Response to Notice of Incomplete Application
087 Cascade High Value Network
Attachment M: Supplemental and Amended Responses

1. HCMO-1 Item 6. The description of the transaction provided does not align with the term sheet, particularly related to payer contract negotiations. Please provide a more detailed and accurate description of the transaction and the clinically integrated network (CIN) activities as reflected in the term sheet.

The proposed transaction is the formation and operation of a CIN by eleven independent, rural hospitals and health districts, including Bay Area Hospital District, Blue Mountain Hospital District, Coquille Valley Hospital District, Curry Health District, Grande Ronde Hospital, Inc., Harney District Hospital, Lake Health District, Lower Umpqua Hospital District, Morrow County Health District, Southern Coos Health District, and Wallowa County Health Care District (each, a "Participating Entity"). To help facilitate the formation and operation of the CIN, which has been organized as an Oregon nonprofit membership corporation named, "Cascades Rural High Value Network," the Participating Entities have engaged Cibolo Health, LLC ("Cibolo") pursuant to a management services agreement, a draft of which is attached as **Attachment M, Exhibit 1**. Cibolo has successfully set up and managed CINs formed by rural hospitals in other states, including Kansas, Minnesota, Montana, Nebraska, North Dakota, Ohio, and Wisconsin. The Participating Entities have been impressed by Cibolo's track record in these other states and are hoping the company can help them achieve similar levels of success in Oregon.

One of the Participating Entities' primary objectives in setting up the CIN is to establish a vehicle by which they can participate in value-based care contracts. Acting alone, no Participating Entity has sufficient patient populations (covered lives) or resources to make participation in such contracts tenable. But acting together, through the CIN, the Participating Entities can overcome some of the entry barriers and unfavorable economies of scale that have historically kept them on the outside looking in.

The specific undertakings of the CIN will be determined and prioritized by the Participating Entities, each of which is a voting member of the CIN corporation, based on available resources, community needs, healthcare industry dynamics, and similar exigencies. As a result, it is difficult to predict with certainty what the CIN will do and when it will do them. In general, though, the CIN is intended to facilitate the pooling of resources, expertise, patient populations, and other assets of the Participating Entities so that they can collectively accomplish goals—many of which relate to population health and participation in value-based purchasing arrangements—that no individual Participating Entity could accomplish on its own.

With respect to payer contracting specifically, the Participating Entities acknowledge that it might someday be possible or reasonable for the CIN to engage in fee-for-service contract negotiations in connection with associated, value-based care programs. But that day is a ways off. The CIN will initially focus exclusively on negotiating value-based care agreements, population health programs, and quality shared-savings arrangements. Ambitiously, the CIN is hoping that it can start work on this front as early as 2028.

a. HCMO-1 Item 6b. The narrative neglects to mention that the proposed CIN will negotiate both value-based payments and fee for service contracts on behalf of the hospitals included in the CIN. Please add these terms and additional information to the summary of the transaction terms.

Please see the response above. The Participating Entities do not plan to have the CIN negotiate fee-for-service contracts on their behalf anytime in the foreseeable future. In fact, the CIN is likely to engage in such negotiations only if payers encourage the Participating Hospitals to participate in total-cost-of-care or downside risk models. The Participating Hospitals would have to be confident that they could identify and control their collective costs before they would be in a position even to consider participation in such models. But, theoretically, if the CIN had matured to the point where the Participating Hospitals had such confidence and were willing to dip their toes into the waters of total-cost-of-care or downside risk arrangements, then it would be almost essential that fee-for-service rates be negotiated by the CIN in connection with these arrangements.

2. HCMO-1 Item 7. The response is incomplete. Please update the response to address the following items:

a. Provide all products, reports, or analyses resulting from the due diligence process, including but not limited to, the following items. If the items listed below do not exist, please state as much.

i. All materials related to the internal assessment of clinical, operational, and financial needs conducted by the Participating Hospitals;

No reports or analyses were created collectively by the Participating Entities to assess their clinical, operational, or financial needs vis-à-vis the CIN. Instead, each Participating Entity conducted its own, internal analyses at board meetings, executive leadership meetings, and similar gatherings. Also, leaders of some of the Participating Entities conducted informal check ins with leaders of entities that are currently participating in Cibolo-run CINs to get their opinions on the pros and cons of participating in a CIN and working with Cibolo.

ii. All materials from the Participating Hospitals' joint working groups; and

All materials from the Participating Entities' joint working groups have already been provided to the HCMO division. (See Exhibit 7.b. of revised HCMO application dated July 7, 2026; Bates numbers 1658-1692).

iii. All materials relating to the Participating Hospitals' evaluation of potential risks and benefits to public access, quality, financial sustainability, and healthcare equity.

