EXHIBIT A

OFFICIAL STATEMENT

PRELIMINARY OFFICIAL STATEMENT DATED JANUARY 5, 2021

REFUNDING ISSUE
BOOK-ENTRY ONLY

RATING: S&P "A"
SEE "BOND RATING"

In the opinion of Freudenthal & Bonds, P.C., Bond Counsel to the County and the Hospital Board, based upon an analysis of existing laws, regulations, rulings and court decisions and assuming, among other matters, the accuracy of certain representations and compliance with certain covenants, interest on the Series 2021 Bonds is excludable from gross income for federal income tax purposes under Section 103 of the Internal Revenue Code of 1986, as amended, and is not an item of tax preference for purposes of the federal individual alternative minimum taxes. See "TAX MATTERS" in this Official Statement.

$69,380,000*
LARAMIE COUNTY, WYOMING
HOSPITAL REVENUE REFUNDING BONDS
(CHEYENNE REGIONAL MEDICAL CENTER PROJECT)
SERIES 2021

Dated: Date of Issuance **Due: May 1, as shown herein**

The above-referenced bonds (the "Series 2021 Bonds") will be issued by Laramie County, Wyoming (the "County") at the request of the Board of Trustees of Memorial Hospital of Laramie County (the "Hospital Board"), as fully registered bonds in minimum denominations of $5,000 or any integral multiple thereof of single maturities, pursuant to a resolution of the governing body of the County and an Amended and Restated Indenture of Trust, dated as of February 1, 2021, as supplemented by a First Supplement to Indenture of Trust, dated as of February 1, 2021 (collectively, the "Indenture"), both between the County, the Hospital Board and Wells Fargo Bank, National Association, Denver, Colorado, as trustee (the "Trustee"), authorizing the issuance of the Series 2021 Bonds. Interest on the Series 2021 Bonds is payable on each May 1 and November 1, commencing May 1, 2021*, to the persons appearing as registered owners on the registration books kept by the Trustee, as of the 15th day of the calendar month immediately preceding each interest payment date. The Series 2021 Bonds will be registered in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York ("DTC"). Purchasers of the Series 2021 Bonds will not receive physical delivery of Series 2021 Bond certificates. The principal or redemption price of and interest on the Series 2021 Bonds are payable by wire transfer to DTC, which, in turn, is to remit such principal, redemption price or interest to DTC Participants for subsequent disbursements to the Beneficial Owners of the Series 2021 Bonds, as more fully discussed herein. See "APPENDIX G – BOOK-ENTRY ONLY SYSTEM" in this Official Statement. Capitalized terms used on this cover and not defined herein shall have the meanings granted to them in the Indenture.

Proceeds derived from the sale of the Series 2021 Bonds, along with funds held by Wells Fargo Bank, National Association as prior trustee of the Series 2012 Bonds (defined below), will be used by the Hospital Board to: (i) current refund the County's outstanding Hospital Revenue Bonds (Cheyenne Regional Medical Center Project), Series 2012 (the "Series 2012 Bonds"), issued in the original aggregate principal amount of $97,455,000; and (ii) pay the costs of issuance of the Series 2021 Bonds. Proceeds of the Series 2012 Bonds were originally used by the Hospital Board in order to: (i) fund a capital project for that certain county memorial hospital, commonly known as "Cheyenne Regional Medical Center" (the "Hospital"), which included (a) the expansion and construction of emergency services facilities, (b) the construction of a freestanding cancer center building, (c) the construction of a two-story parking structure adjacent to the Hospital, (d) the financing of an information technology and software system of integrated medical records, (e) the purchase of equipment to support the expansion and the Hospital Board's facilities, and (f) the reimbursement of certain prior capital expenditures at the Hospital; and (ii) pay the costs of issuance of the Series 2012 Bonds (collectively, the "Series 2012 Project"). The Series 2021 Bonds are subject to optional, mandatory and extraordinary optional redemption prior to their respective maturities, as described in this Official Statement.

THE SERIES 2021 BONDS ARE SPECIAL, LIMITED OBLIGATIONS OF THE COUNTY AND THE HOSPITAL BOARD PAYABLE SOLELY FROM NET PLEDGED REVENUES OF THE HOSPITAL BOARD AS DEFINED IN THE INDENTURE AND CERTAIN FUNDS HELD UNDER THE INDENTURE. NEITHER THE FAITH AND CREDIT NOR TAX REVENUES RECEIVED BY THE COUNTY ARE PLEDGED TO THE PAYMENT OF THE PRINCIPAL OR PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2021 BONDS. THE SERIES 2021 BONDS ARE NOT A DEBT OF THE STATE OF WYOMING (THE "STATE") OR THE COUNTY, AND NEITHER THE STATE NOR THE COUNTY IS LIABLE FOR THE PAYMENT THEREOF. See "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS" in this Official Statement.

This cover page contains certain information for general reference only. This cover page is not intended to be a summary of the Series 2021 Bonds or the security therefor. Potential purchasers of the Series 2021 Bonds should read this Official Statement, including the Appendices hereto, in its entirety prior to making an informed investment decision with respect to the Series 2021 Bonds.

SEE THE INSIDE FRONT COVER FOR MATURITY SCHEDULE FOR THE SERIES 2021 BONDS

The Series 2021 Bonds are offered when, as and if issued by the County and accepted by Piper Sandler & Co. (the "Underwriter"), subject to the approval of certain legal matters by Freudenthal & Bonds, P.C., Cheyenne, Wyoming, as Bond Counsel to the County and the Hospital Board. Certain legal matters will be passed upon for the Underwriter by Ballard Spahr LLP, Minneapolis, Minnesota; for the County by the Laramie County Attorney; and for the Hospital Board by its Vice President and Chief Legal Officer. Ponder & Co. has acted as municipal advisor to the Hospital Board in connection with the issuance of the Series 2021 Bonds. It is expected that the Series 2021 Bonds will be available for delivery through DTC in New York, New York, on or about February ___, 2021. For information with respect to the Underwriter, see "UNDERWRITING" in this Official Statement.

PIPER | SANDLER

The date of this Official Statement is _____, 202___.

$69,380,000*
LARAMIE COUNTY, WYOMING
HOSPITAL REVENUE REFUNDING BONDS
(CHEYENNE REGIONAL MEDICAL CENTER PROJECT)
SERIES 2021

MATURITY SCHEDULE

Maturity Date (May 1)*	Principal Amount*	Interest Rate	Yield	Price	CUSIP[(1)]
2022	$1,975,000				
2023	2,075,000				
2024	2,180,000				
2025	2,290,000				
2026	2,400,000				
2027	2,525,000				
2028	2,650,000				
2029	2,780,000				
2030	2,925,000				
2031	3,070,000				
2032	3,220,000				
2033	3,380,000				
2034	3,550,000				
2035	3,730,000				
2036	3,875,000				
2037	4,035,000				
2038	4,195,000				
2039	4,360,000				
2040	4,535,000				
2041	4,720,000				
2042	4,910,000				

[$_____* ____% Term Bonds Due May 1, 20___*
Price of ____% to Yield ___%
CUSIP: _____[(1)]

$_____* ____% Term Bonds Due May 1, 20___*
Price of ____% to Yield ___%
CUSIP: _____[(1)]]

**Preliminary, subject to change..*

[(1)] CUSIP is a registered trademark of the American Bankers Association ("ABA"). CUSIP data is provided by CUSIP Global Services, managed by S&P Global Market Intelligence on behalf of ABA. The CUSIP numbers listed above are being provided solely for the convenience of Holders of the Series 2021 Bonds only at the time of issuance of the Series 2021 Bonds and neither the County nor the Underwriter makes any representation with respect to such numbers or undertakes any responsibility for their accuracy now or at any time in the future.

The Hospital

_____
Source: The Hospital.

COUNTY OFFICIALS

Name	Position
Gunnar Malm	Chairman
Buck Holmes	Vice Chairman
Linda Heath	Commissioner
Brian Lovett	Commissioner
Troy Thompson	Commissioner
Leigh Anne Manlove	County District Attorney
Debra Lee	County Clerk

BOARD OF TRUSTEES OF MEMORIAL HOSPITAL OF LARAMIE COUNTY DOING BUSINESS AS CHEYENNE REGIONAL MEDICAL CENTER

Name	Position
Jean Halpern, M.D.	President
Mel Muldrow	Vice-President
Mark Parsons	Secretary/Treasurer
Robin Cooley	Trustee
Rick Fortney	Trustee
Denise Green	Trustee
Jonath Jackson	Trustee
Kenneth R. Kranz, M.D.	Trustee
Pete Obermueller	Trustee

HOSPITAL ADMINISTRATION AND MANAGEMENT

Name	Position
Tim Thornell	Chief Executive Officer
Tracy Garcia	Chief Nursing Officer
Dr. Jeffrey Chapman	Chief Medical Officer
Robin Roling	Chief Operating Officer
Neil Bertrand	Chief Financial Officer
Joanna Vilos	Chief Legal and Human Resources Officer
Kerry Slater	President Cheyenne Regional Medical Group
Dawn Swaen	Finance Controller

BOND COUNSEL
Freudenthal & Bonds, P.C.
Cheyenne, Wyoming

UNDERWRITER
Piper Sandler & Co.
Minneapolis, Minnesota

MUNICIPAL ADVISOR TO THE HOSPITAL
Ponder & Co.
Valparaiso, Indiana

UNDERWRITER'S COUNSEL
Ballard Spahr LLP
Minneapolis, Minnesota

INDEPENDENT AUDITORS
Eide Bailly LLP
Fargo, North Dakota

TRUSTEE and PRIOR TRUSTEE
Wells Fargo Bank, National Association
Denver, Colorado

This Official Statement does not constitute an offer to sell the Series 2021 Bonds or the solicitation of an offer to buy, nor shall there be any sale of the Series 2021 Bonds by any person in any state or other jurisdiction to any person to whom it is unlawful to make such offer, solicitation or sale in such state or jurisdiction. No dealer, salesperson or any other person has been authorized to give any information or to make any representation other than those contained herein in connection with the offering of the Series 2021 Bonds, and, if given or made, such information or representation must not be relied upon.

The Underwriter has provided the following sentence for inclusion in this Official Statement. The Underwriter has reviewed the information in this Official Statement, but the Underwriter does not guarantee the accuracy or completeness of such information.

The Trustee has not participated in the preparation of this Official Statement or any other disclosure documents relating to the Series 2021 Bonds. Except for information under the heading "THE TRUSTEE," the Trustee has or assumes no responsibility as to the accuracy or completeness of any information contained in this Official Statement or any other such disclosure documents.

The information set forth herein under the caption "THE SERIES 2021 BONDS – Book-Entry Only System" and in APPENDIX G hereto has been derived from public information provided by DTC. Such information is believed to be reliable but is not guaranteed as to accuracy or completeness and is not to be construed as a representation by the County or the Hospital Board. All other information set forth herein has been obtained from the County or the Hospital Board and other sources that are believed to be reliable. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale of the Series 2021 Bonds made hereunder shall create under any circumstances any indication that there has been no change in the affairs of the County, the Hospital Board or DTC since the date hereof.

The Underwriter is a registered broker/dealer and a member of FINRA and SIPC. Nondeposit investment products offered by the Underwriter are not FDIC insured, are subject to investment risk, including loss of principal, and are not guaranteed by a bank unless otherwise specified. The Underwriter and its affiliates may also act as an investment advisor to issuers whose securities may be sold to a purchaser of the Series 2021 Bonds.

THE SERIES 2021 BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, AND THE INDENTURE HAS NOT BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACTS. THE REGISTRATION OR QUALIFICATION OF THE SERIES 2021 BONDS IN ACCORDANCE WITH THE APPLICABLE PROVISIONS OF LAWS OF THE STATES IN WHICH SERIES 2021 BONDS HAVE BEEN REGISTERED OR QUALIFIED AND THE EXEMPTION FROM REGISTRATION OR QUALIFICATION IN OTHER STATES CANNOT BE REGARDED AS A RECOMMENDATION THEREOF. NEITHER THESE STATES NOR ANY OF THEIR AGENCIES HAVE PASSED UPON THE MERITS OF THE SERIES 2021 BONDS OR THE ACCURACY OR COMPLETENESS OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY MAY BE A CRIMINAL OFFENSE.

References in this Official Statement to Wyoming law, the Indenture, the Continuing Disclosure Agreement, the Bond Purchase Agreement, and other documents do not purport to be complete. Potential investors should refer to such statutes and documents for full and complete details of their provisions. Copies of such documents are on file with the Trustee and the Underwriter.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

Certain statements included or incorporated by reference in this Official Statement constitute "forward-looking statements." Such statements generally are identifiable by the terminology used, such as "plan," "expect," "estimate," "budget" or other similar words. Such forward-looking statements include but are not limited to certain statements contained in the information under the captions "PLAN OF REFUNDING" and "BONDHOLDERS' RISKS" in the forepart of this Official Statement and the statements contained in "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER" and "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019 – FINANCIAL INFORMATION – Management Discussion and Analysis of Three-Month Periods Ended September 30, 2020 and 2019" in this Official Statement. The achievement of certain results or other expectations contained in such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Neither

the Hospital Board nor the County plans to issue any updates or revisions to those forward-looking statements if or when its expectations or events, conditions or circumstances on which such statements are based occur.

TABLE OF CONTENTS

$69,380,000*
LARAMIE COUNTY, WYOMING
HOSPITAL REVENUE REFUNDING BONDS
(CHEYENNE REGIONAL MEDICAL CENTER PROJECT)
SERIES 2021

SUMMARY OF THE OFFERING

The following is a summary of certain information discussed in this Official Statement. Capitalized terms used herein are defined in the text hereof and in "APPENDIX E – SUMMARY OF PRINCIPAL DOCUMENTS." This summary is qualified in its entirety by reference to the more detailed information included elsewhere in this Official Statement.

The County..... Laramie County, Wyoming (the "County") is a body corporate and politic duly organized and existing under the Constitution and laws of the State of Wyoming. The County is authorized pursuant to Wyo. Stat. §§18-8-201 and 35-2-432 (collectively, the "Act") to issue revenue bonds for the purpose of acquiring, erecting, constructing, reconstructing, improving, remodeling, furnishing or equipping hospitals or related facilities or refunding any securities issued pursuant to any act and payable from any pledged revenues of a county memorial hospital when requested by the board of trustees of a county memorial hospital. See "THE COUNTY" in this Official Statement.

The Series 2021 Bonds..... The County, at the request of the Board of Trustees of Memorial Hospital of Laramie County (the "Hospital Board"), will issue its Hospital Revenue Refunding Bonds (Cheyenne Regional Medical Center Project), Series 2021 (the "Series 2021 Bonds"), in the original aggregate principal amount of $69,380,000*. The Series 2021 Bonds will be dated their date of issuance. The Series 2021 Bonds will be fully registered bonds without coupons in book-entry only form. Interest on the Series 2021 Bonds is payable on each May 1 and November 1, commencing May 1, 2021* (each an "Interest Payment Date"). Principal of the Series 2021 Bonds is payable on May 1 of the years and in the amounts shown on the inside front cover page of this Official Statement. See "THE SERIES 2021 BONDS" in this Official Statement.

Use of Proceeds ..... Proceeds derived from the sale of the Series 2021 Bonds will be used by the Hospital Board, along with funds held by Wells Fargo Bank, National Association as prior trustee of the Series 2012 Bonds (defined below), in order to: (i) current refund the County's Hospital Revenue Bonds (Cheyenne Regional Medical Center Project), Series 2012 (the "Series 2012 Bonds"), issued in the original aggregate principal amount of $97,455,000; and (ii) pay the costs of issuance of the Series 2021 Bonds. Proceeds of the Series 2012 Bonds were originally used to: (i) fund a capital project for that certain county memorial hospital, commonly known as "Cheyenne Regional Medical Center" (the "Hospital"), which included (a) the expansion and construction of emergency services facilities, (b) the construction of a freestanding cancer center building, (c) the construction of a two-story parking structure adjacent to the Hospital, (d) the financing of an information technology and software system of integrated medical records, (e) the purchase of equipment to support the expansion and the Hospital Board's facilities, and (f) the reimbursement of certain prior capital expenditures at the Hospital; and (ii) pay the costs of issuance of the Series 2012 Bonds (collectively, the "Series 2012 Project"). See "SOURCES AND USES OF FUNDS," "PLAN OF REFUNDING," and "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS" in this Official Statement.

The Hospital..... The County owns and operates the Hospital, a 206-bed acute care facility licensed by the State of Wyoming Department of Public Health. The Hospital's long-term license is for 206 beds, including 120 medical and surgical, 15 intensive care, 16 pediatric medical and surgical, 19 obstetric, 20 physical

rehabilitation, and 16 psychiatric care. Due to COVID-19, the Hospital has been granted temporary licensure for 248 beds to include 16 same day surgery, 16 additional surge beds, and 10 additional ICU beds. The Hospital is governed by the Hospital Board, a nine member Board of Trustees. The Hospital is located in Cheyenne, Wyoming (the "City") which is located in the southeast corner of Wyoming, and is the State Capitol of Wyoming. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER" in this Official Statement.

Security for the Series 2021 Bonds ..... The Series 2021 Bonds will be issued by the County pursuant to the terms of (i) a resolution (the "Bond Resolution") of the Board of County Commissioners (the "Board"), and (ii) an Amended and Restated Indenture of Trust, dated as of February 1, 2021, as supplemented by a First Supplement to Indenture of Trust, dated as of February 1, 2021 (collectively, the "Indenture"), between the County, the Hospital Board and Wells Fargo Bank, National Association (the "Trustee"). The Series 2021 Bonds are special, limited obligations of the County and the Hospital Board payable solely from: (i) the Net Pledged Revenues (as defined in the Indenture), and (ii) certain funds held by the Trustee under the Indenture. See "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS" and "APPENDIX E – SUMMARY OF PRINCIPAL DOCUMENTS" in this Official Statement.

Book-Entry System ..... The Series 2021 Bonds will be fully registered as to principal and interest in the name of Cede & Co. as nominee of The Depository Trust Company, New York, New York ("DTC"). Subject to certain exceptions described herein all purchases, sales or other transfers of beneficial ownership in the Series 2021 Bonds are to be made by book-entry only, and no owner will receive, hold or deliver any certificates as long as the depository or any successor securities depository is the registered owner of the Series 2021 Bonds. See "APPENDIX G – BOOK-ENTRY ONLY SYSTEM" in this Official Statement.

