Legal entity name	Coquille Valley Hospital District
Assumed name	Coquille Valley Hospital
Tax ID	93-0579541
Mailing address	940 E. Fifth Street, Coquille, OR 97423
Website	https://www.cvhospital.org/
Contact Name	Jeff Lang
Title	Chief Executive Officer
Phone	(541) 396-3101
Cell Phone	Click or tap here to enter text.
Email	Jeff.lang@cvhospital.org

Legal entity name	Curry Health District
Assumed name	Curry General Hospital
Tax ID	93-0937095

Mailing address	94220 4th Street, Gold Beach, OR 97444
Website	https://www.curryhealthnetwork.com/
Contact Name	Virginia A. Williams
Title	Chief Executive Officer
Phone	(541) 247-3000
Cell Phone	Click or tap here to enter text.
Email	Virginia.williams@curryhealth.org

Legal entity name	Grande Ronde Hospital, Inc.
Assumed name	Grande Ronde Hospital
Tax ID	93-0505325
Mailing address	900 Sunset Drive, La Grande, OR 97850
Website	https://www.grh.org/
Contact Name	Jeremy Davis
Title	Chief Executive Officer
Phone	(541) 963-1454
Cell Phone	Click or tap here to enter text.
Email	Jpd01@grh.org

Legal entity name	Harney County Health District
Assumed name	Harney District Hospital
Tax ID	93-6002332
Mailing address	557 W. Washington, Burns, OR 97720
Website	https://harneydh.com/
Contact Name	Robert Gomes
Title	Chief Executive Officer
Phone	(541) 573-7281

Cell Phone	Click or tap here to enter text.
Email	rdgomes@harneydh.com

Legal entity name	Lake Health District
Assumed name	Lake District Hospital
Tax ID	93-0577593
Mailing address	700 South J Street, Lakeview, OR 97630
Website	https://lakehealthdistrict.org/
Contact Name	Landon M. Dybdal
Title	Chief Executive Officer
Phone	(541) 947-2114
Cell Phone	Click or tap here to enter text.
Email	ldybdal@lakehealthdistrict.org

Legal entity name	Lower Umpqua Hospital District
Assumed name	NA
Tax ID	93-0505011
Mailing address	600 Ranch Road, Reedsport, OR 97467
Website	https://www.lowerumpquahospital.org/
Contact Name	John Chivers
Title	Chief Executive Officer
Phone	(541) 271-2171
Cell Phone	Click or tap here to enter text.
Email	jchivers@luhonline.com

Legal entity name	Morrow County Health District
Assumed name	Pioneer Memorial Hospital and Nursing Facility

Tax ID	93-6002451
Mailing address	564 E. Pioneer Drive, Heppner, OR 97836
Website	https://www.morrowcountyhealthdistrict.org/pioneer-memorial-hospital
Contact Name	Bob Houser
Title	Interim Chief Executive Officer
Phone	(541) 676-9133
Cell Phone	Click or tap here to enter text.
Email	bobh@mocohd.org

Legal entity name	Southern Coos Health District
Assumed name	Southern Coos Hospital and Health Center
Tax ID	93-6013768
Mailing address	900 11th Street SE, Bandon, OR 97411
Website	https://southerncoos.org/
Contact Name	Raymond Hino
Title	Chief Executive Officer
Phone	(541) 329-1031
Cell Phone	Click or tap here to enter text.
Email	rhino@southerncoos.org

Legal entity name	Wallowa County Health Care District
Assumed name	Wallowa Memorial Hospital
Tax ID	93-6002339
Mailing address	601 Medical Parkway, Enterprise, OR 97828
Website	https://wchcd.org/
Contact Name	Daniel Grigg
Title	Chief Executive Officer

Phone	(541) 426-3111
Cell Phone	Click or tap here to enter text.
Email	Daniel.grigg@wchcd.org

Are the Participating Entities represented by legal counsel for this transaction?

☒ Yes

☐ No

Provide information regarding the Participating Entities' legal counsel, if applicable.

Name	Gary Bruce
Firm	Schwabe, Williamson & Wyatt, P.C.
Address	360 SW Bond Street, Bend, OR 97702
Phone	(541) 749-1752
Email Address	gbruce@schwabe.com

2. Provide a billing contact for payment of review fees.

Name	Nathan White, President and CEO of Cibolo Health
Address	1858 Springwood Road, Bethlehem, PA 18015
Phone	(605) 254-3342
Email Address	Nate.white@cibolohealth.com

III. About the proposed transaction

4. Provide the type of material change transaction. (See OAR 409-070-0010 for definitions of transactions subject to review.)

☐ Merger

☐ Acquisition

☐ Affiliation

☐ Contract

☒ Other (specify): The Participating Entities have created Cascades Network as an Oregon nonprofit corporation. Cascades Network will own and operate a clinically-integrated network ("CIN") that leverages the combined expertise, resources, and strengths of the Participating Entities.

5. What is the anticipated effective date of the proposed material change transaction?
January 1, 2027

6. Briefly describe the proposed material change transaction, including:

   a. Goals and objectives

   The proposed transaction involves the formation of a CIN among the Participating Entities. A key objective of the CIN is to create a high degree of interdependence and cooperation among the Participating Entities and their respective providers. Efforts to achieve this goal are premised on the belief that the Participating Entities and their providers are stronger collectively than individually. In particular, the CIN will work to:

   - Coordinate and manage the care of patient populations;
   - Improve the quality of care for patient populations;
   - Reduce costs to purchasers of health care services without reducing quality of care;
   - Enhance access to care, especially for rural populations, by leveraging telehealth and similar technologies; and
   - Promote healthcare equity among diverse groups in the Participating Entities' service areas.

   Another key goal of the CIN is to make it possible for the Participating Entities to remain independent. To this end, the CIN will help the Participating Entities enter into value-based contracts that offer incentive payments and other bonuses based on performance. No Participating Entity, by itself, has a patient population large enough to qualify it for participation in value-based contracts. But the Participating Entities, acting together, have a collective patient population that is large enough to overcome most eligibility hurdles.