There are no formal reports or materials that were created collectively by the Participating Entities to evaluate the potential risks and benefits to public access, quality, financial sustainability, and healthcare equity. Again, each Participating Entity evaluated these risks and benefits as part of its standard governance and board

oversight duties rather than through separate written impact studies. The collective determination of the Participating Entities is that the CIN will catalyze their efforts to improve public access, quality, financial sustainability, and healthcare equity.

3. HCMO-1 Section IV. Description of all parties is incomplete. Please address the items below for each of the parties in the resubmission. Responses must include information regarding all parent and subsidiary entities of each of the parties to the transaction.

a. Please confirm whether NPI 1922620558 is an active NPI for Coquille Valley Hospital District. If so, please submit an updated HCMO-1a form that includes this NPI.
Yes, NPI 1922620558 is an active NPI for Coquille Valley Hospital District. See a revised HCMO-1a form attached as **Attachment M, Exhibit 3.a.**

b. Party A: Bay Area Hospital

i. Item c: Please provide an updated organizational chart that demonstrates or explains the relationship between Bay Area District Hospital and Bay Area District Hospital Auxiliary.
Please see an updated organizational chart attached as **Attachment M, Exhibit 3.b.i.**

ii. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii.**

c. Party B: Blue Mountain Hospital District

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

d. Party D: Coquille Valley Hospital

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

e. Party E: Curry General Hospital

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

f. Party F: Grande Ronde Hospital

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

g. Party G: Harney District Hospital

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

h. Party H: Lake District Hospital

i. HCMO-1c: Only one zip code is provided per facility listed. Please provide an updated HCMO-1c that includes all zip codes from which the location or facility draws at least 75% of its patients, per HCMO-1c instructions.
Please see an updated HCMO-1c for Lake District Hospital attached as **Attachment M, Exhibit 3.h.i.**

ii. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

i. Party I: Lower Umpqua Hospital District

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

j. Party J: Pioneer Memorial Hospital

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

k. Party K: Southern Coos Hospital & Health Center

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

l. Party L: Wallowa Memorial Hospital

i. Item f.vii and f.viii: Please provide the actual number of people served, actual number of services provided (by service type), and the timeframe for those numbers.
Please see the patient service statistics chart attached as **Attachment M, Exhibit 3.b.ii**.

4. HCMO-1 Item 13: Please address the following:

a. Item 13a: Please include an org chart that addresses the relationship between the proposed CIN, Cibolo Health, and the participating entities.
Please see the organizational chart attached as **Attachment M, Exhibit 4.a.**

b. Item 13h: This question asks about any changes to payer contracts and payer mix as a result of the proposed transaction. Please describe any and all expected changes to payer contracts and negotiations as a result of the transaction.
Please see the responses to items 1 and 1.a., above. The Participating Entities are optimistic that the CIN will enable them to participate meaningfully in value-based care programs offered by governmental and commercial payers. They do not anticipate using the CIN to negotiate fee-for-service contracts or rates on their behalf, and would probably revisit this issue only if they were presented with an opportunity to participate in a compelling total-cost-of-care or downside risk arrangement. Thus, the fee-for-service contracts and the negotiations associated with them, as well the Participating Entities' payer mixes, will remain unchanged as a result of the proposed transaction.

i. Your response should accurately reflect the terms of the agreement, including that the CIN will negotiate on behalf of partnering hospitals and that negotiations are not limited to value-based payments.

c. Item 13i: This item is intended for transactions involving insurance carriers and does not appear to be applicable to this transaction.
Understood.

d. Item 13j: Please address if the CIN plans to have joint contracts with suppliers and other vendors. Please address if the CIN will have a shared Electronic Health Record.
The CIN does not plan to have joint contracts with suppliers or other vendors, and does not plan to have a shared Electronic Health Records ("EMR") system. However, the Participating Entities will have the opportunity (but not the obligation) to purchase items and supplies through any preferred vendor relationships that may be established by the CIN or Cibolo.

Each Participating Entity will be responsible for maintaining its own EMR system before, during, and after consummation of the proposed transaction. To facilitate the exchange of information between the Participating Entities, the CIN plans to implement Cibolo Connect. This population health management application has the capability to aggregate and organize the disparate feeds from the Participating Entities' EMR systems into an integrated operational and clinical platform. Cibolo Connect will supplement (not replace or modify) the Participating Entities' EMR systems, providing population health analytics, identifying care gaps, tracking quality metrics, and otherwise providing the collective data needed by the CIN to monitor its progress and refine its strategies.