Optional Redemption ..... The Series 2021 Bonds maturing on or after May 1, 20___*, are subject to redemption prior to their respective stated maturities, at the option of the County, upon the request of the Hospital Board, in whole or in part on or after May 1, 20___* at 100% of the principal amount thereof called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium. The County may rescind an optional redemption of Series 2021 Bonds as to which notice has been given as aforesaid by giving notice of the rescission to the Trustee five (5) Business Days prior to the optional redemption date. See "THE SERIES 2021 BONDS – Redemption – *Optional Redemption of the Series 2021 Bonds*" in this Official Statement for a full discussion of redemption provisions.

Mandatory Redemption ..... The Series 2021 Bonds maturing on May 1 in the years 20___ and 20___ are subject to mandatory sinking fund redemption as described under the heading "THE SERIES 2021 BONDS – Redemption – *Mandatory Sinking Fund Redemption of the Series 2021 Bonds"* in this Official Statement. The Series 2021 Bonds are also subject to redemption or acceleration of maturity in certain cases as described under the headings "THE SERIES 2021 BONDS – Redemption – *Redemption of the Series 2021 Bonds upon Occurrence of Certain Events*" or " – *Acceleration of Maturity"* in this Official Statement.

Tax Status ..... The County and the Hospital Board have covenanted to comply with requirements necessary under the Internal Revenue Code of 1986, as amended (the "Code"), to establish and maintain the exclusion from gross income under Section 103 of the Code of the interest on the Series 2021 Bonds, including

without limitation requirements relating to temporary periods for investments, limitations on amounts invested at a yield greater than the yield on the Series 2021 Bonds, and the rebate of excess investment earnings to the United States. See "TAX MATTERS" and "APPENDIX F – FORM OF OPINION OF BOND COUNSEL" in this Official Statement.

Risk Factors ..... Purchase of the Series 2021 Bonds involves a degree of risk. A prospective purchaser of the Series 2021 Bonds is advised to read this entire Official Statement and the Appendices attached hereto in their entirety, particularly the section entitled "BONDHOLDERS' RISKS" in this Official Statement, for a discussion of certain risk factors, which should be considered in connection with an investment in the Series 2021 Bonds.

Continuing Disclosure ..... The Hospital Board will enter into a Continuing Disclosure Agreement, dated as of February 1, 2021 (the "Disclosure Agreement"), with the County, and the Trustee, as dissemination agent, to make certain secondary market disclosure pertaining to the Series 2021 Bonds. See "CONTINUING DISCLOSURE" and "APPENDIX D – FORM OF CONTINUING DISCLOSURE AGREEMENT" in this Official Statement.

Rating ..... The Series 2021 Bonds have been rated "A" (positive outlook) by S&P Global Ratings ("S&P"). See "BONDHOLDERS' RISKS – Maintenance of Credit Rating" and "BOND RATING" in this Official Statement.

Audited and Interim Unaudited Financial Statements ..... The audited financial statements of the Hospital Board for the fiscal years ended June 30, 2020 and 2019 are appended hereto as APPENDIX B. These are the most recent audited financial statements available for the Hospital. The financial statements contained in APPENDIX B have been audited by Eide Bailly LLP, Fargo, North Dakota. See "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019" in this Official Statement.

The unaudited interim financial statements for the three-month periods ended September 30, 2020 and 2019 are contained in APPENDIX C. The unaudited interim financial statements contained in APPENDIX C have been prepared by the Hospital Board and have not been audited, reviewed or examined by any independent accounting firm. See "APPENDIX C – UNAUDITED INTERIM FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE THREE-MONTH PERIODS ENDED SEPTEMBER 30, 2020 AND 2019" in this Official Statement.

Legal Counsel..... Certain legal matters incident to the authorization, issuance, sale and delivery of the Series 2021 Bonds are subject to the approval of Freudenthal & Bonds, P.C., Bond Counsel to the County and the Hospital Board. Certain legal matters in connection with the Series 2021 Bonds will be passed upon for the Underwriter by Ballard Spahr LLP, Minneapolis, Minnesota; for the County by the Laramie County Attorney; and for the Hospital Board by its Vice President and Chief Legal Officer. See "LEGAL MATTERS" and "RELATIONSHIPS AMONG THE PARTIES" in this Official Statement.

Additional Information ..... The summaries of or references to constitutional provisions, statutes, resolutions, agreements, contracts, financial statements, reports, publications and other documents or compilations of data or information set forth in this Official Statement do not purport to be complete statements of the provisions of the items summarized or referred to and are qualified in their entirety by the actual provisions of such items, copies of which are either publicly available or

available upon request and the payment of a reasonable copying, mailing and handling charge from the Trustee or the Underwriter.

OFFICIAL STATEMENT

$69,380,000*
LARAMIE COUNTY, WYOMING
HOSPITAL REVENUE REFUNDING BONDS
(CHEYENNE REGIONAL MEDICAL CENTER PROJECT)
SERIES 2021

INTRODUCTORY STATEMENT

The following introductory statement is subject in all respects to the more complete information set forth in this Official Statement. The descriptions and summaries of various documents hereinafter set forth do not purport to be comprehensive or definitive and are qualified in their entirety by reference to each document. All capitalized terms used in this Official Statement and not otherwise defined herein have the same meaning as in the Indenture (as defined herein). See "APPENDIX E – SUMMARY OF PRINCIPAL DOCUMENTS – Definitions of Certain Terms" in this Official Statement.

Purpose of this Official Statement

This Official Statement, including the cover page and the Appendices hereto, is provided to furnish information in connection with the sale and delivery by Laramie County, Wyoming (the "County") of its Hospital Revenue Refunding Bonds (Cheyenne Regional Medical Center Project), Series 2021 (the "Series 2021 Bonds"), in the original aggregate principal amount of $69,380,000*. The Series 2021 Bonds will be issued by the County pursuant to and secured by an Amended and Restated Indenture of Trust, dated as of February 1, 2021, as supplemented by a First Supplement to Indenture of Trust, dated as of February 1, 2021 (collectively, the "Indenture"), by and between the County, the Board of Trustees of Memorial Hospital of Laramie County (the "Hospital Board") and Wells Fargo Bank, National Association, Denver, Colorado, as trustee (the "Trustee"). The County is a body corporate with the power to make contracts, acquire real estate and personal property and equipment and issue bonds for the purchase of real property, improvements and equipment for hospital purposes and related facilities. The County owns the Memorial Hospital of Laramie County, which does business as and is commonly known as Cheyenne Regional Medical Center (the "Hospital").

Proceeds derived from the sale of the Series 2021 Bonds, along with funds held by Wells Fargo Bank, National Association as prior trustee of the Series 2012 Bonds (defined below), will be used by the Hospital Board in order to: (i) current refund the County's Hospital Revenue Bonds (Cheyenne Regional Medical Center Project), Series 2012 (the "Series 2012 Bonds"), issued in the original aggregate principal amount of $97,455,000; and (ii) pay the costs of issuance of the Series 2021 Bonds. Proceeds of the Series 2012 Bonds were originally used to fund the Series 2012 Project (defined herein).

Security for the Series 2021 Bonds

The Series 2021 Bonds are special, limited obligations of the County and the Hospital Board payable solely from (i) Net Pledged Revenues (as defined in the Indenture), and (ii) certain funds held under the Indenture. Pursuant to the Indenture, the County and the Hospital Board are required to pay in full, when due, the principal of and premium, if any, and interest on the Series 2021 Bonds. See "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS" in this Official Statement.

Series 2012 Project

The proceeds derived from the sale of the Series 2012 Bonds were used by the Hospital Board, together with other available funds, to fund the Series 2012 Project: (i) fund a capital project, which includes (a) the expansion and construction of emergency services facilities (the "Emergency Department"), (b) the construction of a freestanding cancer center building (the "Cancer Center"), (c) the construction of a two-story parking structure adjacent to the Hospital (the "Parking Structure"), (d) the financing of an information technology and software system of integrated medical records, (e) the purchase of equipment to support the expansion and the Hospital Board's facilities, and (f) the reimbursement of $20,500,000 in prior capital expenditures; and (ii) pay the costs of issuance of the Series 2012 Bonds (collectively, the "Series 2012 Project").

The Series 2012 Project also included financing the acquisition and implementation of a comprehensive information technology system, known as Epic Enterprise Solution ("Epic"), to provide a coordinated integration of clinical information throughout the health system. Implementation of Epic enabled the Hospital Board to achieve certain federal requirements under the HITECH Act, which may increase Medicare and Medicaid reimbursement to the Hospital. See "BONDHOLDERS' RISKS – General Health Care Risk Factors – *The HITECH Act*" in this Official Statement for additional information about the HITECH Act. Epic is intended to facilitate workflow integration between and among physician practice sites, the Hospital, and other ambulatory care settings and provide for the effective management of care coordination.

Current and Possible Future Equipment Financing Leases

The Hospital Board and the County, as lessees, previously entered into a Master Equipment Lease/Purchase Agreement, dated December 23, 2019 (the "Lease/Purchase Agreement") with Banc of America Public Capital Corp., as lessor ("Banc of America"), for the lease and purchase of certain equipment identified in the property schedules attached to the Lease/Purchase Agreement. Schedule of Property No. 1 to the Lease/Purchase Agreement, dated December 23, 2019 ("Property Schedule No. 1"), is a $12,500,000 lease for certain Equipment (as defined in the Lease/Purchase Agreement) identified in Property Schedule No. 1. Property Schedule No. 1 has a final maturity date of December 23, 2029 with an interest rate of 1.99%. Schedule of Property No. 2 to the Lease/Purchase Agreement, dated April 3, 2020 ("Property Schedule No. 2"), is a $12,500,000 lease for certain Equipment identified in Property Schedule No. 2. Property Schedule No. 2 has a final maturity date of April 3, 2030 with an interest rate of 1.39%. In February 2021, the Hospital Board anticipates entering into an additional lease property schedule ("Property Schedule No. 3") to the Lease/Purchase Agreement with Banc of America in order to finance the acquisition of additional equipment in an estimated principal amount of $10,000,000 with a ten year final term and an interest rate not to exceed 1.51%. Banc of America has also approved the Hospital Board for an additional $10,000,000 of lending capacity for future equipment acquisitions within the next twelve months if the Hospital Board determines in the future that such lending would be beneficial. The Hospital Board will budget and appropriate annually funds to make the rental payments required under the Lease/Purchase Agreement and the associated Property Schedules No. 1, No. 2, and No. 3 (collectively, the "Equipment Leases").

Bondholders' Risks

There are risks associated with the purchase of the Series 2021 Bonds. See "BONDHOLDERS' RISKS" in this Official Statement for a discussion of certain of these risks.

THE COUNTY

Laramie County, Wyoming, is a body corporate and politic duly organized and existing under the Constitution and laws of the State of Wyoming (the "State"). The County is authorized pursuant to Wyo. Stat. §§18-8-201 and 35-2-432 (collectively, the "Act") to issue revenue bonds for the purpose of acquiring, erecting, constructing, reconstructing, improving, remodeling, furnishing or equipping hospitals or related facilities or refunding any securities issued pursuant to any act and payable from any pledged revenues of a county memorial hospital when requested by the board of trustees of a county memorial hospital.

THE HOSPITAL

The County owns Memorial Hospital of Laramie County, which is commonly known as Cheyenne Regional Medical Center (the "Hospital"). The Hospital is governed and operated by the Board of Trustees of Memorial Hospital of Laramie County (the "Hospital Board"). The Hospital is currently licensed by the State of Wyoming Department of Health as a 206-bed acute care hospital. The Hospital's long-term license is for 206 beds, including 120 medical and surgical, 15 intensive care, 16 pediatric medical and surgical, 19 obstetric, 20 physical rehabilitation, and 16 psychiatric care. Due to COVID-19, the Hospital has been granted temporary licensure for 248 beds to include 16 same day surgery, 16 additional surge beds, and 10 additional ICU beds. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER" in this Official Statement.

PLAN OF REFUNDING

The proceeds of the Series 2021 Bonds, together with other moneys held by Wells Fargo Bank, National Association as prior trustee with respect to the Series 2012 Bonds, will be used by the Hospital Board in order to current refund the Series 2012 Bonds. The Series 2012 Bonds to be refunded with proceeds of the Series 2021 Bonds and additional funds held by the Well Fargo Bank, National Association as prior trustee for the Series 2012 Bonds are described in more detail below. The Series 2012 Bonds maturing May 1, 2021 will be paid at maturity from funds held by Wells Fargo Bank, National Association, as prior trustee.

Maturity Date (May 1)	Interest Rate	Principal Amount Refunded	Redemption Date	Redemption Price	CUSIP (516706)
2022	4.000%	$2,310,000	May 1, 2021	100%	CF3
2023	5.000	2,400,000	May 1, 2021	100	CG1
2024	5.000	2,525,000	May 1, 2021	100	CH9
2025	5.000	2,650,000	May 1, 2021	100	CJ5
2026	5.000	2,780,000	May 1, 2021	100	CK2
2027	5.000	2,920,000	May 1, 2021	100	CL0
2028	5.000	3,065,000	May 1, 2021	100	CM8
2032	4.375	5,000,000	May 1, 2021	100	CN6
2032	5.000	8,830,000	May 1, 2021	100	CR7
2037	4.375	6,365,000	May 1, 2021	100	CP1
2037	5.000	15,000,000	May 1, 2021	100	CS5
2042	4.375	7,000,000	May 1, 2021	100	CQ9
2042	5.000	20,035,000	May 1, 2021	100	CT3

SOURCES AND USES OF FUNDS

The following table sets forth the sources and uses of funds related to the Series 2021 Bonds.

Sources of Funds:*	
Principal Amount of Series 2021 Bonds	
[Net] Original Issue [Premium/Discount]	
Total	
Uses of Funds:*	
Refunding Fund Deposit	
Costs of Issuance[(1)]	
Total	

(1) Includes legal, accountant, printing, Trustee, rating agency and financial advisor fees and expenses, Underwriters' discount, and other miscellaneous issuance costs.

(The remainder of this page is intentionally left blank.)

ANNUAL DEBT SERVICE REQUIREMENTS PAYABLE FROM NET PLEDGED REVENUES

The following table sets forth the gross annual debt service requirements for the Series 2021 Bonds, including amounts required to be made available for payment of principal of the Series 2021 Bonds from mandatory sinking fund redemption. Payment of principal of the Series 2021 Bonds will begin May 1, 2022*. Payment of interest on the Series 2021 Bonds will be made semi-annually on May 1 and November 1, beginning May 1, 2021*.

Fiscal Year Ending June 30	Series 2021 Principal*	Series 2021 Interest	Scheduled Debt Service on the Equipment Leases[(1)]	Total Debt Service
2021			$3,945,265	
2022	$1,975,000		4,516,986	
2023	2,075,000		4,255,022	
2024	2,180,000		4,263,596	
2025	2,290,000		4,045,286	
2026	2,400,000		3,822,650	
2027	2,525,000		3,822,650	
2028	2,650,000		3,822,650	
2029	2,780,000		3,822,650	
2030	2,925,000		2,905,369	
2031	3,070,000		718,685	
2032	3,220,000			
2033	3,380,000			
2034	3,550,000			
2035	3,730,000			
2036	3,875,000			
2037	4,035,000			
2038	4,195,000			
2039	4,360,000			
2040	4,535,000			
2041	4,720,000			
2042	4,910,000			
TOTAL	**$69,380,000**		**$39,940,809**	

[(1)] Includes the existing and proposed $10,000,000 capital leases for medical equipment described above under the heading "INTRODUCTORY STATEMENT – Current and Possible Future Equipment Financing Leases" and as further described in Note 8 of the Hospital's 2020 Audited Financial Statements for the Equipment Leases that were put in place by the Hospital prior to the issuance of the Series 2021 Bonds.

(The remainder of this page is intentionally left blank.)

THE SERIES 2021 BONDS

General

The Series 2021 Bonds are being issued pursuant to a resolution of the Board of County Commissioners and the Indenture in the original aggregate principal amount of $69,380,000*. The Series 2021 Bonds will be delivered in fully registered form without coupons. The Series 2021 Bonds will be dated their date of delivery and will be payable as to principal, subject to the redemption provisions set forth herein, on the dates and in the amounts set forth on the inside cover page hereof. The Series 2021 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2021 Bonds. Ownership interests in the Series 2021 Bonds may be purchased in book-entry form only, in the denominations hereinafter set forth. See "THE SERIES 2021 BONDS – Book-Entry Only System" and "APPENDIX G – BOOK-ENTRY ONLY SYSTEM" in this Official Statement. The Series 2021 Bonds will be transferable and exchangeable as set forth in the Indenture.

The Series 2021 Bonds will bear interest at the rates set forth on the inside cover page hereof, payable semiannually on each May 1 and November 1, commencing on May 1, 2021* (each an "Interest Payment Date"), to the person whose name appears on the bond registration books of the Trustee as the Holder thereof as of the close of business on the Regular Record Date (which will be the fifteenth day of the calendar month (whether or not a Business Day) next preceding an Interest Payment Date) for each Interest Payment Date (except with respect to interest in default, for which a Special Record Date shall be established). So long as Cede & Co. is the registered owner of the Series 2021 Bonds, principal of and premium, if any, and interest on the Series 2021 Bonds are payable by wire transfer by the Trustee to Cede & Co., as nominee for DTC, which, in turn, will remit such amounts to DTC Participants (as defined herein) for subsequent disbursement to the Beneficial Owners. See "APPENDIX G – BOOK-ENTRY ONLY SYSTEM."

Interest on the Series 2021 Bonds will be paid by check mailed by first-class mail on each Interest Payment Date to the registered owner (initially DTC) at its address as it appears on the bond registration books, or at such address as such owner may have filed with the Trustee for that purpose prior to the Record Date for each Interest Payment Date. Alternative means of payment of interest may be used if mutually agreed to between the Registered Owner of any Bond and the Trustee. Payment of the principal or redemption price of Series 2021 Bonds will be payable in lawful money of the United States of America upon surrender or presentation thereof at the principal corporate trust office of the Trustee.