   It is important to point out that the proposed transaction will also advance the State of Oregon's goal of promoting regional partnerships and systems transformation through strategic allocation of its Rural Health Transformation Program ("RHTP") funds. Promoting regional partnerships and systems transformation is one of just five initiatives the state will support with its initial RHTP award of over $197 million. *See* Oregon Health Authority, Rural Health Transformation Program Summary. The Participating Entities have been working closely with the Oregon Office of Rural Health and Cibolo Health, a proven expert

in rural healthcare integration efforts, to establish and develop realistic, measurable goals for the CIN. The Participating Entities will be seeking RHTP dollars to help fund the proposed transaction.

b. Summary of transaction terms

A summary of the transaction terms is as follows:

- The CIN will be collaboratively owned and operated, with all Participating Entities working together to ensure its ongoing success;
- Each Hospital Participant will remain independently owned and governed;
- The transaction does not involve mergers, acquisitions, or any asset transfers among participants;
- The CIN will be governed by Cascades Network, the newly-formed Oregon nonprofit corporation;
- All Participating Entities will have equal "ownership" in Cascades Network, which will be governed according to a one member, one vote philosophy;
- The Board of Directors of Cascades Network will include one appointee from each member;
- Participating Entities will collaborate on clinical integration activities, including care coordination, quality improvement, and population health management;
- Governance and compliance measures will be implemented to ensure the collaboration focuses solely on clinical integration and patient care improvements.

c. Why the transaction is necessary or warranted

The CIN is necessary and warranted to address persistent challenges faced by patients and hospitals in rural and frontier communities in Oregon, including:

- Fragmented care delivery, which can lead to preventable hospitalizations, duplicative testing, and suboptimal patient outcomes;
- Limited access to specialty care and advanced services, particularly for patients in geographically-isolated areas;
- Significant financial pressures caused by high fixed costs, low patient volumes, and other factors that limit the capacity of independent rural hospitals to invest in the infrastructure needed for value-based care;
- Increasing demand for participation in value-based reimbursement programs, which require coordinated care, population health management, and quality measurement capabilities;
- Onerous participation requirements for commercial payor- and government-sponsored value-based care programs—such as the requirement that each participant in the Medicare Shared Savings Program (MSSP) have at least 5,000 Medicare fee-for-service beneficiaries assigned to it each year—that simply cannot be met by a small, rural hospital acting independently.

By forming a CIN, the Participating Entities will enhance their ability to participate in value-based care programs, create mechanisms and protocols for pooling the resources needed to carry out population health initiatives effectively, and open avenues for the sharing of best practices—all while maintaining independent ownership and preserving competition in Oregon's healthcare markets.

d. Any exchange of funds between the parties, including the nature, source and amount of funds or other consideration (such as any arrangement in which one party agrees to furnish the other party with a discount, rebate, or any other type of refund or remuneration in exchange for, or in any way related to, the provision of health care services).

   The proposed formation of the CIN does not involve the transfer of ownership interests or any direct exchange of funds between the Participating Entities.
   - Contributions by the Participating Entities will be used solely to cover operational costs for CIN activities, such as the implementation of data analytics, quality reporting infrastructure, and care coordination programs.
   - Contributions will be proportionally allocated among the Participating Entities based on agreed-upon formulas.
   - There will be no arrangements for discounts, rebates, or other remuneration tied to patient volumes, referrals, or provision of healthcare services.

   In summary, the CIN is a collaborative platform for clinical integration, and there is no financial exchange among the Participating Entities related to the delivery of healthcare services.

7. Describe the negotiation or transaction process that resulted in the entities entering into an agreement.

   The discussions that ultimately led to the formation of Cascades Network developed over time and became more formal in stages.

   Several of the Participating Entities' leaders were first exposed to CINs through interactions with Cibolo Health and hospital leaders from existing Cibolo Health-supported networks in North Dakota and Minnesota. These interactions occurred in informal settings, such as the American Hospital Association's 2025 Rural Health Care Leadership Conference. Following that conference, a small number of Oregon hospital CEOs had informal, exploratory conversations with Cibolo Health regarding what a CIN might look like in Oregon. These early discussions were informational only, did not involve commitments, and did not result in any immediate action.

   In late 2025, following CMS's announcement of the RHTP, several Oregon hospital leaders reached out to Cibolo Health to revisit the possibility of forming a CIN in Oregon. Concurrently, the leaders asked the Oregon Office of Rural Health to assist with research on how a CIN might support rural hospitals in the

state. Cibolo Health presented multiple times to a group of interested hospital leaders regarding CIN concepts, governance, and compliance considerations.

As part of their due diligence, hospital leaders held discussions both with and without Cibolo Health representatives present, including conversations with CEOs of hospitals that participate in other Cibolo Health-supported networks. The leaders also met with other CIN management organizations to understand their offerings and approaches. Ultimately, the leaders determined that Cibolo Health offers the CIN management option that best meets the needs of Oregon's rural hospitals. Based on these discussions, the interested hospitals collectively decided to apply for RHTP funding to support the proposed CIN.

Beginning in early 2026, the process became more formal. Cibolo Health presented its proposed approach for developing and supporting a CIN in Oregon. The Participating Entities agreed to move forward with the formation of a CIN. They engaged Cibolo Health to assist with this work.

Experienced legal counsel was later brought in to provide advice and counsel on applicable laws and regulations. In May of 2026, Cascades Network was officially formed by filing of articles of incorporation with the Oregon Secretary of State's office. Shortly thereafter, the Participating Entities submitted an application to the HCMO Division for approval of the proposed CIN venture.

a. How the entities were identified (e.g., did one party approach the other, did one party engage in a bid/auction process, etc.)