Redemption

Optional Redemption of the Series 2021 Bonds. The Series 2021 Bonds maturing on May 1, 20___* or thereafter are subject to redemption prior to their respective stated maturities, at the option of the County upon the request of the Hospital Board, in whole or in part on or after May 1, 20___* (in such maturities as are designated by the County or, if the County fails to designate such maturities by such method as the Trustee deems fair and appropriate), upon at least forty-five (45) days prior written notice to the Trustee, from money deposited in the Debt Service Fund or from any other source of available funds, at a redemption price equal to the principal amount of the Series 2021 Bonds to be redeemed plus accrued interest to the redemption date, without premium.

[Mandatory Sinking Fund Redemption of the Series 2021 Bonds. The Series 2021 Bonds maturing on May 1 in the years 20___ and 20___, are subject to redemption prior to their respective stated maturities in part (by lot) from mandatory sinking fund payments in accordance with the following schedules, in the amounts set forth below, at the principal amount thereof, together with interest accrued thereon to the date fixed for redemption, without premium.

$_____* ____% Term Bonds Due May 1, 20___*

Redemption Date (May 1)	Principal Amount	Redemption Date (May 1)	Principal Amount

(1)

(1) *Stated maturity.*

$_____* ____% Term Bonds Due May 1, 20___*

Redemption Date (May 1)	Principal Amount	Redemption Date (May 1)	Principal Amount

(1)

(1) *Stated maturity.]*

Redemption of the Series 2021 Bonds upon Occurrence of Certain Events. The Series 2021 Bonds are subject to redemption prior to their respective stated maturities, at the option of the County as directed by the Hospital Board, as a whole or in part (via lottery with the redemption or payment of other Outstanding Bonds), upon the occurrence of one of the following events with respect to a substantial portion of the Facilities (as defined in APPENDIX E) prior to Maturity, on any date at a redemption price of par plus accrued interest to the redemption date, within 365 days following the occurrence of any one of the following events (or, if later, within 60 days following the receipt of any proceeds relating to such event):

(i) the Facilities or a substantial portion thereof shall have been damaged or destroyed to such an extent that, as expressed in a Consulting Architect's Certificate filed with the Trustee, (x) the required restoration and repair could not reasonably be expected to be completed within a period of six (6) months after commencement of restoration or repair, (y) the County and the Hospital Board are prevented or would likely be prevented from using the Facilities or a substantial portion thereof for normal purposes for a period of six (6) months or more or (z) the cost of restoration and repair would not be economically practical or desirable; or

(ii) title to the whole or any part of the Facilities or the use or possession thereof shall have been taken or condemned by a competent authority (other than the County, unless such taking or condemnation is for purposes other than hospital purposes) to such an extent that the County and the Hospital Board are prevented or would likely be prevented from using the Facilities or a substantial portion thereof for normal purposes for a period of six months or more.

Notice of Redemption; Effect of Redemption. (a) The Trustee, at the expense of the Borrower, will send notice of any redemption, identifying the Bonds to be redeemed, the redemption date and the method and place of payment and the information required by subsection (b) of this section, by first-class mail to each holder of a Bond called for redemption to the holder's address listed on the Bond Register. Such notice will be sent by the Trustee by first class mail between 30 and 60 days prior to the scheduled redemption date. With respect to the Book-Entry Bonds, if the Trustee sends notice of redemption to the Securities Depository pursuant to the Letter of Representations, the Trustee will not be required to give

the notice set forth in the immediately preceding sentence. If notice is given as stated in this paragraph (a), failure of any Bondholder to receive such notice, or any defect in the notice, will not affect the redemption or the validity of the proceedings for the redemption of the Series 2021 Bonds.

(b) In addition to the foregoing, the redemption notice will contain with respect to each Series 2021 Bond being redeemed, (1) the CUSIP number, (2) the date of issue, (3) the interest rate, (4) the Maturity Date, and (5) any other descriptive information determined by the Trustee to be needed to identify the Series 2021 Bonds. If a redemption is a Conditional Redemption, the notice will so state. The Trustee will also send each notice of redemption at least thirty (30) days before the redemption date to (A) any Rating Service then rating the Series 2021 Bonds to be redeemed; (B) all of the registered clearing agencies known to the Trustee to be in the business of holding substantial amounts of bonds of a type similar to the Series 2021 Bonds; and (C) one or more national information services that disseminate notices of redemption of bonds such as the Series 2021 Bonds (such services to be identified by the Trustee).

(c) On or before the date fixed for redemption, subject to the provisions of subsections (a) and (d) of this section, moneys will be deposited with the Trustee to pay the principal of, redemption premium, if any, and interest accrued to the redemption date on the Series 2021 Bonds called for redemption. Upon the deposit of such moneys, unless the County has given notice of rescission as described in subsection (d) of this section, the Series 2021 Bonds will cease to bear interest on the redemption date and will no longer be entitled to the benefits of the Indenture (other than for payment and transfer and exchange) and will no longer be considered Outstanding.

(d) Any Conditional Redemption may be rescinded (in whole or in part) at any time prior to the redemption date if the County delivers an Officer's Certificate to the Trustee instructing the Trustee to rescind the redemption notice. The Trustee will give prompt notice of such rescission to the affected Bondholders. Any Series 2021 Bonds subject to Conditional Redemption where redemption has been rescinded will remain Outstanding, and the rescission will not constitute an Event of Default. Further, in the case of a Conditional Redemption, the failure of the County to make funds available in part or in whole on or before the redemption date will not constitute an Event of Default, and the Trustee will give immediate notice to the Securities Depository or the affected Bondholders that the redemption did not occur and that the Series 2021 Bonds called for redemption and not so paid remain Outstanding.

The County may rescind an optional redemption of Series 2021 Bonds as to which notice has been given by giving notice of the rescission to the Trustee five (5) Business Days prior to the optional redemption date. The Trustee must give notice of such rescission to the same persons and in the same manner as the notice of redemption was given no later than the second (2nd) Business Day prior to the optional redemption date. Upon the mailing of the notice of rescission to the Trustee, the optional redemption of such Series 2021 Bonds will be cancelled, and no Holder of such Series 2021 Bonds will be entitled to the redemption thereof on such date. Failure of any Holder of Series 2021 Bonds to receive such notice of rescission will not invalidate any of the proceedings taken in connection with such rescission.

Acceleration of Maturity. If an Event of Default (other than an Event of Default resulting solely from a failure to provide information required under Rule 15c2-12(b)(5)(i) of the Securities and Exchange Commission) occurs and is continuing, the Trustee or the Holders of not less than 25% in principal amount of the Bonds Outstanding (or, in the case of any Event of Default resulting in the loss of any exclusion from gross income of interest on, or the invalidity of, any Debt secured by a pledge of Bonds, the Holders of not less than 25% in principal amount of the Bonds Outstanding of the affected series) may declare the principal of all of the Bonds to be due and payable immediately, by a notice in writing to the County and the Hospital Board (and to the Trustee if given by the Holders), and upon any such

declaration such principal shall become immediately due and payable; provided, however, that if a Credit Facility or Credit Confirmation is then in effect and not both then in payment default, the consent of each such Credit Enhancer and Credit Confirmer shall be required prior to any such declaration. At any time after such a declaration of acceleration has been made and before a judgment or decree for payment of the money due has been obtained by the Trustee, the Holders of a majority in principal amount of the Bonds Outstanding, by written notice to the County, the Hospital Board and the Trustee, may rescind and annul such declaration and its consequences if certain criteria are met, including the payment by the County or Hospital Board of all overdue installments of interest on all Bonds and the principal of (and premium, if any) on Bonds which have become due (other than by such declaration of acceleration).

Book-Entry Only System

The Series 2021 Bonds will be issued in book-entry form. DTC will act as securities depository for the Series 2021 Bonds. The Series 2021 Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee). One fully-registered Bond will be issued for each maturity in the total aggregate principal amount due on such maturity and will be deposited with DTC. See "APPENDIX G – BOOK-ENTRY ONLY SYSTEM" in this Official Statement.

SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS

General

The Series 2021 Bonds are special, limited obligations of the County and the Hospital Board and, except to the extent payable from Series 2021 Bond proceeds, investment earnings or proceeds of insurance or condemnation awards, are payable solely from Net Pledged Revenues and from certain other funds held under the Indenture. In the Indenture, the County and the Hospital Board agree to make payments to the Trustee, which payments, in the aggregate, are required to be in amounts sufficient for the payment in full of all amounts payable with respect to all Series 2021 Bonds, including the total interest payable on the Series 2021 Bonds to their respective stated maturities, the principal amount of the Series 2021 Bonds, and any redemption premiums, less any amounts available for such payment, as provided in the Indenture.

Limited Liability of the County

THE SERIES 2021 BONDS ARE SPECIAL, LIMITED OBLIGATIONS OF THE COUNTY AND THE HOSPITAL BOARD PAYABLE SOLELY FROM NET PLEDGED REVENUES OF THE HOSPITAL BOARD AS DEFINED IN THE INDENTURE AND CERTAIN FUNDS HELD UNDER THE INDENTURE. NEITHER THE FAITH AND CREDIT NOR TAX REVENUES RECEIVED BY THE COUNTY ARE PLEDGED TO THE PAYMENT OF THE PRINCIPAL OR PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2021 BONDS. THE SERIES 2021 BONDS ARE NOT A DEBT OF THE STATE OF WYOMING (THE "STATE") OR THE COUNTY, AND NEITHER THE STATE NOR THE COUNTY IS LIABLE FOR THE PAYMENT THEREOF.

Parity Bonds

All Bonds from time to time issued under the Indenture will be equally and ratably secured by the Indenture. The Equipment Leases are not parity bonds, but rather are capital leases that are subject to annual appropriation and are secured by the specific medical equipment financed by such specific Equipment Leases.

Pledge of Net Pledged Revenues

The Series 2021 Bonds are payable solely from and secured by a first and prior lien (but not necessarily an exclusive first lien) on the Net Pledged Revenues. Net Pledged Revenues generally consist of the net operating and non-operating revenues of the Hospital (excluding any income attributable to ad valorem taxes derived by the County and transferred to the Hospital Board, after provision is made for the payment of all Operating Expenses, excluding depreciation, amortization, and interest expense). Specifically, Net Pledged Revenues consist of (a) patient fees (whether paid by the patient or by any other party) and other charges payable by or on behalf of the patients; (b) all revenues, rents and income relating to the Hospital, whether such revenues are carried on the books of the County or the Hospital (excluding all money attributable to ad valorem taxes and all other taxes derived by the County and transferred to the Hospital Board); and (c) investment income, less (i) contractual allowances and allowances for doubtful accounts, (ii) profits or losses on the sale or disposition, not in the ordinary course of operations, of investments in fixed or capital assets or resulting from extinguishment of debt, (iii) restricted donor contributions and income thereon; and (iv) income from Irrevocable Deposits (as defined in the Indenture).

The foregoing pledge of Net Pledged Revenues will be perfected to the extent that such security interest can be perfected by filing or notice under the Uniform Commercial Code of the State of Wyoming and may, in several instances, be subordinated to the interest and claims of others. Some examples of cases of subordination or prior claims are (i) statutory liens, (ii) rights arising in favor of the United States of America or any agency thereof, (iii) present or future prohibitions against assignment in any federal statutes or regulations, (iv) constructive trusts, equitable liens or other rights impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction, (v) federal or State of Wyoming bankruptcy or insolvency laws that may affect the enforceability of the Indenture or pledge of Net Pledged Revenues, and (vi) rights of third parties in Net Pledged Revenues converted to cash and not in the possession of the Trustee. In addition, enforceable security interests in certain types of Net Pledged Revenues (e.g., restricted donations, certain insurance proceeds, payments from Medicare and Medicaid, and other revenues derived from governmental programs) prior to actual receipt by the County or the Hospital Board for deposit in the Revenue Fund may not be feasible in certain circumstances.

Property May Not Be Mortgaged

Pursuant to the Indenture, the Hospital Board and the County have represented that there are no liens or encumbrances on or against the Facilities or against the Net Pledged Revenues. Pursuant to the Indenture, the Hospital Board and the County have covenanted not to mortgage the Facilities, or create, assume, incur any liens or encumbrances, except for Permitted Encumbrances, on or against the Facilities or any part thereof unless all Bonds Outstanding under the Indenture are equally and ratably secured by such lien or encumbrance. The Hospital Board and County are also prohibited by State law from entering into any mortgage of the Facilities. The Hospital Board and the County may create purchase money security interests or capital leases with respect to the Facilities to the extent the book value of the portion of the Facilities so encumbered at any time does not exceed 15% of the book value of the Facilities.

No Pledge of County Tax Revenues

Net Pledged Revenues pledged under the Indenture to the payment of debt service on the Series 2021 Bonds do not include tax revenues of the County. The taxing power of the County is not pledged to the payment of the principal of, interest on, and premium, if any, on the Series 2021 Bonds. The Series 2021 Bonds are not an obligation of the County to which the full faith and ad valorem tax power of the County has been pledged.

Rate Covenant

The County and the Hospital Board will operate the Facilities as a revenue producing health facility on a nondiscriminatory basis and, in each Fiscal Year will charge such fees and rates for such Facilities and services and to exercise such skill and diligence as to provide Net Income Available for Debt Service equal to at least 110% of the Maximum Annual Debt Service Requirements payable in any Fiscal Year. Debt coverage below 110% of the Maximum Annual Debt Service Requirements will require the retention of a Management Consultant (which, if requested by the Trustee, is accompanied by an Opinion of Counsel acceptable to the Trustee as to any conclusions of law supporting the opinion of such Management Consultant). The Hospital's use of a Management Consultant's findings that applicable laws or regulations have prevented the compliance with the 100% of the Maximum Annual Debt Service Requirements rate covenant may not be used to excuse compliance therewith more than once every three (3) years. Coverage below 100% of the Maximum Annual Debt Service Requirements for two (2) consecutive years will constitute an Event of Default. If in any Fiscal Year, Net Income Available for Debt Service is less than required by the Indenture, the Hospital Board will notify the Trustee of such deficiency not later than 150 days after the end of such Fiscal Year and within 30 days of such notice will engage a Management Consultant to make recommendations, to be set forth in a certificate of the Management Consultant at the earliest possible date. If the Hospital Board does not engage a Management Consultant within 30 days of the notice to the Trustee of such deficiency, the Trustee will engage a Management Consultant at the expense of the Hospital Board. The County and the Hospital Board will (in accordance with applicable laws and governmental regulations) follow the recommendations of the Management Consultant, to the extent practicable.

Additional Bonds and Additional Debt

The County may authorize the issuance of additional series of revenue bonds ("Additional Bonds") upon the terms and conditions provided in the Indenture. "Debt" includes short-term debt, the current and non-current portions of long-term debt, capital leases, guarantees by the Hospital and synthetic "off-balance sheet" leases involving real estate. Long-Term Debt, including Additional Bonds, must meet the following requirements: (1) the Available Revenues of the Hospital for the Fiscal Year preceding, or any consecutive period of comparable length ending within 180 days preceding, the date of the incurrence of such Debt, were at least 110% of the Maximum Annual Debt Service Requirements of the Hospital for any future Fiscal Year with respect to the Long-Term Debt of the Hospital immediately prior to the incurrence of such Debt; and (2) unless the Available Revenues of the Hospital for the Fiscal Year preceding, or any consecutive period of comparable length ending within 180 days preceding, the date of incurrence of such Debt were at least 125% of the Maximum Annual Debt Service Requirements of the Hospital for any future Fiscal Year with respect to the Long-Term Debt of the Hospital immediately after the incurrence of such Debt, the estimated Available Revenues of the Hospital for each of the two Fiscal Years next succeeding the Fiscal Year or, in case any substantial construction project of the Hospital shall be financed with such Debt or shall then be in progress, for each of the two Fiscal Years immediately succeeding the anticipated date of material completion of such construction project, shall be at least 125% of the Maximum Annual Debt Service Requirements for any future Fiscal Year with respect to the Long-Term Debt of the Hospital to be Outstanding immediately after the incurrence of such Debt. See "APPENDIX E – SUMMARY OF PRINCIPAL DOCUMENTS" in this Official Statement.

BONDHOLDERS' RISKS

The purchase of the Series 2021 Bonds involves certain investment risks that are discussed throughout this Official Statement. Accordingly, each prospective purchaser of the Series 2021 Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. This section on Bondholders' Risks focuses primarily on

the general risks associated with healthcare providers, whereas APPENDIX A describes the Hospital and the Hospital Board specifically. These sections should be read together.

General

As described herein, the Series 2021 Bonds are special, limited obligations of the County and the Hospital Board, secured under the provisions of the Indenture, as described herein, and payable solely from Net Pledged Revenues and from certain funds held under the Indenture. There can be no assurance that income and receipts will be realized by the Hospital Board in amounts sufficient to pay the principal or premium, if any, or interest on the Series 2021 Bonds when due. The Series 2021 Bonds are not a general obligation of the County or the State of Wyoming (the "State") and the taxing power of the County and the State is not pledged to the payment of debt service on the Series 2021 Bonds. See "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS" in this Official Statement.

The Hospital Board's Facilities are subject to a wide variety of federal and state regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare, Medicaid and other payors, and is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("DHHS"), and other federal, state and local government agencies. The future financial condition of the Hospital could be adversely affected by, among other things, changes in the method and amount of payments to the Hospital by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, decreased demand for health care, changes in the methods by which employers purchase health care for employees, capability of management, changes in the structure of how health care is delivered and paid for (*e.g.*, a "single-payor" system), future changes in the economy, demographic changes, availability of physicians, nurses and other health care professionals, and malpractice claims and other litigation.

The Hospital derives a significant portion of its revenues from Medicare, Medicaid, and other third-party-payor programs. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER – MARKET COMPETITION AND UTILIZATION – Payor Mix" in this Official Statement. The Hospital is subject to governmental regulations applicable to health care providers and the receipt of future revenues from the operation of the Hospital's Facilities is subject to, among other factors, federal and State policies affecting the health care industry and other conditions that are impossible to predict. Such conditions may include difficulties in increasing room charges and other fees while maintaining an appropriate amount and quality of health services, changes in reimbursement or prospective payment policies and unanticipated competition from other health care providers. The effect on the Hospital of recently enacted laws and regulations and of future changes in federal and State laws and policies cannot be fully or accurately determined at this time.