Please see response above. The initial idea of forming a CIN came from leaders of the Participating Entities and similar rural hospitals in Oregon. These leaders sought to learn more about CINs and their potential benefits for Oregon. So they conducted due diligence, meeting with representatives of CIN management companies, leaders of hospitals that participate in CINs, and other experts. After multiple conversations and much deliberation, the leaders of the Participating Entities decided to engage Cibolo Health to assist with the establishment, operation, and management of the CIN.

Importantly, the opportunity to participate in the CIN was offered to independent, rural hospitals throughout the state. The Participating Entities are the ones that self-selected into the CIN membership group.

b. Any due diligence performed by any of the parties to the transaction. Provide any products, reports, or analyses resulting from due diligence processes.

The leaders of the Participating Entities participated in numerous meeting and discussions about the potential formation of a CIN. Most of these meetings were informal. However, there were a number of more formal meetings organized with the support of Cibolo Health and the Oregon Office of Rural Health. Minutes of these meetings, as well as slides of a presentation that Cibolo Health gave to

leaders of the Participating Entities on May 29, 2026, are attached as **Exhibit 7.b.**

Cascades Network has now been established as an Oregon nonprofit corporation. Its bylaws, which are attached as **Exhibit D**, were adopted by the CEOs of the Participating Entities at their meeting on May 29, 2026. These bylaws and the Hospital Participation Agreement, which is attached as **Exhibit C**, help establish the governance and operational framework for the CIN. But it must be acknowledged that the way the CIN operates, as well as the number and scope of the projects and initiatives that the CIN is able to undertake, will be decided by the Participating Entities in the months and years to come, and will be dictated, in part, by the amount of funding that the CIN is able to generate from the RHTP and other sources.

The Participating Entities are optimistic that the CIN will help them advance their goals of improving healthcare access for rural populations, reducing the cost of care, advancing healthcare quality, and promoting healthcare equity.[1] They are also sanguine about the possibility of being able to accomplish collectively, through the CIN, a number of goals that they would struggle to accomplish individually. For example, the cost of purchasing the software, analytical support, and other resources needed to succeed in value-based care initiatives is prohibitive for a standalone rural hospital, especially given expected returns on investment and competing priorities. But a purchase of these technologies through the CIN, which will be operated on a shared cost model, may be feasible. (For a list of specific initiatives that the Participating Entities hope to undertake through the CIN, please see the response to item 13.c., below.)

All of the foregoing is intended to suggest that the Participating Entities have yet to determine all that can be accomplished through the CIN. Suffice it to say, they are optimistic that they will identify as they jointly operate the CIN, and as technologies and applicable laws and funding opportunities evolve, certain economies of scale, efficiencies, and collective benefits that will help them better serve the healthcare needs of their respective populations while remaining independent and financially sound.

8. Will the proposed material change transaction change control of a public benefit corporation or religious corporation?

   ☐ Yes

[1] The HCMO Division has asked whether these four goals are the totality of the common goals identified by the Participating Entities. The short answer is no. Additional goals include maintaining the independence and improving the financial wherewithal of the Participating Entities, as well as better positioning the Participating Entities to thrive in a healthcare marketplace that is increasingly dominated by value-based payer models and programs.

☒ No

9. List any applications, forms, notices, or other materials that have been submitted to any other state or federal agency regarding the proposed material change transaction. Include the data and nature of any submissions. This includes, but is not limited to, the Oregon Department of Consumer and Business Services, Oregon Public Health Division, Oregon Department of Justice, U.S. Department of Health and Human Services (e.g., Pioneer ACO or Medicare Shared Savings Program application), Federal Trade Commission, and U.S. Department of Justice.

   To date, no applications or other materials have been submitted to federal or state agencies. However, the Participating Entities have submitted information, with the assistance and support of the Oregon Office for Rural Health and Cibolo Health, to obtain funding through the RHTP. A copy of the submitted information is attached as **Exhibit 9**.

   a. If a pre-merger notification was filed with the Federal Trade Commission or U.S. Department of Justice, please attach the pre-merger notification filing along with this notice submission.

      NA

IV. About the entities involved in the proposed transaction

10. Describe the Participating Entities.

    All of the Participating Entities, except for Bay Area Hospital, own and operate critical access hospitals. All of the Participating Entities are independently owned and operated (i.e., not affiliated with larger health systems). Seven of the Participating Entities serve rural communities east of the Cascades, the remaining five serve rural communities on the southern Oregon coast.

    None of the Participating Entities owns or operates any facilities or services outside the State of Oregon. While they may occasionally provide care to patients coming from outside the State of Oregon, the Participating Entities primary serve patients who live in rural or frontier communities in Oregon.

    a. Describe Party A's business, including business lines or segments

       See **Attachment A**.

    b. Describe Party A's governance and operational structure (including ownership of or by a health care entity)

       See **Attachment A**.

    c. Provide a diagram or chart showing the organizational structure and relationships between business entities.

See **Attachment A**.

d. List all of Party A's business entities currently licensed to operate in Oregon using HCMO-1b: Business Entities form. Provide the business name, assumed business name, business structure, date of incorporation, jurisdiction, principal place of business, and FEIN for each entity.

   See **Attachment A**.

e. Provide financial statements for the most recent three fiscal years. If Party A also operates outside of Oregon, provide financial statements both for Party A nationally and for Party A's Oregon business.

   See **Attachment A**.

f. Describe and identify Party A's health care business. Provide responses to i-ix as applicable:

   i. Provider type (hospital, physician group, etc.)

      See **Attachment A**.

   ii. Service lines, both overall and in Oregon

      See **Attachment A**.

   iii. Products and services, both overall and in Oregon

      See **Attachment A**.

   iv. Number of staff and FTE, both overall and in Oregon

      See **Attachment A**.

   v. Geographic areas served, both overall and in Oregon

      See **Attachment A**.

   vi. Addresses of all facilities owned or operated using HCMO-1c: Facilities and Locations form

      See **Attachment A**.

   vii. Annual number of people served in Oregon, for all business, not just business related to transaction

      See **Attachment A**.

   viii. Annual number of services provided in Oregon

      See **Attachment A**.

   ix. For hospitals, number of licensed beds

      See **Attachment A**.