Healthcare providers, including the Hospital, have been under increasing economic pressure from various third-party payors, both governmental (particularly Medicare and Medicaid) and private (e.g., health maintenance organizations). Certain payors have pressured health care providers to accept "capitated" reimbursement, which has the effect of shifting the economic risk of providing healthcare from the payors to the health care providers. Shifts in third-party payor policies and the need for providers to adapt to changing and complex payment arrangements have had and will continue to have a significant impact upon the economic performance of the Hospital.

Future economic and other conditions, including demand for healthcare services, the ability of the Hospital to provide the services required by residents, public confidence in the Hospital, economic developments in the service area, competition, rates, costs, third-party reimbursement and governmental

regulations may adversely affect revenues and, consequently, payment of principal of and interest on the Series 2021 Bonds. Any of these factors may affect the Hospital's ability to generate revenues and to pay the principal of and premium, if any, and interest on the Series 2021 Bonds. There can be no assurance that the financial condition of the Hospital and/or the utilization of the Hospital's facilities will not be adversely affected by any of these circumstances.

For information concerning the Hospital, its operations and management, see "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER" and "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019" in this Official Statement.

Maintenance of Credit Rating

The Series 2021 Bonds will be rated as to their creditworthiness by S&P Global Ratings (the "Rating Agency") based upon the credit rating of the Hospital. No assurance can be given that the Series 2021 Bonds will maintain their original rating from the Rating Agency. If the rating on the Series 2021 Bonds decreases, the Series 2021 Bonds may lack liquidity in the secondary market in comparison to other municipal bonds. Adverse developments with respect to the financial condition of the Hospital may have an unfavorable effect upon a holder's ability to sell the holder's Series 2021 Bonds or the bid and ask prices for the Series 2021 Bonds. See "BOND RATING" in this Official Statement.

No Pledge of County Tax Revenues

The County and the Hospital Board will rely solely upon the Net Pledged Revenues to pay debt service on the Series 2021 Bonds. The tax revenues of the County are not pledged to the payment of debt service on the Series 2021 Bonds. The Series 2021 Bonds are not an obligation of the County to which the full faith and ad valorem taxing power of the County has been pledged.

No Mortgage Securing the Series 2021 Bonds

The Series 2021 Bonds are not secured by a mortgage lien or any other real estate security interest in any property or real estate (including the Facilities or the Hospital). The Series 2021 Bonds are payable solely from and secured by (i) the amounts to be paid by the Hospital Board, and (ii) amounts in funds and accounts held under the Indenture. Accordingly, the Trustee will not have any right to foreclose on and gain title to the Facilities or any other real property of the County or the Hospital Board as a result of an Event of Default under the Indenture. Neither the County nor the Hospital Board has any obligation to make available any of their assets to pay debt service on the Series 2021 Bonds other than the Net Pledged Revenues. See "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS" in this Official Statement.

No Debt Service Reserve Fund for the Series 2021 Bonds

The Series 2021 Bonds will not be secured by a debt service reserve fund. The lack of a debt service reserve fund will affect the ability of the registered owners of the Series 2021 Bonds to receive payments of debt service on the Series 2021 Bonds should revenues of the Hospital Board be insufficient to make such payments.

Tax-Exempt Status

The Internal Revenue Code of 1986, as amended (the "Code") imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Series 2021 Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations

on the use of Series 2021 Bond proceeds, limitations on the investment earnings of the Series 2021 Bond proceeds prior to expenditure, a requirement that certain investment earnings on Series 2021 Bond proceeds be paid periodically to the United States and a requirement that the County file an information report with the Internal Revenue Service (the "IRS"). The County and the Hospital Board have covenanted in certain of the documents referred to herein that the County and the Hospital Board will comply with such requirements. Failure by the County or the Hospital Board to comply with the requirements in the Code and related regulations, rulings and policies may result in the treatment of interest on the Series 2021 Bonds as taxable, retroactively to the date of issuance of the Series 2021 Bonds. The Series 2021 Bonds are not subject to mandatory redemption and the rate of interest on the Series 2021 Bonds is not subject to adjustment if the interest on the Series 2021 Bonds is determined to be included in gross income for the purposes of federal income taxation.

Internal Revenue Service Tax-Exempt Bond Program

The Internal Revenue Service has an active program of conducting examinations of tax-exempt bonds. In recent years, the number of Internal Revenue Service tax-exempt bond examinations has increased, and public statements made by individual Internal Revenue Service officials indicate that the number of Internal Revenue Service examinations of tax-exempt bonds, including governmental issues such as the Series 2021 Bonds, may continue to increase in the future. On the date of issuance of the Series 2021 Bonds, Bond Counsel will render an opinion with respect to the tax-exempt status of interest on the Series 2021 Bonds, as described under the caption "TAX MATTERS" herein. However, neither the County nor the Hospital Board has sought and is not expected to seek a ruling from the Internal Revenue Service with respect to the tax status of the Series 2021 Bonds. No assurance can be given that the Internal Revenue Service will not examine the Series 2021 Bonds. If the Internal Revenue Service examines the Series 2021 Bonds, such examination, if it occurs, may have an adverse impact on the marketability and price of the Series 2021 Bonds. See "THE SERIES 2021 BONDS" and "TAX MATTERS" in this Official Statement.

Various Covenants and Restrictions

The Series 2021 Bonds are issued by the County under the terms of the Indenture. Such restrictive terms include, among others, restrictions on liens against the property of the Hospital Board, restrictions relating to Additional Bonds or Indebtedness, rights of credit enhancers, maintenance of certain rates and charges and compliance with certain debt service coverage and days cash on hand. The Indenture imposes certain restrictions on the actions of the Hospital Board for the benefit of the Holders of all Bonds issued under the terms of the Indenture (as supplemented by each supplemental indenture). Each supplemental indenture for a series of Additional Bonds may contain or contains rights, covenants, or restrictions that relate specifically to a series of Additional Bonds (including the Series 2021 Bonds). See "APPENDIX E – SUMMARY OF PRINCIPAL DOCUMENTS" in this Official Statement.

Future Affiliations, Joint Ventures, Acquisitions, and Divestiture

In addition to relationships with other health care providers and physicians, the County or the Hospital Board may consider investments, ventures, affiliations, development, and acquisition of other healthcare-related entities, to the extent permitted by State law and County Resolution. These may include home health care, long-term care entities or operations, pharmaceutical providers, and other health care enterprises which support the overall operations of the Hospital. In addition, the County or Hospital Board may pursue such transactions with health insurers, HMOs, preferred provider organizations, third-party administrators and other health insurance-related businesses. Because of the integration occurring throughout the health care field, management of the Hospital will consider such arrangements if there is a perceived strategic or operational benefit for the County or the Hospital. Any such initiative may involve significant capital commitments and/or capital or operating risk (including,

potentially, insurance risk) in a business in which the County or Hospital Board may have less expertise than in hospital operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences to the Hospital. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER – OWNERSHIP AND GOVERNANCE –Strategic Review of Hospital Operations" in this Official Statement.

Additional Indebtedness

The County may issue Additional Bonds or the Hospital Board may incur Additional Indebtedness on parity with the Series 2021 Bonds, for which the revenues of the Hospital may be pledged, if certain conditions and covenants of the Indenture are met, including certain limitations on debt. Incurring additional obligations or guarantees could materially and adversely affect coverage on the Series 2021 Bonds. See "SECURITY AND SOURCE OF PAYMENT FOR THE SERIES 2021 BONDS – Additional Bonds and Additional Debt" and "APPENDIX E – SUMMARY OF PRINCIPAL DOCUMENTS" in this Official Statement.

Early Redemption

Purchasers of the Series 2021 Bonds should consider that the Series 2021 Bonds are subject to optional redemption and extraordinary redemption upon certain events of casualty or condemnation with respect to the Facilities, and mandatory sinking fund redemption upon the terms set forth in the Indenture and described herein under the caption "THE SERIES 2021 BONDS – Redemption" in this Official Statement. Purchasers of Bonds at a premium will not be compensated for any unamortized premium as of the date of such optional or mandatory redemption.

General Health Care Risk Factors

Certain of the primary risks associated with the operations of the Hospital's health facilities are briefly summarized in general terms below, and are explained in greater detail in subsequent sections. The occurrence of one or more of these risks could have a material adverse effect on the financial condition and results of operations of the County and, in turn, the ability of the County and Hospital Board to make payments of principal of, and premium, if any, and interest on the Series 2021 Bonds.

The Borrower May Be Adversely Affected by Health Care Reform Legislation in Ways and To an Extent That Cannot Be Predicted

The discussion herein describes risks associated with certain existing federal and state laws, regulations, rules, and governmental administrative policies and determinations to which the Hospital Board and the healthcare industry are subject. While these are regularly subject to change, many of the existing provisions were enacted by or promulgated pursuant to the Patient Protection and Affordable Care Act (the "ACA") and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Reform Acts"), to which opposition has been expressed by President Trump and the Secretary of DHHS, as well as certain leaders of each chamber of Congress and members of their caucuses. However, President-elect Biden, who will be inaugurated in January 2021, has expressed clear support for the Reform Acts. It is not possible to predict with any certainty whether or when the Reform Acts or any specific provision or implementing measure will be repealed, withdrawn, expanded or modified in any material respect, but the federal government could enact legislation, withdraw, modify or promulgate rules, regulations and policies, or make determinations affecting the healthcare industry and the Hospital Board, any of which individually or collectively could have a material adverse effect on the Hospital Board's operations, financial condition and financial performance. Therefore, the following discussion should be read with the understanding that significant changes may occur in the foreseeable future in many of the statutory and regulatory matters discussed.

The Reform Acts, enacted in March 2010, address almost all aspects of hospital and provider operations and health care delivery, and have changed and are changing how health care services are covered, delivered, and reimbursed. These changes have resulted and will result in new payment models with the risk of lower health care provider reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for health care providers to assess, and potentially alter, their business strategy and practices, among other consequences. While many providers have received and will receive reduced payments for care, millions of previously uninsured Americans may have coverage. "Health insurance exchanges" have and could continue to fundamentally alter the health insurance market and negatively impact health care providers, enabling insurers to aggressively negotiate rates.

Some of the provisions of the Reform Acts took effect immediately or within a few months of final approval, while others were or have been phased in over time, ranging from one year to ten years. Because of the complexity of the Reform Acts generally, additional legislation may be considered and enacted over time. The Reform Acts have also required, and will continue to require, the promulgation of substantial regulations with significant effects on the health care industry. Thus, the health care industry is the subject of significant new statutory and regulatory requirements and consequently to structural and operational changes and challenges for a substantial period of time. The full ramifications of the Reform Acts may also become apparent only over time and through later regulatory and judicial interpretations. Portions of the Reform Acts have already been limited and nullified as a result of legislative amendments and judicial interpretations, and future actions may further change their impact. The 2020 Presidential election, electing President-elect Biden, is likely to affect the outcome of those efforts. The uncertainties regarding the implementation of the Reform Acts create unpredictability for the strategic and business planning efforts of health care providers, which in itself constitutes a risk.

The changes in the health care industry brought about by the Reform Acts have had and may have both positive and negative effects, directly and indirectly, on the nation's hospitals and other health care providers. For example, the projected increase in the numbers of individuals with health care insurance occurring as a consequence of Medicaid expansion, creation of health insurance exchanges, subsidies for insurance purchase and the penalty on certain individuals who do not purchase insurance could result in lower levels of bad debt and increased utilization or profitable shifts in utilization patterns for hospitals. However, the extent to which Medicaid expansion, which is optional on a state-by-state basis, is either not pursued or results in a shifting of significant numbers of commercially-insured individuals to Medicaid, or health insurance options on exchanges are limited or unaffordable, as well as the cost containment measures and pilot programs that the Reform Acts require, may offset these benefits.

Beginning in 2014, the Reform Acts authorized the creation of state "health insurance exchanges" in which health insurance can be purchased by certain groups and segments of the population, expanded the availability of subsidies and tax credits for premium payments by some consumers and employers, and required that certain terms and conditions be included by commercial insurers in contracts with providers. In addition, the Reform Acts imposed many new obligations on states related to health insurance. The health insurance exchanges may have a positive impact for hospitals by increasing the availability of health insurance to individuals who were previously uninsured. Conversely, health insurance exchanges may have a negative financial impact on health care providers to the extent (1) insurance plans purchased on the exchanges reimburse providers at lower rates or (2) high-deductible plans offered on the exchanges become more prevalent and lead to lower inpatient volumes as patients choose to forgo medical treatment. The exchanges could alter the health insurance markets in ways that cannot be predicted, and exchanges might, directly or indirectly, take on a rate-setting function that could negatively impact providers.

The Reform Acts will likely affect some health care organizations differently from others, depending, in part, on how each organization adapts to the legislation's emphasis on directing more

federal health care dollars to integrated provider organizations and providers with demonstrable achievements in quality care. The outcomes of these projects and programs, including the likelihood of their being made permanent or expanded or their effect on health care organizations' revenues or financial performance, cannot be predicted.

The Reform Acts contain amendments to existing criminal, civil and administrative anti-fraud statutes and increases in funding for enforcement and efforts to recoup prior federal health care payments to providers. Under the Reform Acts, a broad range of providers, suppliers and physicians are required to adopt a compliance and ethics program. While the government has already increased its enforcement efforts, failure to implement certain core compliance program features provides new opportunities for regulatory and enforcement scrutiny, as well as potential liability if an organization fails to prevent or identify improper federal health care program claims and payments.

The Reform Acts are projected to expand access to Medicaid and the scope of services covered thereunder. With respect to access, Medicaid is expected to cover all individuals with incomes of less than 133% of the federal poverty level. The Reform Acts give states the option to expand Medicaid eligibility to non-elderly, non-pregnant individuals who are not otherwise eligible for Medicare if they have incomes of less than 133% of the federal poverty level. To assist states with the cost of covering such newly eligible individuals, the federal government agreed to pay 100% of the new cost for a limited number of years. Thereafter, the cost share decreased to 90% in 2020. If a state chooses not to participate in the expanded Medicaid program, the net effect of the reforms in the Reform Acts could be significantly reduced. Additionally, Medicaid reimbursement rates differ by state and the effect of expanded Medicaid enrollment must be determined on a state-by-state basis.

The Reform Acts and their implementation have been, and remain, politically controversial. Beginning in 2017, President Trump and leadership of the then-Republican-controlled Congress commenced actions to repeal the Reform Acts. On January 20, 2017, President Trump issued an executive order to effectively repeal two major provisions of the Reform Acts: the individual mandate and the requirement that large employers offer coverage to their full-time workers. In May 2017, the House passed the American Health Care Act ("AHCA"), the first step of an ultimately unsuccessful plan to repeal and replace the Reform Acts. Procedurally, the AHCA was written to fit within the budget reconciliation process, and therefore limited to repealing only the budget-related provisions of the Reform Acts. A budget reconciliation bill only requires a majority vote for passage, whereas the repeal of non-budget related provisions of the Reform Acts requires an affirmative vote of at least 60 votes to avoid a filibuster by the opponents of the law under the Senate's "Byrd rule". Before the budget reconciliation opportunity expired in late September, Senate leadership introduced its own version of the bill, the Better Care Reconciliation Act ("BCRA"), which was later modified into the Health Care Freedom Act ("HCFA"), a "skinnier" version of the BCRA, and further altered in September by the Graham-Cassidy-Heller-Johnson Amendment. Each bill provided for some form of phased elimination of Medicaid expansion provisions and transferred control of all or most of the market reforms and Medicaid program requirements to individual states. The Congressional Budget Office published projections for each version, advising that if enacted, each would lead to a substantial increase in uninsured Americans. Ultimately, none of the bills obtained enough votes to pass before the Senate.

In the wake of its failure to repeal the Reform Acts in their entirety, Congress turned to an incremental repeal approach. Initiatives to incrementally repeal the Reform Acts, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify their provisions have been persistent. In the December 2017 tax legislation and the January 2018 government spending authorization bills, Congress delayed taxes on medical devices for an additional two years and delayed the tax on highly valued employer group plans (known as the Cadillac Tax) until 2022. These taxes and penalties were intended to fund Reform Acts coverage subsidies. The Tax Cuts and Jobs Act,

signed into law in late 2017, effectively eliminated the individual mandate by reducing the penalty to zero dollars effective January 1, 2019. This has the potential to cause adverse selection and rapid cost increases in the individual market as people in good health opt out of more expensive coverage and people with high-cost health conditions remain insured. Individual states, such as New Jersey in 2018, have implemented statewide individual mandates in response to the repeal of the federal mandate.

The federal government has also taken steps to reduce Medicaid expenditures by, among other steps, streamlining the process for states to obtain waivers of Medicaid coverage mandates. For example, CMS approved Kentucky's plan to introduce employment requirements for Medicaid eligibility. Other efforts to weaken the Reform Acts include the Trump administration's refusal to defend key parts of the Reform Acts in a federal case filed in Texas, where plaintiffs have argued that the ACA is unconstitutional as a result of the repeal of the individual mandate penalty. On December 14, 2018, the judge ruled in favor of the plaintiffs, holding the elimination of the tax penalty makes the individual mandate an unconstitutional exercise of Congress' taxing power, the basis for upholding the ACA in the 2012 Supreme Court case *Nat'l Fed. of Independent Bus. v. Sebelius*. Because the judge found the balance of the ACA was not severable from the unconstitutional individual mandate, the district court held the entire ACA was unconstitutional. On appeal, the Fifth Circuit agreed with the district court that the tax penalty is unconstitutional, however it did not decide that the rest of the ACA was also unconstitutional.

On March 2, 2020, the Supreme Court agreed to hear two consolidated cases, filed by the State of California and the United States House of Representatives, asking the Supreme Court to review the ruling by the U.S. Court of Appeals for the Fifth Circuit and to review whether, if the mandate is unconstitutional, it can be separated from the rest of the Reform Acts. Oral argument will take place in November 2020. The Reform Acts will remain law while the case proceeds through the appeals process; however, the case creates additional uncertainty as to whether any or all of the Reform Acts could be struck down, which creates operational risk for the health care industry. Management of the Hospital Board cannot predict the effect of the elimination of the individual mandate tax penalty, the likelihood of any future Reform Acts repeal bills or other health care reform bills becoming law, or the subsequent effects of any such laws or legal decisions, though such effects could materially impact the Hospital Board's business or financial condition. In particular, any legal, legislative or executive action that (1) reduces federal health care program spending, (2) increases the number of individuals without health insurance, (3) reduces the number of people seeking health care, or (4) otherwise significantly alters the health care delivery system or insurance markets, could have a material adverse effect on the Hospital Board's business or financial condition. According to the US Census Bureau, 47.2 million people (15.5%) were uninsured in 2010. In 2016, 27.3 million people (8.6%) were uninsured. In May 2019, the Congressional Budget Office projected that 32 million people would be uninsured in 2020.

Executive branch actions may also have a significant impact on the viability of the Reform Acts. President Trump has issued two broad executive orders aimed at de-regulation: (i) requiring federal agencies to remove two previously implemented regulations for every new regulation added, and (ii) directing each federal agency to set up a "regulatory reform task force" to review existing regulations and eliminate those that are costly or unnecessary. President Trump has issued executive actions directly aimed at the Reform Acts: (i) requiring federal agencies with authorities and responsibilities under the Reform Acts to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay" parts of the law that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers; (ii) instructing federal agencies to make new rules allowing the proliferation of "association health plans" and short-term health insurance, which plans have fewer benefit requirements than those sold through Reform Acts insurance exchanges; (iii) ordering the federal government to withhold Reform Acts cost-sharing subsidies currently paid to insurance companies in order to reduce deductibles and co-pays for many low-income people; and (iv) regarding health care price and quality transparency that directs federal rulemaking by executive agencies to increase transparency of

health care price and quality information. Additional executive branch actions include: (i) the issuance of a final rule in June 2018 by the Department of Labor to enable the formation of health plans that would be exempt from certain Reform Acts essential health benefits requirements; (ii) the issuance of a final rule in August 2018 by the Departments of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance; (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level, (iv) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (v) the issuance of a final rule by the Departments of Labor, Treasury, and Health and Human Services that would incentivize the use of health reimbursement arrangements by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these executive branch policies led to reduced exchange enrollment in 2018 and 2019 with final CMS reported data for 2020 indicating further decline, and such policies are expected to further worsen the individual and small group market risk pools in future years. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals.

Further advancing the Trump administration's goal of de-regulation, on November 4, 2020, DHHS issued a proposed rule that would require DHHS to assess its regulations every decade. Pursuant to the proposed rule, any regulation issued by DHHS would cease to be in effect ten years after it was issued, unless DHHS performed an assessment of the regulation. This requirement would apply to all DHHS regulations except for rules jointly issued with other agencies, rules issued for a military or foreign affairs function or rules that solely apply to personnel matters. The proposed rule would give DHHS two years to review any rules that are more than 10 years old.

These executive actions have the potential to significantly impact the insurance exchange market by causing a reduction in the number of healthy individuals in the Reform Acts health insurance exchanges, a reduction in the number of plans available on the health insurance exchanges, and an increase in insurance premiums.

As President-elect Biden has expressed support for the Reform Acts, it is likely that his administration will use executive authority to undo the Trump administration's efforts to reduce the impact of the Reform Acts. When, to what extent, and how successfully the Biden administration will undo these efforts is difficult to predict.

Due to the law's complexity, the pending nature of certain implementing regulations or interpretive guidance, and gradual implementation, as well as an inability to foresee how states, businesses and individuals will respond to the choices afforded them by the law, management is unable to predict the full impact of the Reform Acts on the Borrower at this time.

COVID-19 and Infectious Disease Outbreak

The Hospital's business and financial results may be harmed by an international, national or localized outbreak of a highly contagious or epidemic disease. The current pandemic of the novel coronavirus ("COVID-19") is having numerous and varied medical, economic, and social impacts, any and all of which may adversely affect the Hospital's business and financial results. Health care providers have cancelled or delayed non-urgent appointments and procedures. Business disruptions could also include temporary closures of the Hospital's facilities or the facilities of suppliers and their contract manufacturers, and a reduction in the business hours of health care facilities. A substantial portion of the population is subject to voluntary or involuntary quarantine, leading to general and substantial reductions in economic activity. Health care providers are disproportionately likely to become ill from COVID-19, which may limit the ability of the Hospital to provide care. Throughout the United States, health care

providers have been, are experiencing, or may experience, shortages of pharmaceuticals, protective gear, testing materials, medical equipment, and blood. Even if the Hospital was able to find alternate sources for such products, they may cost more, which could adversely impact profitability and the financial condition of the Hospital Board. Health care providers and facilities may become overburdened if the number of COVID-19 cases grows in their respective regions, limiting their ability to provide comprehensive care to patients, which may lead to diversion of medical resources and priorities toward the treatment of COVID-19 patients. In addition, health care providers may be required to provide significant amounts of uncompensated care. Changes in operations at the Hospital's facilities may result in additional costs being incurred related to enhanced safety protocols, adjustments to the use of various facilities and to staffing during this outbreak, including overtime wages, wages paid to employees who are unable to work due to quarantine, and utilization of more expensive contract staff to provide care. The effects of COVID-19 could severely affect the Hospital Board's ability to conduct normal business operations and, as a result, the operating results of the Hospital Board could be materially adversely affected.

National, state, and local governments have taken, and are expected to continue to take, various actions, including the passage of laws and regulations, on a wide array of topics, in an attempt to slow the spread of COVID-19 and to address the health and economic consequences of the outbreak. Many of these government actions are expected to cause substantial changes to the way healthcare is provided, and how society in general functions. It is not clear how long such measures will remain in place.

Various states, including Wyoming, and local governments have issued general "shelter-in-place" orders or directives that mandate or strongly encourage social distancing, closed school systems and closed or limited non-essential business activities in an effort to slow the spread of COVID-19. Even if such actions help reduce the rate of increase in COVID-19 cases in the near term, they may prove to be ineffective in reducing the total number of cases. COVID-19 outbreak developments, and attendant governmental and regulatory responses, are rapidly changing. The Hospital Board cannot presently quantify or estimate the cumulative impact of these recent developments taken as a whole. Although the federal government is considering additional legislation that may assist health care providers, including economic stimulus packages and other financial assistance, passage of any such legislation is uncertain.

The federal government is working with private companies to increase the manufacture and supply of pharmaceuticals and personal protective equipment, such as masks, respirators, gloves and ventilators needed to treat COVID-19 patients. In addition, the federal government may, from time to time, distribute ventilators and various personal protective equipment nationwide and make certain military hospital facilities, including hospital ships, and other facilities available to provide additional bed capacity for COVID-19 patients in hard hit areas. As state and federal actions in response to COVID-19 are far-reaching and rapidly changing, management of the Hospital Board cannot predict how governmental responses may impact the COVID-19 outbreak, financial or otherwise.

Overall, the extent of the impact of the COVID-19 on the State's operational and financial performance, and on State's general financial condition, will depend on future developments, many of which are out of the State's control, including without limitation the implementation of federal aid, the duration and spread of the COVID-19 pandemic, restrictions, limitations and changes on school and university attendance, public gatherings and other public events, and restrictions in operations of public and private entities nationwide and internationally, travel restrictions, and other restrictions and measures taken in response to the COVID-19 pandemic. State officials have stated that they believe it may be months and perhaps years before the State is able to accurately determine the full impact that the various events surrounding COVID-19 have on the State's economy and financial condition.

Market Disruption. The COVID-19 outbreak has affected, and is expected to continue to affect, travel, commerce and financial markets in the United States and globally and is widely expected to affect economic growth worldwide. The COVID-19 outbreak has resulted in volatility in the U.S. and global financial markets, and significant realized and unrealized losses in investment portfolios. Financial results, generally, and liquidity, in particular, may be materially diminished. Access to capital markets may be hindered and increased costs of borrowing may occur as a result. The impact of the outbreak on the Hospital Board's future operations, business and financial results cannot be predicted at this time due to the dynamic nature of the outbreak, including uncertainties relating to its duration and severity, as well as what actions may be taken by governmental authorities and other institutions to contain or mitigate its impact. The continued spread of COVID-19 and containment and mitigation efforts could have a material adverse effect on the operations of the Hospital Board and on the Wyoming, national and global economies.

CPRSAA. The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (the "CPRSAA") was enacted on March 6, 2020. The CPRSAA provides $8.3 billion in emergency funding for federal agencies to respond to the COVID-19 outbreak. Of this amount, $6.2 billion was designated for the DHHS, for research and development of vaccines, therapeutics, and diagnostics. The CPRSAA also included a temporary waiver removing restrictions on Medicare providers allowing them to offer telehealth services to beneficiaries regardless of whether the beneficiary is in a rural community while DHHS's declaration of a national public health emergency in response to the COVID-19 outbreak remains in place. Management of the Hospital Board cannot predict when DHHS's declaration will be lifted or how the regulatory landscape around telehealth services may otherwise change over time.

FFCRA. A variety of federal, state and local government efforts have been initiated in response to the COVID-19 outbreak. On March 13, 2020, President Trump declared a national emergency with respect to the COVID-19 outbreak. Thereafter, the United States Congress enacted several COVID-19 related bills. President Trump signed the Families First Coronavirus Response Act (the "FFCRA") on March 18, 2020, which provided additional support for the domestic COVID-19 response. The FFCRA included provisions for establishing a federal emergency paid leave program for individuals unable to work as a result of COVID-19, expanded state unemployment benefits, required employers to provide paid sick leave, provided SARS-CoV-2 diagnostic testing free of charge to consumers, and provided liability protection for "respiratory protective devices" used as part of the COVID-19 response. The FFCRA also increases the Federal Medicaid Assistance Percentage ("FMAP") for state Medicaid programs by 6.2%. The enhanced federal funding began in the calendar quarter of the emergency period and will end in the quarter when the emergency period ends.

CARES Act. On March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"). The CARES Act provides temporary and limited relief to hospitals during the COVID-19 outbreak, including the appropriation of $100 billion under the Public Health and Social Services Emergency Fund ("Provider Relief Fund") to reimburse providers for expenses and lost revenue attributable to COVID-19. The CARES Act provided employee retention tax credits to employers affected by COVID-19 and delayed the $4 billion reduction in Medicaid funding for Medicare disproportionate share hospitals until November 30, 2020. This reduction was further delayed, by legislation signed into law on October 1, 2020, until December 11, 2020. On September 19, 2020, DHHS issued its General and Targeted Distribution Post-Payment Notice of Reporting Requirements guidance, which set forth reporting requirements related to how relief payments may be allocated to expenses and lost revenues and how lost revenues must be calculated. Providers failing to meet these requirements may be subject to recoupment of funds by DHHS. It is not clear whether these provisions and the increased funding to hospitals provided in the CARES Act will be adequate to cover the significant costs borne by hospitals treating patients with COVID-19 or the shortfall in revenues that is anticipated from reductions in elective and other procedures during the COVID-19 outbreak.

Accelerated Medicare Payments Program. In addition to CARES Act funding, CMS has expanded and streamlined the process for its Accelerated and Advance Payments Program, pursuant to which providers can receive advance Medicare disbursements. Advance and accelerated payments are loans that providers must pay back. CMS has announced that it will begin to offset the accelerated/advance payments 120 days after disbursement. Offsets will be processed for up to one year after the disbursement date, at which time the providers will have to repay the outstanding balance without interest, or to the extent any amount remains outstanding after one year, interest on the outstanding balances will accrue at the rate of 10.25% per annum. On April 26, 2020, CMS announced it was reevaluating and temporarily suspending the Accelerated and Advance Payments Program in light of the availability of the Provider Relief Fund and significant funds available through other programs.

Following the announced suspension of the Accelerated and Advance Payments Program, CMS continued accepting applications for accelerated or advance payments related to the COVID-19 public health emergency (PHE). A Medicare provider or supplier that applied to the program is eligible to receive an accelerated or advance payment during the PHE if the provider or supplier: billed Medicare for claims within 180 days immediately prior to date of application; and is not in bankruptcy, under active medical review or program integrity investigation, or subject to any outstanding delinquent Medicare overpayments. As of October 8, 2020, CMS will no longer accept applications. CMS will, instead, continue to "monitor the ongoing impacts of COVID-19 on the Medicare provider and supplier community."

On October 1, 2020, the "Continuing Appropriations Act, 2021 and Other Extensions Act" amended the repayment terms for recipients of accelerated and advance payments. Recipients must make repayments by contacting a Medicare Administrative Contractor (MAC). The repayment period begins one year following issuance of payment and continues for seventeen (17) months. Over the first eleven (11)-month period, Medicare will recoup 25% of payments owed to recipients. The rate increases to 50% for the subsequent six (6) months. Medicare will bill recipients for any remaining balance following the repayment period.

Paycheck Protection Program and Health Care Enhancement Act. On April 24, 2020, President Trump signed the Paycheck Protection Program and Health Care Enhancement Act, which amended the CARES Act to increase the amounts authorized for the Paycheck Protection Program and authorized an additional $75 billion in funding for the Provider Relief Fund, reimbursing eligible health care providers for health care-related expenses or lost revenues that are attributable to COVID-19. DHHS established a number of terms and conditions related to the use and repayment of CARES Act funds. Funds utilized for stipulated purposes need not be repaid to the federal government. Recipient providers must agree not to seek collection of out-of-pocket payments from a patient treated for COVID-19. Other relief provided for acute care hospitals in the CARES Act includes the elimination of the 2% reduction to Medicare Payments through sequestration for a temporary period, a 20% increase to the inpatient Prospective Payment System DRG weight for patients diagnosed with COVID-19 during the public health emergency, and expansion of the CMS accelerated payment program. Receipt of such relief funding by the Hospital Board requires increased compliance efforts to comply with above requirements.

Regulatory Waivers. COVID-19 has led to legislative and regulatory changes specifically impacting the healthcare industry. In March and April of 2020, CMS published two interim final rules related to hospitals furnishing inpatient services under-arrangement with other providers and outpatient services in a patient's home or other expansion sites. The rules established processes for seeking payment rate exceptions for temporary hospital outpatient locations utilized due to the COVID-19; expanding physician supervision flexibilities for inpatient/outpatient hospital services; expanding services that may be furnished through telehealth and the types of practitioners eligible to furnish services through telehealth; and expanding coverage related to ambulance transport services. CMS issued "blanket"

Section 1135 waivers for certain hospital Conditions of Participation, provider-based rules, and the physician self-referral law. The waivers enable rapid expansion of hospital services provided in on and off campus clinical and nonclinical spaces, including through partnerships with other entities; other facility types, such as ambulatory surgical centers, to qualify as hospitals, governed by more flexible Conditions of Participation and streamlined enrollment and cost reporting requirements; and hospitals and other providers to provide items such as free meals, child care and laundry services to healthcare workers. It is too soon to tell how these and other waivers and rule changes in response to the COVID-19 pandemic will affect the operations and revenue of the Hospital Board, and it is impossible to predict their short term and long term effects on the Hospital Board.

General Economic Conditions; Bad Debt, Indigent Care and Investment Losses. Hospitals are economically influenced by the environment in which they operate. To the extent that (1) employers reduce their workforces, (2) employers reduce their budgets for employee health care coverage, or (3) private and public insurers seek to reduce payments to or utilization of hospital services, hospitals may experience decreases in insured patient volume and payments for services. In addition, to the extent that state, county or city governments are unable to provide a safety net of medical services, pressure is applied to local hospitals to increase free care. Economic downturns and lower funding of federal Medicare and state Medicaid and other state health care programs may increase the number of patients treated by hospitals who are uninsured or otherwise unable to pay for some or all of their care. An increase in unemployment may result in a significant number of patients no longer having health insurance coverage, which may result in decreased payments to hospitals or loss of payment for services provided. These conditions may give rise to increased bad debt and higher indigent care utilization. In the current economic environment, nonoperating revenue from investments may be reduced or eliminated. Investment losses (even if unrealized) may trigger debt covenants to be violated and may jeopardize hospitals' economic security. Losses in pension and benefit funds may result in increased funding requirements by hospitals. Potential failure of lenders, insurers or vendors may negatively impact hospital financial conditions and operations and philanthropic support may decrease. These factors may have a material adverse impact on hospitals.

Capital Needs vs. Capital Capacity. Hospital operations are capital intensive. Regulation, technology and physician/patient expectations require constant and often significant capital investment. Furthermore, capital capacity of hospitals may be reduced as a result of recent credit market dislocations. It is uncertain how long these conditions may persist, and it is possible that capital capacity may be negatively affected over the long term for reasons related to the credit markets.

Technical and Clinical Developments. New clinical techniques and technology, as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in ways that are currently unanticipated, and that may dramatically change medical and hospital care. These could result in higher hospital costs, reductions in patient populations and/or new sources of competition for hospitals.

Rate Pressure from Insurers and Major Purchasers. Certain hospital markets, including many communities in Wyoming, are strongly impacted by large health insurers and, in some cases, by major purchasers of health services. In those areas, health insurers may have significant influence over hospital rates, utilization and competition. Rate pressure imposed by health insurers or other major purchasers may have a material adverse impact on hospitals, particularly if major purchasers put increasing pressure on payors to restrain rate increases. Business failures by health insurers also could have a material adverse impact on contracted hospitals in the form of payment shortfalls or delays, and/or continuing obligations to care for managed care patients without receiving payment.

Costs and Restrictions from Governmental Regulation. Nearly every aspect of hospital operations is regulated, in some cases by multiple agencies of government. The level and complexity of regulation and compliance audits appear to be increasing, imposing greater operational limitations, enforcement and liability risks, and significant and sometimes unanticipated costs.