11. Describe Party B.

    a. Describe Party B's business, including business lines or segments

       See **Attachment B**.

    b. Describe Party B's governance and operational structure (including ownership of or by a health care entity)

       See **Attachment B**.

    c. Provide a diagram or chart showing the organizational structural and relationships between business entities.

       See **Attachment B**.

    d. List all of Party B's business entities currently licensed to operate in Oregon using HCMO-1b: Business Entities form. Provide the business name, assumed business name, business structure, date of incorporation, jurisdiction, principal place of business, and FEIN for each entity.

       See **Attachment B**.

    e. Provide financial statements for the most recent three fiscal years. If Party B operates outside of Oregon, provide financial statements both for Party B nationally and for Party B's Oregon business.

       See **Attachment B**.

    f. Describe and identify Party B's health care business. Provide responses to i-ix as applicable.

       See **Attachment B**.

       i. Provider type (hospital, physician group, etc.)

          See **Attachment B**.

       ii. Service lines, both overall and in Oregon

          See **Attachment B**.

       iii. Products and services, both overall and in Oregon

          See **Attachment B**.

       iv. Number of staff and FTE, both overall and in Oregon

          See **Attachment B**.

       v. Geographic areas served, both overall and in Oregon

          See **Attachment B**.

       vi. Addresses of all facilities owned or operated using HCMO-1c: Facilities and Locations form

See **Attachment B**.

vii. Annual number people served in Oregon, for all business, not just business related to transaction

See **Attachment B**.

viii. Annual number of services provided in Oregon

See **Attachment B**.

ix. For hospitals, number of licensed beds

See **Attachment B**.

For any additional Parties, please provide a supplemental attachment describing the information requested in Section 11 (a) – (f).

12. Describe all mergers, acquisitions, and joint ventures that closed in the ten (10) years prior to filing this notice of material change transaction involving any entities party to the current proposed transaction, the same or related services, and health care entities. For each previous transaction, include:

    a. Legal names of all entities party to the transaction

    b. Type of transaction

    c. Description of the transaction

    d. Date the transaction closed

    See **Attachments A-L**.

13. Describe any anticipated changes resulting from the proposed material change transaction, including:

    a. Operational structure

        i. Provide a chart or diagram showing the pre- and post-transaction organizational structure and relationships between entities.
        The proposed transaction will not change the operational or organizational structures of the Participating Entities. Instead, the CIN will supplement the existing service offerings of the Participating Entities, enhancing their ability to participate in value-based care programs and population health initiatives.

    b. Corporate governance and management

        Following the close of the transaction, the Participating Entities will continue to be governed and managed under their existing corporate structures, boards, and executive leadership teams. The transaction does not alter any Participating Entity's corporate form, local board of directors, bylaws, or reserved powers. Each Participating Entity's governing body will retain

ultimate authority over its own operations, medical staff, credentialing, budgets, and quality of care.
Cascades Network is organized as an Oregon nonprofit corporation whose members are the Participating Entities. Each member retains its own corporate independence but, through Cascades Network, voluntarily participates in a shared clinical integration and value-based contracting program. Members hold specific reserved rights that can be exercised only by a supermajority (two-thirds) vote of all members. These rights include admission or removal of members, material changes to Cascades Network's mission or operations, amendments to Cascades Network's governing documents, and dissolution, merger, or sale of substantially all assets. Except with respect to the Founding Directors, members elect the individuals who serve on the Cascades Network Board of Directors (the "Board").

Post-transaction, overall governance of Cascades Network will rest with the Board. Each Founding Member has the right to appoint one director to the initial Board and to replace that director, ensuring direct representation of all Participating Entities in network governance. The Board will be responsible for setting network strategy; approving participation criteria and policies; overseeing Cascades Network's clinical integration program and value-based contracting activities; establishing Board committees (e.g., clinical integration, care coordination, business integration); and monitoring network performance and compliance. Directors serve two-year terms and may be re-elected, providing continuity while allowing for a periodic refresh of leadership.

Cascades Network's day-to-day operations and program implementation will be carried out by Cibolo Health, which will serve as the management entity under a management services agreement approved by the Board. Cibolo Health's role will include coordinating network operations, managing shared infrastructure (such as data and analytics, care management tools, and population health platforms), supporting value-based contract implementation, and staffing Board-authorized committees. Cibolo Health will report to, and operate under the oversight of, Cascades Network's Board and will not have authority to alter hospital corporate governance, direct clinical decision making, or unilaterally change member rights under the Cascades Network articles of incorporation, bylaws, or Hospital Participation Agreements.

Cascades Network's officers (Chair, Vice-Chair, Treasurer, Secretary, and any additional officers the Board may appoint) will be elected by the Board and will discharge the duties described in the bylaws. These duties may include presiding over Board meetings, ensuring accurate financial and corporate records, and executing contracts, as authorized. The Board may also establish committees, comprised of directors and other qualified individuals, to oversee quality, finance, and compliance, with all such committees remaining subject to the Board's direction and control.

In sum, the transaction does not change the corporate governance or management of the Participating Entities. Instead, it creates a formal, member-governed network entity whose Board provides network-level governance and oversight, while Cibolo Health functions as the accountable management entity implementing Board-approved strategies and programs under clear contractual and fiduciary oversight.

c. Investments or initiatives

It is contemplated that, in connection with the proposed transaction, and to the extent that available funding allows, the Participating Entities will undertake the following investments and initiatives:

- Establishment of a CIN—Working with Cibolo Health and the Oregon Office of Rural Health, the Participating Entities will form a CIN that aligns their governance, care, finances, data, and other attributes in order to improve and enhance their clinical care offerings, to enable them to participate in value-based care programs, to invest in shared resources that can be used by all parties, and to realize other benefits of collective action.
- Development of Population Health Platform—The Participating Entities will develop an integrated data and analytics system that connects electronic health records, claims, pharmaceutical data, and social determinants of health to provide actionable insights at the point of care.
- Development of Centralized Care Coordination—The Participating Entities will develop centralized care coordination and AI-enabled workflows to close quality gaps, improve timeliness of interventions, and reduce treatment delays.
- Development of a Data Warehouse—The Participating Entities will develop a data warehouse that consolidates clinical data, financial data, and other data in one location, obviating the need for each Participating Entity to maintain its own data warehouse.
- Expansion of Telemedicine Capabilities—The Participating Entity will invest in telemedicine resources that make it possible for patients to receive emergency and specialty care services close to home.
- Development of a Remote Patient Monitoring Program—The Participating Entities will develop a shared, remote patient monitoring program that can help prevent avoidable hospitalizations and improve chronic disease outcomes.
- Optimization of AI-Enabled Documentation and Decision Support—The Participating Entities will invest in automation and AI-powered tools to reduce administrative burdens, improve coding accuracy, and enhance clinician satisfaction.

d. Type and level of staffing

The proposed transaction will not change staffing levels or types at the Participating Entities.

e. Type and level of services provided

As a result of the proposed transaction, the Participating Entities expect to offer a more consistent and comprehensive set of care models to their patient populations, supported by shared infrastructure and clinical standards across the Cascades Network. For example, the Participating Entities intend to expand hospital-to-home transitional care and telemedicine services, including standardized discharge risk stratification, telemedicine-enabled follow-up visits, and remote monitoring for selected post-acute and post-ED patients. These services are expected to allow rural patients to receive timely follow-up care from their local hospital care team, supported by network-wide protocols and shared technology platforms, rather than relying solely on in-person visits or transfers.

The Participating Entities also expect to implement chronic disease and high-risk patient management pathways for conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes, and other high-risk chronic conditions. These pathways are expected to include patient registries, evidence-based care plans, proactive outreach, and virtual touchpoints that Participating Entities cannot consistently operate today on a standalone basis.

In addition, the CIN is expected to support remote patient monitoring-enabled care models for selected cohorts, including high-risk chronic disease patients and post-surgical patients, allowing earlier identification of deterioration, improved symptom management, and reduced avoidable emergency department visits and readmissions.

The proposed transaction is also expected to enhance access to specialty and behavioral health services through common telehealth tools and coordinated referral processes, helping rural patients obtain services that are currently difficult to access locally while keeping the local hospital at the center of care coordination.

Collectively, these initiatives are expected to increase both the type and level of services that Participating Entities can reliably offer, moving from isolated, hospital-specific efforts toward integrated, network-wide care models that support population health and value-based care participation.

f. Number and type of locations

The proposed transaction will not change the numbers or types of locations owned and operated by the Participating Entities.

g. Geographic areas served

The proposed transaction will not change the geographic areas served by the Participating Entities, except to the extent that any telemedicine initiatives undertaken by the CIN expand the reach of a Participating Entity’s care team.

h. For providers, payer contracts and payer mix

A primary goal of the proposed transaction is to enable Participating Entities to qualify for and succeed in value-based care programs. Currently, many Participating Entities are ineligible for, or unable to participate effectively in, Medicare and commercial accountable care organization arrangements and similar population-based contracts because they do not meet minimum attribution thresholds, have sufficient infrastructure for quality reporting and care management, or maintain a formal clinically integrated network structure.

The first of these barriers is, perhaps, the most challenging. To form or renew a Medicare Shared Savings Program (MSSP) accountable care organization, an entity must have at least 5,000 assigned fee-for-service beneficiaries. None of the Participating Entities individually approaches this threshold. In fact, preliminary analyses suggest that the largest of the Participating Entities could garner only about 3,800 beneficiaries. Each of the other Participating Entities could expect far fewer.

Of course, meeting the minimum qualifications for participation in the MSSP is different from managing the number of lives needed to thrive in the value-based care space. Through Cascades Network, the Participating Entities not only hope to become eligible to take part in the MSSP; they also hope to combine their attributed lives with a critical mass of other attributed lives in order to decrease some of the volatility and risk associated with value-based care arrangements involving small patient populations.

Cascades Network is projected to attribute on the order of 15,000 to 16,000 beneficiaries, roughly three times the 5,000-life minimum. This scale makes it feasible that the network could generate several million dollars in net shared savings annually. It also protects the Participating Entities against the downside risk that a small number of chronic, expensive-to-treat conditions within the patient population will upend the financial viability of the value-based care model.

The Participating Entities are hopeful that the MSSP is just one of many value-based care programs for which Cascades Network will make them eligible. It is difficult to say exactly at this point what program offerings will become available, or what payer mixes may be associated with those offerings. Suffice it to say, Cascades Network will be actively pursuing shared-savings arrangements with commercial payers, participation in ACO-type or other population-based programs, bundled payment arrangements, and other value-based contracts that reward improved outcomes and total-cost performance.

Although the proposed transaction will not change the underlying geographic service areas of the Participating Entities, it is expected to increase progressively the proportion of the Participating Entities' patients whose care is covered under value-based arrangements.

i. For insurance carriers, provider contracts and networks

The Participating Entities have both short- and longer-term goals for how the proposed transaction may affect insurance carriers, provider contracts, and networks. These goals are as follows:

Short-term goal (12-24 months)—Kick off discussions and negotiations with key payers, laying the foundation for value-based contracts that build trust, establish data-sharing infrastructure, and align values and expectations around value-based care

Long-term goal (3-5 years)—Evolve payer relationships into mature, multi-year, value-based agreements that cover significant swaths of the Participating Entities' patient populations, including managed Medicaid, Medicare Advantage, and commercially-insured patients.

j. Other contractual arrangements, including contracts with suppliers, partners, ancillary service providers, PBMs, or management services organizations

The Participating Entities have contracted with Cibolo Health, a well-regarded healthcare company that has a proven track record of helping rural hospitals form CINs and otherwise collaborate to serve their respective patient populations more effectively. Cibolo Health will be guiding many of the efforts of the proposed CIN, helping the Participating Entities develop effective care models, monitor health outcomes, expand their telemedicine offerings, participate in value-based care initiatives, and otherwise improve the quality, cost, availability, and equity of the services they offer.