Audits. Most hospitals, including those operated by the Hospital, are audited for compliance with the requirements for participation in the Medicare and Medicaid programs. If audits discover alleged overpayments, the Hospital could be required to pay a substantial rebate of prior years' payments. The federal government contracts with third-party "recovery audit contractors" on a contingent fee basis to audit the propriety of payments to Medicare and Medicaid providers. CMS employs Medicaid Integrity Contractors to audit payments of Medicaid claims and Zone Program Integrity Contractors to identify Medicare fraud and abuse. Consistent with the federal government's increased focus on recovery of overpayments, recent legislation has expanded the look-back period from three to five years, during which time previously paid claims may be audited and denied and corresponding funds recouped as overpayments. [The Hospital has not received any claims denials or been a party to settlement negotiations outside of these routine audit processes. Management believes that it has reserved sufficiently for these actions and future audit adjustments.] **[Please confirm]** Nevertheless, ultimate liability could exceed reserves, and any excess could be substantial. Medicare and Medicaid regulations also provide for withholding Medicare and Medicaid payment in certain circumstances, which could adversely affect the Hospital's cash flow.

Violations Carry Significant Sanctions. The government and/or private "whistleblowers" often pursue aggressive investigative and enforcement actions. The government has a wide array of civil, criminal and monetary penalties, including withholding essential hospital payments from the Medicare or Medicaid programs, or exclusion from those programs.

State Medicaid Programs. State Medicaid and other state health care programs constitute an important payor source to many hospitals. These programs often pay hospitals and physicians at levels that may be below the actual cost of the care provided. As Medicaid and other state health care programs are partially funded by states, the financial condition of states may result in lower funding levels and/or payment delays. These could have a material adverse impact on hospitals. See "Patient Service Revenues" below.

Federal and State Anti-Fraud and Abuse Laws. Federal and state governments have enacted health care fraud and abuse laws to regulate both the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to those beneficiaries. These laws penalize individuals and organizations for submitting claims for services (i) they did not provide, (ii) that were not medically necessary, (iii) provided by an improper person, (iv) that involved an illegal inducement to utilize or refrain from utilizing a service or product, or (v) billed in a manner that does not comply with applicable government requirements. The scope of certain federal and state fraud and abuse laws has been expanded to include non-governmental private health care plans.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud and abuse, including imposing civil money penalties, suspending payments and excluding the provider from participating in the federal and state health care programs. One or more government entities and/or private individuals can prosecute fraud and abuse cases, and courts and/or regulators can impose more than one of the available penalties for each violation.

Laws governing fraud and abuse apply to virtually all individuals and entities with which a hospital does business, including other hospitals, home health agencies, long-term care entities, infusion providers, pharmaceutical providers, insurers, HMOs, PPOs, Indian Health Services, third party

administrators, physicians, physician groups and physician practice management companies. Violations and alleged violations may be deliberate, but also occur in circumstances where management is unaware of the conduct in question, as a result of mistake, or where the individual participants do not know that their conduct is in violation of law. Violations may occur and be prosecuted in circumstances that do not have the traditional elements of fraud, and enforcement actions may extend to conduct that occurred in the past. Fraud and abuse prosecutions can have a catastrophic effect on any of these entities, which can result in a material adverse impact on the financial condition of other entities in the same health care delivery system.

The Hospital Board believes that the Hospital is in compliance with the above-referenced laws; however, there can be no assurance that enforcement agencies would agree.

False Claims Act. The False Claims Act ("FCA") makes it illegal to submit or present a false, fictitious or fraudulent claim to the federal government, and may include claims that are simply erroneous. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and compliance agreements. Health care providers, including hospitals and physician clinics, are also subject to criminal, civil, and exclusionary penalties for violations. A common prosecutorial position is to threaten exclusion from the Medicare and Medicaid programs unless the hospital (or other provider or supplier) agrees to voluntary settlement, which is often very costly and imposes ongoing compliance and monitoring obligations. Because the consequence of exclusion from Medicare and Medicaid programs would have such an adverse effect, hospitals may find it necessary to enter into these costly settlement agreements, even if they believe they have a meritorious position.

Anti-Kickback Laws. The Medicare/Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act (the "Anti-Kickback Law") make it unlawful to knowingly offer, pay, solicit, or receive "remuneration" intended to induce a person to refer, recommend or arrange for the referral of patients or the purchase or lease of goods or services, payable in whole or in part under the Medicare and Medicaid programs (and other government-funded programs). Violation is a felony, punishable by a fine, imprisonment and/or exclusion from the Medicare and Medicaid programs. Submission of claims in violation of the Anti-Kickback Law is further regarded as a false claim punishable under the FCA.

In October 2019, the OIG released a proposed rule proposing a number of new safe harbors and modifying existing safe harbors. This new rule, if enacted, may increase the Hospital Board's costs for remaining compliant with the Anti-Kickback Law, as the Hospital may have to make adjustments to remain compliant with the revised Anti-Kickback Law implementing regulations.

Management of the Hospital Board believes that the Hospital is taking appropriate steps to be in material compliance with the Anti-Kickback Law. In light of the broad scope of the Anti-Kickback Law, the narrowness of the safe harbor regulations and the limited case law and regulatory activity interpreting the Anti-Kickback law, there can be no assurance that no violation of the Anti-Kickback Law will be found, and if found, that any sanction imposed would not have a material adverse effect on the operations or the financial condition of the Hospital.

Physician Self-Referral Prohibition. The Ethics in Patient Referral Act (the "Stark Law") provides that if a physician (or family member) has a financial relationship with an entity that does not fit a published exception, the physician may not refer and the entity may not bill for any "designated health services" referred by the physician and payable in whole or in part under Medicare. Hospital inpatient and outpatient services are on the list of "designated health services," along with laboratory, radiology, physical therapy, and many other services. There is no "intent" requirement as with the Anti-Kickback

Law. A provider, such as the Hospital, is prohibited from billing anyone for improperly referred "designated health services."

In October 2019, CMS released a proposed rule regarding a number of new exceptions related to value-based arrangements, certain limited remuneration payments to physicians and electronic health record items and services donations. The proposed rule also provides guidance regarding the application of the Stark Law and its exceptions, by making changes to existing exceptions and the definitions contained in the Stark Law's implementing regulations. This new rule, if enacted, may increase costs for the Hospital to remain compliant with the Stark Law because the Hospital may have to make adjustments as a result of the revised regulations. In June 2020, CMS announced an anticipated publication of a final rule in August 2020. In September 2020, CMS announced that the agency is still reviewing the complexity of certain issues raised in comments to the proposed rule; publication of a final rule did not occur within the anticipate timeframe.

Management of the Hospital believes that the Hospital is presently in material compliance with the Stark Law. However, there can be no assurances that the Hospital will not be found to have violated the Stark Law, and if so, whether any sanction imposed would have a material adverse effect on the operations of the Hospital and its financial condition.

Civil Monetary Penalty Statute. The Civil Monetary Penalties Law in part authorizes the government to impose money penalties against individuals and entities committing a variety of acts. For example, penalties may be imposed for the knowing presentation of claims that are (i) incorrectly coded for payment, (ii) for services that are known to be medically unnecessary, (iii) for services furnished by an excluded party, or (iv) otherwise false. An entity that offers remuneration to an individual that the entity knows is likely to induce the individual to receive care from a particular provider may also be fined. Moreover, a hospital may not knowingly make a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to Medicare or Medicaid patients under the physician's direct care. In the Reform Acts, Congress amended the Civil Monetary Penalties Law to authorize civil monetary penalties for a number of additional activities, including (i) knowingly making or using a false record or statement material to a false or fraudulent claim for payment; (ii) failing to grant the Office of Inspector General timely access for audits, investigations, or evaluations; and (iii) failing to report and return a known overpayment within statutory time limits. Violations of the Civil Monetary Penalties Law can result in substantial civil money penalties plus three times the amount claimed.

Health Data Privacy. Congress enacted The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") in August 1996 as part of a broad health care reform effort. Among other things, HIPAA established a program administered jointly by the Secretary of DHHS and the United States Attorney General designed to coordinate federal, state and local law enforcement programs to control fraud and abuse in connection with the federal health care programs. In addition, HIPAA also increased funding for health care fraud enforcement activity, enabling the OIG to substantially expand its investigative staff and the Federal Bureau of Investigation to increase the number of agents assigned to health care fraud. The result has been a dramatic increase in the number of civil, criminal and administrative prosecutions for alleged violations of the laws relating to payment under the federal health care programs, including the Anti-Kickback Law and the False Claims Act. This expanded enforcement activity, together with the whistleblower provisions of the False Claims Act, have significantly increased the likelihood that all health care providers, including Hospital, could face inquiries or investigations concerning compliance with the many laws governing claims for payment and cost reporting under the federal health care programs.

HIPAA's Privacy and Security Requirements. In addition to the expanded enforcement activity noted above, the "Administrative Simplification" provisions of HIPAA mandate the use of uniform

standard electronic formats for certain administrative and financial health care transactions, the adoption of minimum security standards for individually identifiable health information maintained or transmitted electronically, and compliance with privacy standards adopted to protect the confidentiality of personal health information. The Administrative Simplification provisions apply to health care providers, health plans, and health care clearinghouses, and their agents and subcontractors referred to as Business Associates (collectively, the "Covered Entities"). DHHS issued final regulations strengthening many aspects of the privacy and security rules under HIPAA so that they are more aligned with the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"). The final rules change certain requirements for covered entities and establish rules that now apply directly to their vendors that handle protected health information ("PHI") and qualify as business associates under HIPAA. A Covered Entity and its business associates must make reasonable efforts to use, disclose and request only the minimal amount of protected health information needed to accompany the intended use. HIPAA confidentiality provisions extend not only to patient medical records, but also to a wide variety of healthcare clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These confidentiality provisions add costs and create potentially unanticipated sources of legal liability.

Various requirements of HIPAA apply to virtually all health care organizations, and significant civil and criminal penalties may result from a failure to comply with the Administrative Simplification regulations. Compliance requires changes in information technology platforms, major operational and procedural changes in the handling of data, and vigilance in the monitoring of ongoing compliance with the various regulations. The financial costs of compliance with the Administrative Simplification regulations are substantial.

The HITECH Act. The American Recovery and Reinvestment Act of 2009 ("ARRA") appropriated approximately $20 billion for the development and implementation of health information technology standards and the adoption of electronic health care records. The law also significantly expanded the HIPAA privacy and security provisions applicable to Covered Entities and their business associates. The law provides that individuals be notified when there is a breach of their unsecured electronic personal health information, increases civil monetary and criminal penalties for HIPAA violations, and authorizes the state attorneys general to enforce its provisions. Each Covered Entity must report any breach involving over 500 individuals in a state to DHHS and the local media. All other breaches must be reported annual to DHHS. The financial costs of continuing compliance with HIPAA and the Administrative Simplification regulations are substantial and will increase as a result of the ARRA amendments.

ARRA also includes the HITECH Act, which contains a number of provisions that affect HIPAA's privacy regulations that provide generally that Covered Entities must keep a person's personal health information private. The HITECH Act limits a Covered Entity's discretion in determining what health care information about a person may be properly disclosed under the HIPAA privacy regulations.

Covered Entities that use an "electronic health record" are required to account for disclosures of information that are currently not subject to the accounting requirements, including disclosures for treatment, payment and health care operations. In addition, if a Covered Entity maintains an electronic health record, individuals have a right to receive a copy of the protected health information maintained in the record in an electronic format. Again, the Secretary of DHHS is charged with developing guidance and implementing regulations for these requirements.

The HITECH Act includes provisions requiring Covered Entities to agree to a patient request to restrict disclosure of information to a health plan, if the information pertains solely to an item or service for which the provider was paid out of pocket in full. The HITECH Act also includes a prohibition on the

payment or receipt of remuneration in exchange for protected health information without specific patient authorization, except in limited circumstances, and places additional restrictions on the use and disclosures of protected health information for marketing communications and fundraising communications.

In the event of an unauthorized disclosure of protected health information, Covered Entities now are required to notify the affected individuals, DHHS and sometimes the media of the unauthorized disclosure, depending on the nature of the breach, the type of unauthorized disclosure and its scope.

The HITECH Act revises the civil monetary penalties associated with violations of HIPAA, and provides state attorneys general with authority to enforce the HIPAA privacy and security regulations in some cases, through a damages assessment of $100 per violation or an injunction against the violator. The revised civil monetary penalties range: (a) in the case of violations due to willful neglect, from a minimum of $10,000 or $50,000 per violation depending on whether the violation was corrected within 30 days of the date the violator knew or should have known of the violation, and (b) in the case of all other violations, from a minimum of $100 to $1,000 per violation. The Hospital Board is actively engaged in continuing compliance efforts with HIPAA and HITECH regulations. However, no guarantee can be made that the Hospital Board will remain HIPAA compliant in the future.

Labor Costs and Disruption. Hospitals are labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant impact on hospital operations and financial condition. Hospital employees are increasingly organized in collective bargaining units, and may be involved in work actions of various kinds, including work stoppages and strikes. Overall costs of the hospital workforce are high, and turnover is high. Pressure to recruit, train and retain qualified employees is expected to accelerate. These factors may materially increase hospital costs of operation. Workforce disruption may negatively impact hospital revenues and reputation.

Negative Reviews from Third Parties. Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard–setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "pay for performance," "never events" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs to influence the behavior of consumers and providers. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize the Hospital Board negatively may adversely affect its reputation and the financial condition of the Hospital Board.

Labor Relations and Collective Bargaining. Hospitals are large employers with a wide diversity of employees. Although the Hospital's employees do not belong to any labor unions, many hospital have collective bargaining agreements with one or more labor organizations. Increasingly, various labor unions repeatedly attempt to organize employees at hospitals. If the Hospital Board's employees become union members in the future, employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and hospital reputation.

Health Care Worker Classification. Health care providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are generally not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. If the IRS were to reclassify a significant

number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

Staffing. In recent years, the health care industry has suffered from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained health care technicians. A significant factor underlying this trend includes a decrease in the number of persons entering such professions. This is expected to intensify in the future, aggravating the general shortage and increasing the likelihood of hospital-specific shortages. In addition, state budget cuts to university programs may impact the training available for nursing personnel and other health care professionals. Competition for employees, coupled with increased recruiting and retention costs will increase hospital operating costs, possibly significantly, and growth may be constrained. This trend could have a material adverse impact on the financial conditions and results of operations of hospitals.

Professional Liability Claims and General Liability Insurance. In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in health care nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against health care providers.

Litigation also arises from the corporate and business activities of hospitals, from a hospital's status as an employer or as a result of medical staff or provider network peer review or the denial of medical staff or provider network privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims or business disputes are not covered by insurance or other sources and may, in whole or in part, be a liability of the Hospital Board if determined or settled adversely.

Many hospitals and health care providers are having difficulty renewing or obtaining all types of commercial insurance, including insurance against malpractice and general liability claims, at reasonable cost. The insurers are providing lower amounts of coverage, requiring greater deductibles and charging larger premiums. Insurance policies issued may not be renewed or renewable. While management of the Hospital Board considers the current insurance coverage of the Hospital Board to be adequate, no assurance can be given that such insurance coverage will be available in the same amounts and on the same terms in the future. There is no assurance that the Hospital Board will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover malpractice judgments rendered against a hospital or that such coverage will be available at a reasonable cost in the future. For a discussion of the insurance coverage of the Hospital Board, see "APPENDIX A – ADDITIONAL INFORMATION – Insurance and Litigation."

Patient Service Revenues

Overview of Medicare and Medicaid Program. Medicare and Medicaid are the commonly used names for health care reimbursement or payment programs governed by certain provisions of the federal Social Security Act Amendments of 1965. The federal government, the largest health care purchaser in the country, uses reimbursement as a key tool to implement health care policies, to allocate health care resources and to control utilization, facility and provider development and expansion, and promote the use and development of health technology. These programs reflect the national policy that persons who are aged and persons who are poor should be entitled to receive medical care regardless of ability to pay. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient hospital, home health, nursing home care and certain other services, and Medicare Part B covers certain physicians' services, medical supplies and durable medical equipment. Medicare Part C, the Medicare Advantage program (formerly known as the Medicare+Choice Program) enables Medicare beneficiaries who are

entitled to Part A and are enrolled in Part B to choose to obtain their benefits through a variety of private, managed care, risk-based plans.

In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") was signed into law. This law provides for Medicare Part D, under which outpatient prescription drug benefits are available to Medicare beneficiaries. MMA also enhanced the Medicare Part C managed care programs. The private Medicare Part D plans are funded through premium payments from enrolled Medicare beneficiaries and subsidies from the federal government. Enrollment is available on an ongoing and intermittent basis. While participation in the program is voluntary, those who wait to enroll beyond their initial point of eligibility are penalized with additional surcharges which increase over time. The ACA includes changes to the Medicare Part D program, including the gradual reduction of the cost sharing burden by beneficiaries under Medicare Part D (the so-called "donut hole"). Although Medicare Part D reimbursement does not cover inpatient prescriptions, changes in enrollment or program administration could affect Hospital's revenue. An expansion of coverage for outpatient pharmaceutical therapy may reduce the Hospital's admissions or shift the characteristics of those patients that are admitted.

Medicaid is designed to pay providers for care given to the indigent and other persons who qualify based on certain conditions. Medicaid is funded by federal and state appropriations and is administered by an agency of the applicable state. Under the ACA beginning January, 2014, states have the option to expand Medicaid eligibility to cover individuals with income under 133% of the Federal Poverty Level ("FPL"). See Medicaid Reimbursement below for more information.

Conditions of Participation. Hospitals must comply with standards called "Conditions of Participation" in order to be eligible for Medicare and Medicaid reimbursement. CMS is the federal agency responsible for ensuring that hospitals meet the regulatory Conditions of Participation. Generally, under Medicare rules, hospitals accredited by the Joint Commission (a private nonprofit corporation that accredits health care programs and providers in the United States) are deemed to meet the Conditions of Participation. Failure to maintain Joint Commission accreditation or to otherwise comply with the Conditions of Participation could have a materially adverse effect on the continued participation in the Medicare and Medicaid programs, and ultimately on the revenues of the Hospital. The Medicare Improvements for Patients and Providers Act of 2008 revised hospital accreditation standards, revoking the exclusive deeming authority of the Joint Commission. While each hospital certified by the Joint Commission will continue to be certified for the duration of its accreditation, the process going forward has been opened to competition between accrediting organizations. It is not clear what effect, if any, this legislation will have on the Hospital's accreditation in the future.

CMS issued a final rule reforming the Conditions of Participation for hospitals and critical access hospitals, which became effective July 16, 2012. The revised Conditions of Participation are an attempt to increase the flexibility and eliminate the burden of certain elements of the Conditions of Participation. The Hospital Board cannot anticipate the effect of the reformed Conditions of Participation on the Hospital and its affiliates but continues to analyze the full impact of the final regulation to maintain compliance with the Conditions of Participation.

Medicare. Medicare is administered by CMS which delegates to the states the process for certifying those organizations to which CMS will make payment.

DHHS's rule-making authority is substantial and the rules are extensive and complex. Substantial deference is given by courts to rules promulgated by DHHS.

Medicare claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the federal government to locally process Medicare's Part A and Part B claims. These claims processors are known as "Medicare Administrative Contractors" or "MACs". They apply the Medicare coverage rules to determine the appropriateness of claims. CMS selects organizations (generally insurance companies) to act as MACs in various states or regions, and enters into a "prime contract" with each. Most Medicare hospital services are provided through a fixed rate per case program under the reimbursement methods described below. Some Medicare recipients, however, enroll in Medicare Advantage managed care plans, which reimburse providers on a contractually determined basis. Health care providers that participate in the Medicare program must agree to be bound by the terms and conditions of the program such as meeting the quality standards for rendering covered services and adopting and enforcing policies to protect patients from certain discriminatory practices.

The ACA reduces cost sharing by Medicare beneficiaries for certain preventive services and wellness visits and expands coverage for these services. It also includes programs that link Medicare payments for hospitals and physicians with quality outcomes and the development of new patient care models that stress primary care and community-based care. The objective of these programs is to manage chronic diseases better and to reduce inpatient admissions and other high cost care provided by health care facilities, such as hospitals and nursing homes. While additional governmental reporting, oversight and audits are a certainty, it is difficult to determine what effect the health care reform legislation and its implementation will ultimately have on the financial or operating condition of the Hospital or its competitors in the future.

The Bipartisan Budget Act of 2015 (the "BBA 2015") changed the reimbursement methodology for items and services furnished in certain off-campus hospital outpatient departments ("HOPDs"). Beginning January 1, 2017, off-campus HOPDs established on or after November 2, 2015 ("non-excepted HOPDs") are no longer eligible for payment under the hospital outpatient prospective payment system ("OPPS") for non-emergency services. A hospital outpatient department is considered to be "off-campus" if it is located more than 250 yards from a main provider hospital or a remote location of a hospital. Instead, non-emergency services performed at these facilities will be paid under the Medicare Physician Fee Schedule ("PFS") at a set of PFS payment rates that are specific to hospitals. Effective January 1, 2018, these hospital specific PFS rates are based on 40% of the comparable OPPS rate. Beginning January 1, 2019, CMS began applying the PFS equivalent pay rate for certain evaluation and management services when provided at an off-campus HOPD that is paid under the OPPS, including at those HOPDs grandfathered under BBA 2015, stepping down from 70% of OPPS rates in 2019 and 40% of OPPS rates in 2020 and thereafter. The reimbursement changes implemented under the BBA 2015 and the recent CMS reimbursement policies for calendar year 2019 threaten to further reduce revenues to off-campus HOPDs. Following a successful challenge by hospitals to these reimbursement changes in U.S. District Court in 2019, CMS announced its plans to reimburse hospitals for site-neutral payment cuts the agency made to off-campus hospital facilities in 2019. However, CMS will continue phasing in the site-neutral payment policy to pay off-campus departments at the 40% of OPPS rate in 2020. For the fiscal years ended June 30, 2020 and 2019, Medicare represented approximately 46% and 47%, respectively, of the Hospital Board's gross patient service revenues. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER – MARKET COMPETITION AND UTILIZATION – Payor Mix" in this Official Statement.

System Inpatient Services. Medicare payments for operating expenses incurred in the delivery of inpatient hospital services and inpatient psychiatric services are based on a prospective payment system ("PPS") which essentially pays hospitals a fixed amount for each Medicare in-patient discharge based upon patient diagnosis and certain other factors used to classify each patient into a Diagnosis Related Group ("DRG"), or more recently Medical Severity DRGs or "MS-DRGs". Each MS-DRG is given a

relative value from which a fixed payment can then be established. With limited exceptions, such payments are not adjusted for actual costs, variations in intensity of illness, or length of stay. MS-DRG rates are adjusted annually by the use of an "update factor" based on the projected increase in a market basket inflation index which measures changes in the costs of goods and services purchased by hospitals, but the adjustments historically have not kept pace with inflation.

If a hospital treats a patient and incurs less cost than the applicable MS-DRG-based payment, the hospital will be entitled to retain the difference. Conversely, if a hospital's cost for treating the patient exceeds the DRG-based payment, the hospital generally will not be entitled to any additional payment. CMS continually attempts to adjust reimbursements to better reflect hospital costs rather than charges. If a case is unusually complex or expensive, it may qualify for an "outlier" payment, which is added to the MS-DRG-adjusted base rate payment. There can be no assurance that payments under the PPS will be sufficient to cover all actual costs of providing inpatient hospital services to Medicare patients. The MS-DRG system has undergone changes to increase and refine the classifications system, with certain classifications receiving increases in payment and others a decrease. There can be no assurance that payments under PPS will be sufficient to cover all actual costs of providing in-patient hospital services to Medicare patients.

Medicare and Medicaid currently make additional payments to hospitals that serve a disproportionate share of low income patients. Beginning in 2014, the ACA incrementally reduced the Medicare payments for disproportionate share hospitals by 75%, or $49 billion by 2019. The 2014 final rule for inpatient PPS established a new policy for the distributions of the Medicare DSH, which will be based on hospitals' uncompensated care. Congress has repeatedly delayed reductions to Medicaid DSH payments. For example, the Bipartisan Budget Act of 2018 eliminated fiscal year 2018 and fiscal year 2019 Medicaid DSH reductions, but maintained the $4 billion in reductions for fiscal year 2020, and set the amount of Medicaid DSH reductions for fiscal year 2021 through fiscal year 2025 at $8 billion per fiscal year. The CARES Act further delayed the implementation of Medicaid DSH payment reductions, until November 30, 2020, which was further delayed by recent legislation until December 11, 2020.

In September 2019, a CMS final rule formulated a methodology for calculating the annual reductions for fiscal years 2020 through 2025. The methodology uses five factors (the uninsured factor (UPF), Medicaid volume factor (HMF), uncompensated care factor (HUF), low DSH state factor (LDF), and budget neutrality factor (BNF)) to calculate DSH reduction applicable to individual states. PPS and DSH adjustments may impact the Hospital Board. There can be no assurance that payments received by the Hospital will be sufficient to cover all actual costs of providing inpatient hospital services to Medicare patients. Hospitals report certain quality measures under the Hospital Inpatient Quality Initiative ("Inpatient Quality Reporting" or "IQR"). Hospitals that report these measures receive the full DRG inflation update - known as the "hospital market basket", while non-participating hospitals suffer a 2% reduction from the market basket update. The market basket update for federal fiscal year 2019 is 1.85%, and for federal fiscal year 2020 is 3.1%. Per the CMS final rule of September 2020, for fiscal year 2021, a market basket update of 2.4%, as well as a statutory increase of 0.5%, will result in an increase of approximately 2.9% to operating payment rates for general acute care hospitals paid under the inpatient prospective payment system (that are meaningful electronic health record users).

The ACA continues and expands earlier Congressional measures taken to address the growing cost of the Medicare and Medicaid programs. CMS periodically promulgates regulations, such as its annual inpatient PPS rules, to adjust the rates paid to hospitals based on its continuing experience with hospital operating and capital costs, and to implement various quality improvement, patient safety and fraud and abuse programs. Depending on the mix of future services delivered, the overall result of these changes to the inpatient PPS reimbursement rules may be to reduce Medicare reimbursement to the Hospital.

System Outpatient Services. Medicare hospital outpatient services are also reimbursed on a prospective payment basis. Under the outpatient PPS methodology, procedures, evaluations and management services, and drugs and devices in outpatient departments are classified into one of approximately 750 groups called Ambulatory Payment Classifications ("APC"). Services provided within an APC are similar clinically and in terms of the resources they require. Each APC is assigned a weight derived from the median hospital cost of the services in the group relative to the median hospital cost of the services included in the APC for mid-level clinic visits. CMS determines the portion of the median labor related hospital costs and adjusts those costs for variations in hospital labor costs across geographic regions.

Payment rates for each APC are calculated by multiplying the relative weight for an APC by a conversion factor to arrive at a dollar figure. Outpatient PPS includes additional adjustments for transitional pass-through payments and outlier payments. Transitional pass-through payments are costs associated with new technology items (drugs, biologicals and medical devices) that were not reflected in the data that CMS used to calculate PPS payment rates, and are intended to allow for adequate payment of new and innovative technology until there is enough data to incorporate the costs for these items into the base APC group.

APCs include payment for related ancillary services provided in conjunction with the procedure or medical visit. Although hospitals may receive payment for more than one APC for an encounter, payment for multiple surgical APC procedures are subject to substantial discounting.

CMS makes annual changes to its policies and payment structure with respect to outpatient services in response to an increase in amounts paid for outpatient services delivered to Medicare patients. For example, CMS adjusted the market basket update in 2007 and tied rate increases to additional quality measure reporting requirements applicable to outpatient services beginning in 2009. CMS also revised the APC structure, expanding a hospital's ability to be reimbursed for infusion services. In exchange, CMS reduced per diem payments to hospital outpatient departments for the delivery of partial hospitalization services. Additionally, CMS adjusted the reimbursement rates for Ambulatory Surgery Centers to reflect the reimbursement for equivalent procedures being delivered in hospital outpatient departments. Overall, these changes to the outpatient prospective payment system may result in decreased reimbursement for services, depending on the service mix that the Corporation can expect to deliver in the future.

Outpatient renal dialysis services are reimbursed on the basis of prospective reimbursement, though different rates are paid for hospital-based and free-standing facilities, and are adjusted for geographic differences in labor costs. This composite rate is the same regardless of whether the treatment is furnished in the facility or in the patient's home to incentivize home dialysis, and must be accepted by the facility as payment in full for covered outpatient dialysis.

Under outpatient PPS, a hospital with costs exceeding the applicable payment rate would incur losses on such services provided to Medicare beneficiaries. There can be no assurance that outpatient PPS payments will be sufficient to cover all of the Hospital's actual costs of providing hospital outpatient services to Medicare patients.

Physician Payments. Payment for physician fees is covered under Part B of Medicare. Under Part B, physician services are reimbursed in an amount equal to the lesser of actual charges or the amount determined under a fee schedule known as the "resource-based relative value scale" or "RBRVS". RBRVS sets a relative value for each physician service; that value is then multiplied by a geographic adjustment factor and a nationally-uniform conversion factor to determine the amount Medicare will pay for each service.

In October 2011, the Medicare Payment Advisory Commission ("MedPAC") recommended to Congress that the Sustainable Growth Rate ("SGR") system be fully repealed and replaced by a different methodology for determining the nationally-uniform conversion factor. With the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), the SGR System was repealed. Beginning in July 2015 and continuing through 2019, the Medicare Physician's Fee Schedule ("PFS") increases by 0.5% annually. The PFS will then remain at the same reimbursement level for five years (2020-2025). Beginning in 2026, the PFS will be increased either by (i) 0.25% annually for providers participating in the Merit-Based Incentive Payment System, or (ii) 0.75% annually for providers participating in Alternative Payment Models.

Under MACRA, CMS created a new framework to reward health care providers to provide better care rather than more care, and combined the existing quality reporting programs under one new system: the MACRA Quality Payment Program. The MACRA Quality Payment Program is comprised of the Merit-Based Incentive Payment System ("MIPS") and Advanced Alternative Payment Models ("APMs"). Both MIPS and APMs went into effect in 2015 and will continue to be implemented over several years. MIPS and APMs are two alternative tracks for physicians. MIPS combines the Physician Quality Reporting System, Electronic Health Records Incentive Program, and Physician Value-Based Modifier into a single payment adjustment. The payment adjustment can be an increase or a decrease. The MIPS creates four categories which will be used to calculate the payment adjustment:

1. Quality (which will be 50% of the total adjustment in 2019 and decrease to 30% of the total adjustment by 2021);
2. Resource Use (which will be 10% of the total adjustment in 2019 and increase to 30% of the total adjustment by 2021);
3. Clinical Improvement (which will be 15% of the total adjustment); and
4. Electronic Health Record Use (which will be 25% of the total adjustment).

The range of potential payment adjustments based on performance increases each year through 2022. The adjustments are capped (both positively and negatively) as follows: plus/minus 4% in 2019; plus/minus 5% in 2020; plus/minus 7% in 2021; and plus/minus 9% from in 2022 and onward. The program is designed to be budget neutral, meaning the total negative adjustments will equal total positive adjustments across all providers. Additionally, high performers are eligible to share in an additional pool of bonus funds.

Alternatively, providers may participate in the Alternative Payment Models ("APMs"). APMs are programs that involve more than nominal financial risk on behalf of the provider. MACRA had created an advisory panel to consider proposals for new payments models and coverage for telehealth services in APMs. By April 1, 2017, the Secretary must establish criteria for the panel to use in making recommendations on the APMs. By July 1, 2017, MedPAC must submit a report to Congress on how physician spending and ordering patterns relate to spending under Parts A, B, and D. A final report is due by July 1, 2021.

From 2019 through 2024, providers qualifying for APMs will receive an annual lump sum bonus of 5% of PFS payments. To qualify for APM participation, providers must meet a certain threshold for the percentage of revenue received through qualifying APMs, which will increase over time. Providers are also required to report quality measures and use electronic health records. Providers who have not reached these thresholds, but whose revenue is close to the required threshold may be exempt from adjustments. For 2026 and after, physicians who qualify for APMs are excluded from MIPS adjustments and receive higher fee schedule updates.

The specific parameters of these programs are still being developed by CMS. The new quality reporting programs may negatively impact the reimbursement amounts received by the Hospital for the cost of providing physician services.

In July 2014, CMS proposed to transition all 10-day and 90-day global billing codes to 0-day global codes in 2017 and 2018, respectively. Under this proposal, medically reasonable and necessary visits would have been billed separately during the preoperative and postoperative periods outside the day of the surgical procedure. MACRA preserved the 10-day and 90-day global billing period for over 4,000 surgical service codes, reversing the CMS rule.

On March 22, 2020, CMS announced additional extreme and uncontrollable circumstances policy exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submissions. This announcement was made as part of the Trump Administration's COVID-19 relief efforts.

There can be no assurance that payments to the Hospital for the services of its employed physicians or other employed health care professionals will be sufficient to fully reimburse the Hospital for its cost of providing the services of such professionals.

System Capital Expenditures. Medicare payments for capital costs are based upon a PPS system similar to that applicable to operating costs. Payment for capital related costs for all hospitals will be determined based on a standardized amount referred to as the federal rate. Payments for capital costs are calculated by multiplying the federal rate by the DRG weight for each discharge and by a geographical adjustment factor. The payments are subject to further adjustment by a disproportionate share hospital factor that contemplates the increased capital costs associated with providing care to low income patients, and an indirect medical education factor that contemplates the increased capital costs associated with medical education programs.

There can be no assurance that payments under the PPS inpatient capital costs regulations will be sufficient to fully reimburse System for its capital expenditures.

Outlier Payments. As noted above, hospitals are eligible to receive additional payments under the inpatient PPS for individual cases incurring extraordinarily high costs. Historically, the amount of an outlier payment was based, in part, on the hospital charges for a particular case as compared to that hospital's cost-to-charge ratio. As the hospital specific cost-to-charge ratio was calculated based on the most recently settled cost report, it was typically many months or years old and out of date.

Following an audit of aggressive pricing strategies at one of the nation's largest hospital chains, and a determination that some hospitals might be manipulating current hospital charge data to maximize reimbursement from Medicare under the outlier payment provisions, the Office of the Inspector General of DHHS ("OIG") began investigating past outlier billing practices, and CMS amended the regulations on how outlier payments were to be calculated in the future. The methodology for calculating outlier payments went into effect in August 2003. It was designed to prevent hospitals from manipulating the outlier formula to maximize reimbursement and allows for recovery of overpayments in certain cases.

The OIG continues to scrutinize outlier payments in an effort to determine whether outlier payments to the hospitals were paid in accordance with Medicare regulations or whether such payments were the result of potentially abusive billing practices. While the Hospital Board believes that it has calculated its outlier payments appropriately, there can be no assurance that the Hospital will not become the subject of an investigation or audit with respect to its past outlier payments, or that such an audit would not have a material adverse impact on the Hospital. Moreover, there can be no assurance that any

future revisions to the formula for calculating outlier payments will not reduce the payments to the Hospital, or that any such reduction will not have a material adverse impact on the Hospital.

Medicare Managed Care Program. Every individual entitled to Medicare Part A benefits, and who is enrolled in Medicare Part B, with the exception of individuals who suffer from End Stage Renal Disease, may elect coverage under either the traditional Medicare fee for service program (Parts A and B) or a Medicare managed care (Part C) program, known as the Medicare Advantage Program. The Medicare Advantage program is designed to expand the number and types of private regional plans available to beneficiaries as an alternative to traditional Parts A and B Medicare coverage. Payments for Medicare Advantage plans are based on competitive bids to the government rather than administered pricing.

Public and private health maintenance organizations, preferred provider organizations, fee for service and medical savings account plans may qualify as authorized Medicare Advantage plans. With limited exceptions, Medicare Advantage plans are risk-bearing programs that accept a fixed annual amount in return for providing beneficiaries with a defined level of benefits (basic or basic plus supplemental), either directly or through arrangements with other providers. All Medicare Advantage plans are required to provide coverage, even if out of network, for emergency services, renal dialysis services provided while the enrollee was temporarily outside of the plan's service area, post stabilization care services (under limited circumstances) and services for which coverage was denied but, following appeal by the enrollee, were determined to be covered services. Providers wishing to participate in Medicare Advantage plans are subject to specific requirements concerning enrollee protection and accountability.