V. Impacts from the proposed material change transaction

14. Describe how the proposed material change transaction will impact the public and people served by the entities in Oregon.

The proposed transaction involves the creation of a CIN among the Participating Entities and their affiliated providers. The primary purposes of the CIN are to enhance coordination of care, improve clinical outcomes, and support the transition from volume-based to value-based healthcare delivery models.

The CIN is expected to positively impact the public and patients served by the Participating Entities by improving care coordination across providers and care settings. All of the Participating Entities serve rural or frontier communities where geographic isolation, workforce shortages, and limited access to specialty care create barriers for patient seeking timely and coordinated healthcare services. Through the CIN, Participating Entities will collaborate on evidence-based clinical protocols, population health initiatives, and shared quality improvement programs designed to improve patient outcomes and reduce fragmentation of care.

The CIN will also support the ability of the Participating Entities and providers to share clinical best practices, utilize common data analytics tools to identify care gaps, and coordinate services for patients with complex or chronic medical

conditions. These efforts are expected to improve preventive care delivery, reduce avoidable hospitalizations, and enhance care transitions between providers and care settings.

In addition, the CIN will allow the Participating Entities collectively to develop the infrastructure needed to participate in emerging value-based payment arrangements and quality reporting programs. Access to these programs may help sustain essential healthcare services in rural communities by enabling the Participating Entities to adopt reimbursement models that reward high-quality, coordinated care.

Importantly, the formation of the CIN will not change where patients may seek care or which providers they may choose to serve their healthcare needs. Moreover, key funding to support the proposed transaction is expected to come from the RHTP, ensuring that the Participating Entities maintain the financial wherewithal to carry out their traditional responsibilities while pursuing their ambitious rural healthcare system transformation goals.

a. If there are any anticipated negative effects, describe how the entities will seek to mitigate negative impacts.

The Participating Entities do not anticipate any negative effects on patients or the public resulting from the formation of the CIN. Because the transaction does not involve consolidation of hospital ownership or elimination of competing providers, patients will continue to have the same choices among healthcare providers and facilities as they did prior to the formation of the CIN. In fact, a primary driver of the proposed transaction is the desire to maintain hospital independence, thus avoiding the industry trend of hospital mergers or consolidations.

One potential concern with CINs is that they might affect competitive dynamics in negotiations between the Participating Entities and health plans. To mitigate this risk, the CIN will implement safeguards designed to ensure compliance with applicable competition laws and regulatory guidance.

These safeguards include:

- Ensuring that each Participating Entity maintains independent governance and operations;
- Implementing “clean teams” to ensure that sensitive pricing information is not shared between and among the Participating Entities;
- Allowing the Participating Entities to contract independently with health plans and participate in other networks outside the CIN.

15. Explain how the proposed material change transaction will:

a. Impact health outcomes for people in Oregon. Provide applicable data, metrics, or documentation to support your statements.

The proposed transaction involves the creation of a CIN among the Participating Entities and their affiliated providers. The purpose of the CIN is to improve health outcomes by enabling providers to coordinate care more effectively, implement evidence-based clinical protocols, and use shared data infrastructure to monitor and improve quality performance across the network.

Improved Care Coordination and Chronic Disease Management

The CIN will allow the Participating Entities to share clinical data, implement standardized care pathways, and coordinate care across primary care, specialty care, hospital, and post-acute settings. These efforts are expected to improve outcomes for patients with chronic conditions such as diabetes, cardiovascular disease, and respiratory illness. In addition, the CIN will develop a tele-specialty clinic model that pools specialty visits across the Participating Entities, allowing low-volume rural sites to offer regular virtual cardiology, neurology, endocrinology, behavioral health, and other specialty clinics without needing full-time on-site specialists.

By aggregating demand across communities, these pooled clinics support timely consults, earlier diagnosis, and tighter longitudinal follow-up for complex and chronic conditions. The CIN's shared population health platform will integrate clinical, claims, and social-risk data to support risk stratification, care gap identification, and closed-loop outreach across all of the Participating Entities. This common infrastructure will enable standardized registries (for example, for diabetes, heart failure, COPD, and cancer screening), network-wide performance dashboards, and aligned care pathways that are difficult for any single rural hospital to sustain alone.

The Participating Entities will also deploy remote patient monitoring (RPM) for selected high-risk populations (such as heart failure, COPD, and uncontrolled hypertension) supported by centralized care coordination teams. RPM programs have been associated in the literature with reductions in all-cause and condition-specific readmissions when paired with timely clinical intervention and medication management. Within the CIN, these services will be coordinated through a centralized, AI-enabled care coordination hub that receives real-time RPM alerts, facilitates rapid follow-up by local clinicians, and supports transitions of care after ED visits or hospitalizations.

Clinical integration programs will focus on proactive patient management and early intervention for high-risk patients, which research has shown can reduce avoidable hospitalizations and emergency department utilization. Key outcome measures to be monitored may include:

- 30-day hospital readmission rates
- Preventable emergency department visits
- Chronic disease management indicators, such as diabetes HbA1c control
- Preventive screening rates, including colorectal and breast cancer screenings

- Hospital-acquired condition rates

These metrics align with nationally-recognized performance standards used in programs administered by the Centers for Medicare & Medicaid Services ("CMS") and other oversight bodies.

Reduction in Avoidable Hospital Utilization

Clinical integration programs will focus on proactive patient management and early intervention for high-risk patients, which research has shown can reduce avoidable hospitalizations and emergency department utilization, including 30-day readmissions for conditions such as heart failure. *See* Chang and Tung, 2024, attached as **Exhibit 15.a.1**.

National studies of CINs and coordinated care programs have shown reductions in avoidable hospital utilization and improvements in care quality when providers share clinical data and implement coordinated care management programs. *Id*. For example, coordinated care programs implemented through provider networks have demonstrated measurable improvements such as: reductions in avoidable hospital readmissions improved adherence to preventive screening guidelines improved chronic disease management outcomes The CIN's shared analytics infrastructure will allow participating providers to identify care gaps, monitor utilization trends, and implement targeted interventions to improve patient outcomes *See* Cerezo-Cerezo et al., 2025, attached as **Exhibit 15.a.2**; *see also* Allen and Burton, 2013, attached as **Exhibit 15.a.3**.

Expansion of Telehealth and Specialty Access

The CIN will also support expanded access to specialty care and telehealth services for patients in rural communities. Geographic distance and workforce shortages can limit timely access to specialty services in rural Oregon, often resulting in delayed treatment and poorer health outcomes. By coordinating specialty resources across the network and expanding telehealth consultation programs, the CIN will enable patients in participating communities to receive specialty care without having to travel long distances. Expanded access to telehealth services has been shown to improve clinical outcomes in rural communities by enabling earlier diagnosis, more frequent follow-up care, and improved management of chronic conditions. *See* Batsis et al., 2021, attached as **Exhibit 15.a.4**; *see also* Mensah and Goldstein, 2023, attached as **Exhibit 15.a.5**.

Continuous Quality Improvement

The CIN will establish a clinical governance structure responsible for monitoring performance on quality metrics, implementing quality improvement initiatives, and ensuring adherence to evidence-based clinical protocols across the Participating Entities' service locations. Performance data will be reviewed regularly to identify opportunities for improvement, implement targeted interventions, and measure progress toward predefined goals. Through these coordinated clinical programs

and data-driven quality improvement initiatives, the CIN is expected to support measurable improvements in health outcomes for patients served by the Participating Entities across Oregon.

b. Benefit the public good by reducing the growth in health care costs. Provide applicable data, metrics, or documentation to support your statements.

The proposed transaction will benefit the public by helping reduce the growth in healthcare costs through improved care coordination, enhanced population health management, and increased participation in value-based reimbursement models. The formation of the CIN will enable the Participating Entities to collaborate on initiatives designed to reduce unnecessary healthcare utilization, improve efficiency, and deliver higher-quality care at lower overall cost.

Reduction in Avoidable Hospital Utilization

One of the primary drivers of healthcare cost growth is avoidable hospital utilization, including preventable hospital admissions, emergency department visits, and hospital readmissions. Through coordinated care management programs and improved transitions of care, the CIN will focus on identifying high-risk patients and providing proactive interventions designed to prevent avoidable acute care utilization. Clinical integration initiatives may include:

- Care coordination for high-risk and chronically ill patients;
- Standardized discharge planning and follow-up protocols;
- Medication management programs;
- Population health analytics to identify patients at risk for hospitalization.

Research demonstrates that coordinated care programs can meaningfully reduce avoidable utilization. For example, care management initiatives implemented within integrated provider networks have shown reductions in hospital readmissions and emergency department utilization while improving patient outcomes *See supra* Cerezo-Cerezo et al., 2025; Allen and Burton, 2013.

Population Health Management and Preventive Care

The CIN will support the implementation of population health management programs that focus on preventive care and early intervention for chronic disease. Preventive care and effective chronic disease management can significantly reduce the long-term costs of healthcare by preventing complications that require expensive hospital or specialty care. *See supra* Cerezo-Cerezo et al., 2025.

For example, effective management of chronic conditions such as diabetes, hypertension, and cardiovascular disease can reduce costly hospitalizations and complications. The CIN's shared analytics infrastructure will allow providers to identify care gaps and implement targeted interventions designed to improve disease management and reduce downstream healthcare costs.

Participation in Value-Based Payment Models

The formation of the CIN will also allow the Participating Entities and their providers to participate more effectively in value-based payment arrangements that reward providers for delivering high-quality, cost-effective care. These payment models increasingly require providers to demonstrate coordinated care delivery, quality reporting, and population health management capabilities. Through the CIN, the Participating Entities will be able to satisfy these requirements, thereby making themselves eligible to participate in programs that they lack the scale, resources, and personnel to qualify for independently.

Shared Infrastructure and Operational Efficiency

The CIN will also allow the Participating Entities to share infrastructure related to quality reporting, data analytics, and clinical program development. By sharing these resources across the CIN, the Participating Entities can avoid duplicative investments and improve operational efficiency. Shared infrastructure may include:

- Population health analytics platforms
- AI-enabled centralized care coordination
- Clinical quality reporting systems
- Care management and patient navigation programs
- Telehealth and remote consultation platforms

A standalone rural hospital is unlikely to generate enough value-based care revenue to justify an investment in these technologies. But a group of rural hospitals, acting through a CIN, can share costs in a manner that makes such investments feasible and worthwhile.

Alignment with Statewide Cost Containment Goals

The proposed CIN is consistent with healthcare cost containment goals promoted by the OHA, which seeks to slow the growth of healthcare spending while maintaining or improving access and quality of care. Through coordinated care delivery, improved population health management, and expanded participation in value-based reimbursement programs, the CIN is expected to contribute to more efficient healthcare delivery and help moderate the growth of healthcare costs for patients, employers, and public payers.

c. Benefit the public good by increasing access to services for medically underserved populations. Provide applicable data, metrics, or documentation to support your statements.

The CIN will support improved access to services for medically-underserved populations through:

- Expansion of telehealth and virtual specialty consultation programs;
- Shared specialty care resources across participating facilities;
- Enhanced care coordination for patients requiring services outside their local communities;

By coordinating resources across the network, the CIN will help the Participating Entities maintain and expand services that might otherwise be difficult to sustain independently. *See supra* Mensah and Goldstein, 2023.

The CIN will support the implementation of population health management programs that focus on preventive care and early intervention for chronic disease. Preventive care and effective chronic disease management can significantly reduce the long-term costs of healthcare by preventing complications that require expensive hospital or specialty care.

For example, effective management of chronic conditions such as diabetes, hypertension, and cardiovascular disease can reduce costly hospitalizations and complications. The CIN's shared analytics infrastructure will allow providers to identify care gaps and implement targeted interventions designed to improve disease management and reduce downstream healthcare costs. *See supra* Cerezo-Cerezo et al., 2025; Allen and Burton, 2013.

d. Benefit the public good by rectifying historical and contemporary factors contributing to health inequities or access to services. Provide applicable data, metrics, or documentation to support your statements.

The CIN will incorporate health equity considerations into its care coordination and quality improvement programs. Participating entities intend to monitor health outcomes across patient populations to identify disparities in access, treatment, or outcomes.

Key strategies may include:

- Enhanced data collection related to social determinants of health
- Community partnerships to address barriers to care
- Care management programs targeting vulnerable populations
- Improved care coordination for patients with complex medical and social needs

These initiatives are consistent with statewide priorities related to health equity promoted by the OHA.

e. If the transaction will not benefit the public good as described in b-d, explain why this proposed material change transaction is in the best interest of the public.

NA

16. Describe any competitive effects that may result from the proposed material change transaction.

NA

a. Will the proposed material change transaction result in a decrease in competition?

The proposed transaction will not result in a decrease in competition. The formation of the CIN will not change the availability of healthcare providers or services within the affected communities, nor will it limit patients' ability to choose among providers. Participation in the CIN will also be non-exclusive, meaning that Participating Entities and providers will retain the ability to participate in other provider networks.

The respective service areas of the Participating Entities are mostly separate and distinct. *See* **Exhibits 16.a.1 and 16.a.2.** Arguably, the overlap of one provider's service area with another provider's service area would be more consequential in a transaction involving a merger of the two providers or an acquisition of one provider by the other. Even so, the fact that there is little competition between the Participating Entities for patients lends credence to the claim that the CIN is being set up to improve healthcare in Oregon's rural and frontier communities; not to inhibit competition.

i. If yes, describe any anticompetitive effects that will result from the proposed transaction.

NA

ii. If yes, describe any plans to mitigate potential anticompetitive effects, including any divestiture plans.

NA

b. Provide applicable data, metrics, or documentation to support your statements.

NA

17. Describe the proposed material change transaction's impact on the financial stability of any entity involved in the transaction.

The proposed material change transaction—the formation of a CIN among the Participating Entities and their affiliated providers— will have a positive impact on the financial stability of the entities involved. In particular, the CIN will provide a structure and protocols to facilitate and streamline the Participating Entities' collaboration on initiatives that improve operational efficiency, enhance care coordination, and support participation in emerging value-based reimbursement models. The CIN will also allow Participating Entities to reduce costs by sharing certain clinical integration resources and infrastructure, including data analytics capabilities, quality improvement programs, and care coordination tools.

In addition, the CIN will provide the Participating Entities with opportunities to tap into new revenue streams, such as value-based payment arrangements and alternative reimbursement models that reward providers for delivering coordinated, high-quality care. Participation in such programs increasingly requires providers to demonstrate clinical integration, population health

management capabilities, and performance on quality metrics—capabilities that may be difficult for individual rural hospitals to develop independently.

It is important to reiterate that the Participating Entities, as well as the Oregon Office of Rural Health and Cibolo Health, anticipate receiving RHTP funding to support the proposed transaction. The state is actively trying to promote the kind of regional partnerships and system transformation initiative that the proposed transaction represents. Indeed, the Oregon Health Authority expressly states in its Rural Health Transformation Program Project Summary that it will use RHTP funding to "intensify efforts around partnerships such as clinically integrated networks (CINs) to better coordinate patient care, collaborate on staff recruitment and retention, share technology, right-size facilities and services, reduce health care entities' administrative costs, and deploy value-based payment arrangements." *See supra* OHA, **Exhibit 6.a.**, at 18.

VI. Supplemental materials

Submit the following materials, if applicable, with your submission. Apply Bates numbering to all confidential documents submitted with the Notice and include the applicable Bates number sequence on all redaction logs.

☒ HCMO-1a: NPI form (required for health care provider entities). *See* **Exhibit A.**

☒ HCMO-1b: Business Entities form (required parties with multiple business entities licensed to operate in Oregon). *See* **Attachments A-L**.

☒ HCMO-1c: Facilities and Locations form. *See* **Attachments A-L.**

☒ Pre- and post-transaction organizational structure diagram. *See* **Exhibit B**.

☒ Copies of all current agreements or term sheets for the proposed transaction. *See* **Exhibit C**.

☒ Financial statements for all entities for the most recent three fiscal years. *See* **Exhibit 1.e. to Attachments A-L**.

☒ Copies of current governance documents for all entities (for examples, bylaws, articles of incorporation, corporate charter, etc.). *See* governance documents for Cascades Rural High Value Network, attached as **Exhibit D**. *See also* **Exhibit 1.b. to Attachments A-L**.

☒ Documentation or analytic support for your responses, as applicable. *See* attached articles in **Exhibits 15.a.1 to 15.a.5**.

☒ Redaction log. See **Exhibit E** on Public-Facing Version of Application.

VII. Certification

I, the undersigned, being first duly sworn, do say:

1. I have read ORS 415.500 et seq. and OARs 409-070-0000 to 409-070-0085.
2. I have read this Notice of Material Change Transaction and the information contained therein is accurate and true.

Signed on the 29th day of June, 2026.

SUBSCRIBED AND SWORN TO before me, this 29th day of June, 2026.

OFFICIAL STAMP
KELLY K DUNN
NOTARY PUBLIC-OREGON
COMMISSION NO. 1027070
MY COMMISSION EXPIRES AUGUST 17, 2026

Notary Public in and for Lake County OR

My Commission Expires: 8-17-2026