The shift of Medicare eligible beneficiaries from traditional Part A and Part B coverage to Part C Medicare Advantage programs was intended to increase competitive pressure to improve benefits, reduce premiums and generate cost reductions. However, because the cost to the Medicare Advantage program was on average 114% higher than traditional Medicare, the ACA changed some of the Medicare Advantage payment methodologies and began paying bonuses to plans that achieve certain quality metrics in 2012. For fiscal year 2020, CMS announced that payments under the "Medicare Advantage" programs (Medicare managed care) were expected to increase by an average of 2.53%. However, these payments may be reduced again, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans and may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. Reductions in the Medicare Part C program may have an impact on reimbursement from these insurance plans, which in turn may have a material negative impact upon the revenue of the Hospital and its affiliates.

New Models for Care. The ACA directed the Secretary of DHHS (the "Secretary") to establish a Medicare shared savings program that promotes accountability for the care of Medicare beneficiaries and encourages coordination of care and other efficiencies through entities called Accountable Care Organizations ("ACOs"). Under this shared savings program, Medicare providers are offered a financial incentive to band together in an ACO with the shared goals of improving the quality of care provided to Medicare beneficiaries and coordinating care to achieve cost savings. If the ACO realizes savings in Medicare expenditures above an expenditure benchmark established by CMS for the group, and meets or exceeds quality performance standards established by the Secretary, it will be paid a share of Medicare's savings.

Although the Hospital has a well-established infrastructure for cost containment and electronic medical records, and has significant experience in the management of chronic diseases that make it well suited to participate in the shared savings program, it is unclear what effect these proposed regulations

will have on the Hospital and its revenues in the future should the Hospital choose to participate in the shared savings program.

Transparency in Pricing. The ACA requires hospitals to establish and make public a list of the hospital's standard charges for items and services, including MS-DRGs. CMS also has made "outcomes" reporting a condition of Medicare participation. These requirements are examples of a trend in which hospitals will be required to divulge proprietary information to the general public in order to participate in federal health care programs. The 2015 inpatient PPS rule requires hospitals to make public a list of their standard changes in response to an inquiry. The disclosure of proprietary information may have a negative impact on the ability of the Members of the Hospital Board to gain advantages in negotiations with payors. This, in turn, could negatively influence the Hospital Board's revenues. The ACA includes various public disclosure obligations for financial arrangements between hospitals, physicians, imaging pharmaceutical and medical device manufacturers. It is difficult to predict the effect, if any, that cost and outcomes reporting will have on the finances of the Members of the Hospital Board.

On November 27, 2019, CMS published a final rule on "Price Transparency Requirements for Hospitals to Make Standard Charges Public." This rule is scheduled to take effect on January 1, 2021 and will require hospitals to make public their payor-specific negotiated rates, minimum negotiated rates, maximum negotiated rates, and cash for all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient. In addition, under this rule, hospitals must either (i) make available an internet-based price estimator tool that provides an estimate of a patient's financial liability for 300 shoppable services (including 70 CMS-specified shoppable services) or (ii) make public charges, payor-specific negotiated rates, minimum negotiated rates, and maximum negotiated rates for 300 shoppable services (including 70 CMS-specified shoppable services) in a consumer-friendly manner. Hospitals must display the required information prominently, in a consumer-friendly manner, and clearly identify the hospital location with which the standard charge information is associated on a publicly available website. Failure to comply with these requirements may result in daily monetary penalties to the hospital. In June 2020, a federal district court judge rejected a lawsuit challenging implementation of the final rule. The American Hospital Association has appealed this decision to the U.S. Court of Appeals for the D.C. Circuit. Management of the Hospital Board is unable to predict the ultimate outcome of this litigation. If the rule takes effect, it may result in further legislative or regulatory action to restrain hospital charges or rates and litigation concerning fees and charges. In addition, if this rule becomes effective, competitively sensitive rate information will be available to competing hospitals and insurers as well as employer sponsors of group health plans, which could lead to market distortions and possible anti-competitive effects that could impact hospital rates and revenue. Publication of hospital standard charges (including negotiated rate) as required, may result in changes to consumer choice in a manner that may negatively impact the Hospital Board. Accordingly, compliance with these requirements could have a material adverse financial or operational impact on the Hospital Board.

Audits, Exclusions, Fines and Enforcement Actions. Providers participating in Medicare are subject to audits and retroactive audit adjustments by fiscal intermediaries under the Medicare program. From an audit, a fiscal intermediary may conclude that a patient discharge has been claimed under an incorrect MS-DRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to admission as an inpatient should not have been billed as outpatient services, that certain outpatient services were subjected to quantity limits or should have been bundled with the outpatient APC payment, or that certain required procedures or processes were not satisfied. As a consequence, payments may be retroactively disallowed. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the hospital to civil or criminal sanctions.

The federal government uses a national recovery audit contractor ("RAC") program to identify overpayments and underpayments to providers under the Medicare program. The RAC auditors are compensated on a contingent fee basis. Audits typically result in far more overpayments than underpayments. Medicare contractors will recoup RAC identified overpayments unless appeals are filed timely. RAC assessments against the Hospital are anticipated; however, the outcome of such assessments are unknown and cannot be reasonably estimated. The ACA expands the scope of the RAC program to include Medicare Parts C and D and Medicaid.

Medicaid Program. Medicaid is a program of medical assistance, funded jointly by the federal government and the states, for certain needy individuals and their dependents. Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. Attempts to balance or reduce federal and state budgets will likely negatively impact Medicaid and other state health care program spending. Federal and state budget proposals contemplate significant cuts in Medicaid spending which will likely negatively impact provider reimbursement.

Medicaid is the commonly accepted name for the jointly funded federal and state program for paying for certain health care services created by certain provisions of the Federal Social Security Act to benefit indigent persons who are aged, blind or disabled, or the members of families eligible for certain income maintenance programs. Medicaid payments have been affected by efforts to reduce government spending.

For the fiscal years ended June 30, 2020 and 2019, Medicaid represented approximately 7% and 8%, respectively, of the Hospital Board's gross patient service revenues. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER – MARKET COMPETITION AND UTILIZATION – Payor Mix" in this Official Statement. Health care providers, including the Hospital Board, have been affected by changes in the last several years in federal and state Medicaid laws and regulations. The purpose of much of this statutory and regulatory activity has been to contain the rate of increase in health care costs. Diverse and complex mechanisms to limit the amount of money paid to health care providers under the Medicaid program have been enacted.

Disproportionate Share Payments. The federal Medicaid law permits states to include a "disproportionate share" adjustment in payments ("DSH Payments") to hospitals in order to compensate those hospitals that serve a disproportionate share of indigent patients. DSH payments under Medicaid are limited to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received for such patients. The Bipartisan Budget Act included provisions that substantially reduce DSH Medicaid funds and a formula for establishing each state's allotment of DSH funds. Congress has repeatedly delayed reductions to Medicaid DSH payments. For example, the Bipartisan Budget Act of 2018 eliminated fiscal year 2018 and fiscal year 2019 Medicaid DSH reductions, but maintained the $4 billion in reductions for fiscal year 2020, and set the amount of Medicaid DSH reductions for fiscal year 2021 through fiscal year 2025 at $8 billion per fiscal year. The CARES Act delayed the implementation of Medicaid DSH payment reductions, until November 30, 2020. And recent legislation enacted on October 1, 2020, as noted above, further delays the implementation of these reductions. It is impossible to predict whether the Hospital Board will qualify for DSH funds in any year, and, if so, exactly what payment may be expected.

WCHIP. The State Children's Health Insurance Program ("SCHIP") provides federal matching funds to states that cover 65% to 84% of the costs of health care coverage, primarily for low-income children. CMS administers SCHIP, but each state creates its own program based on minimum federal guidelines, or the state may apply for a waiver, which allows the state to create its own program using the federal funds, but often with different criteria for eligibility. CMS administers the WCHIP (defined below), but each state creates its own program based upon minimum federal guidelines. Wyoming has

implemented its version of the Wyoming Children's Health Insurance Program ("WCHIP"), known as "Kid Care CHIP" to increase the Medicaid program income eligibility standard for children in Wyoming. Among other things, to be eligible for Kid Care CHIP, children must be under 19, uninsured and meet certain income guidelines. HHS provides health coverage to children enrolled in WCHIP and the Wyoming Department of Health will manage the WCHIP program. While generally considered to be beneficial for both patients and providers by reducing the number of uninsured children, it is difficult to assess the fiscal impact of WCHIP on the payments to the Hospital Board. Moreover, Wyoming must periodically submit its WCHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for its program. Finally, the future existence and amount of WCHIP funding in Wyoming is dependent on federal legislation.

From time to time, Congress or the President may seek to expand or reduce WCHIP. The Bipartisan Budget Act of 2019 extended SCHIP funding through 2027. When such funding expires, there can be no assurances that funding for an increase will be reestablished at either a state or federal level, or that professional and/or facility reimbursement rates will not subsequently be reduced in efforts to manage costs.

Wyoming Medicaid Program. In order to qualify for the Wyoming program, a person must be a resident of the State of Wyoming, a U.S. national, citizen, permanent resident, or legal alien, in need of health care/insurance assistance, whose financial situation would be characterized as low income or very low income. A person must also be either pregnant, a parent or relative caretaker of a dependent child(ren) under the age of 18, blind, have a disability or a family member in your household with a disability, or be 65 years of age or older.

In order to qualify for the program, a person much have an annual household income (before taxes) that is below the following amounts:

Household Size	Maximum Income Level (Per Year)
1	$16,971
2	22,930
3	28,888
4	34,846
5	40,805
6	46,763
7	52,722
8	58,680

Payments for services rendered to Wyoming Medicaid beneficiaries remain subject to an appropriation by the Wyoming Legislature of sufficient funds to pay the incurred payment obligations for the Medicaid program. Delays in appropriations and state budget deficits, which may occur from time to time, create a risk that payment to health care providers for services to Medicaid beneficiaries will be delayed or withheld.

Wyoming is one of a minority of states where Medicaid has not been expanded pursuant to the ACA. Future actions by the Federal Government and/or State of Wyoming relative to limiting or reducing the total amount of funds available under Medicaid, or otherwise restructuring Medicaid, may decrease or eliminate the amount of reimbursement available to the Hospital. No assurance can be given as to the timing or extent of future changes.

Changes in Response to COVID-19. On March 22, 2020, CMS announced new tools for states to use in connection with their Medicaid programs during the COVID-19 pandemic. The tools announced were a 1115 demonstration opportunity to assist states with addressing the public health emergency; a 1135 waiver checklist template to expedite state abilities to apply for waivers available under the federal national emergency declaration; a 1915(c) Appendix K template to assist states in accelerating changes to their 1915(c) home and community-based services waiver operations or to request emergency amendments; and a Medicaid disaster state plan amendment template, to streamline the process for a state to submit requests for temporary changes in response to COVID-19.

Health Plans and Managed Care. Most private health insurance coverage is provided by various types of "managed care" plans, including HMOs and preferred provider organizations ("PPOs"), that generally use discounts and other economic incentives to reduce or limit the cost and utilization of health care services. Medicare and Medicaid also purchase hospital care using managed care options. Payments to hospitals from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

Managed care plans have replaced indemnity insurance as the prime source of non-governmental payment for hospital services, and hospitals must be capable of attracting and maintaining managed care business, often on a regional basis. Regional coverage and aggressive pricing may be required. However, it is also essential that contracting hospitals be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment.

Many HMOs and PPOs currently pay providers on a negotiated fee-for-service basis or, for institutional care, on a fixed rate per day of care, which, in each case, usually is discounted from the typical charges for the care provided. As a result, the discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and/or changes in the utilization may be dramatic and unexpected, thus jeopardizing the provider's ability to manage this component of revenue and cost.

Failure to maintain contracts could have the effect of reducing a hospital's market share and net patient services revenues. Conversely, participation may result in lower net income if participating hospitals are unable to adequately contain their costs. Thus, managed care poses one of the most significant business risks (and opportunities) the hospitals face.

Licensing, Surveys, Investigations and Audits

Healthcare facilities, including those of the Hospital, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare and Medicaid participation and payment, state licensing agencies and private payors. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require or include affirmative activity or response by the Hospital. These activities generally are conducted in the normal course of business of healthcare facilities. Nevertheless, an adverse result could cause a loss or reduction in the Hospital's scope of licensure, certification or accreditation, could reduce the payment received, or could require repayment of amounts previously remitted to the provider.

Management of the Hospital currently anticipates no difficulty renewing or continuing currently held licenses, certifications or accreditations, nor does it anticipate a reduction in third-party payments from such events that would materially adversely affect the operations or financial condition of the Hospital. Nevertheless, actions in any of these areas could result in the loss of utilization or revenues, or the Hospital's ability to operate all or a portion of its health facilities, and, consequently, could have a

material and adverse effect on the County and the Hospital Board to make the debt service payments relating to the Series 2021 Bonds.

Market Dynamics and Competition

In providing health care services, the Hospital competes with a number of other providers in its service area, which may include for-profit and not-for-profit providers of acute health care services. See "APPENDIX A – INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER – MARKET COMPETITION AND UTILIZATION" in this Official Statement for a description of the principal competitors of the Hospital.

In addition, competition could also result from certain health care providers that may be able to offer lower priced services to the population served by the Hospital. These services could be substituted for some of the revenue generating services currently offered by the Hospital. The services that could serve as substitutes for services provided by the Hospital include ambulatory surgical centers, expanded preventive medicine and outpatient treatment, freestanding independent diagnostic testing facilities, and increasingly sophisticated physician group practices. Certain forms of health care delivery are designed to offer comparable services at lower prices, and the federal government and private third-party payors may increase their efforts to encourage the development and use of such programs. In addition, future changes in state and federal law may have the effect of increasing competition in the health care industry. The effect on the Hospital of any such affiliations or entry into the market of alternative providers of certain services, if completed, cannot be determined at this time, but the management of the Hospital believes that it has positioned itself to effectively provide community-based health care throughout the service area of the Hospital.

Need to Achieve and Maintain Utilization Levels

The economic feasibility of the Hospital and the ability of the Hospital to meet its obligations under the Indenture depends, in large part, upon the Facilities and the Hospital being utilized and generating revenues. There can be no assurance that utilization will meet or exceed the levels needed for the feasibility of the Hospital and overall Hospital operations. Utilization levels can be affected by a number of factors outside the Hospital's control, such as competition from other facilities or other forms of service delivery. Because it is estimated that approximately 46% of the Hospital's revenues are from Medicare reimbursement, the revenues are dependent on Medicare reimbursement rates remaining at current levels. There can be no assurance, however, that the Facilities and overall Hospital operations will be able to meet such utilization projections or that Medicare reimbursement rates will remain at current levels.

Audited and Unaudited Interim Financial Statements of the Hospital

The audited financial statements of the Hospital as of and for the fiscal years ended June 30, 2020 and 2019, including the report of Eide Bailly, LLP Fargo, North Dakota (the "Auditors"), thereon, are included in this Official Statement as APPENDIX B. APPENDIX C of this Official Statement contains the unaudited interim financial statements of the Hospital as of and for the three-month periods ended September 30, 2020 and 2019. The unaudited internally prepared interim financial statements of the Hospital for the three-month periods ended September 30, 2020 and 2019 have not been audited by the Auditors or any independent public accountant. No assurance can be given that the Auditors will agree with the accounting treatment in the internally prepared unaudited interim financial statement contained in APPENDIX C. See "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019" and "APPENDIX C – UNAUDITED INTERIM FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE THREE-MONTH PERIODS ENDED SEPTEMBER 30, 2020 AND 2019" in this Official Statement

Forward-Looking Statements

This Official Statement contains certain statements that are "forward-looking" statements within the meaning of Section 27A of the Securities Act of 1933, as amended and Section 21E of the Securities Exchange Act of 1934, as amended. All statements other than statements of historical facts included in this Official Statement, including without limitation the Forecasts and any statements that use terminology such as "estimate," "plan," "budget," "expect," "intend," "anticipate," "believe," "may," "will," "continue," and similar expressions, are forward-looking statements. These forward-looking statements include, among other things, the discussions related to the Hospital's operations and expectations regarding patient utilization, future operations, revenues, capital resources, and expenditures for capital projects. Although the Hospital Board believes that the assumptions upon which the forward-looking statements contained in this Official Statement are based are reasonable, any of the assumptions could prove to be inaccurate and, as a result, the forward-looking statements based on those assumptions also could be incorrect. All phases of the operations of the Hospital involve risks and uncertainties, many of which are outside the control of the Hospital Board and any one of which, or a combination of which, could materially affect the results of the Hospital's operations and whether the forward-looking statements ultimately prove to be correct. Factors that could cause actual results to differ from those expected include, but are not limited to, general economic conditions such as inflation and interest rates, both nationally and in Wyoming where the Facilities are located; the continuation of Medicare and Medicaid funding at current levels; competitive conditions within the Facilities' market; lower utilization than projected; unanticipated expenses; the capabilities of Hospital's management; changes in government regulation of the medical industry; future claims for accidents at the Facilities and the extent of insurance coverage for such claims; and other risks discussed in this Official Statement.

No representation or assurance can be given that the Hospital will realize revenues in amounts sufficient to make the required payments under the Indenture. The realization of future revenues is dependent upon, among other things, the matters described in this "BONDHOLDERS' RISKS" section and future changes in economic and other conditions that are unpredictable and cannot be determined at this time. The Underwriter makes no representation as to the accuracy of the projections contained herein or as to the assumptions on which the projections are based.

Bankruptcy

The rights and remedies of the holders of the Series 2021 Bonds are subject to various provisions of the federal Bankruptcy Code. If the County or the Hospital Board were to become a debtor in a bankruptcy case, its revenues and certain of its accounts receivable and other property created or otherwise acquired after the filing of such petition and for up to ninety (90) days prior to the filing of such petition may not be subject to the security interest created under the Indenture. The filing would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against the County or the Hospital Board and its property, and as an automatic stay of any act or proceeding to enforce a lien upon or to otherwise exercise control over its property. If the bankruptcy court so ordered, the property of the County or the Hospital Board, including accounts receivable and the other revenues of the Hospital, could be used for the financial reorganization of the County or the Hospital despite the security interest of the Trustee under the Indenture. The County or the Hospital Board could file a plan for reorganization of its debts in any such proceeding which could include provisions modifying or altering the rights of creditors generally, or any class of them, secured or unsecured.

Failure to Provide Ongoing Disclosure

The Hospital Board, the County, and the Wells Fargo Bank, National Association, as dissemination agent, will enter into the Continuing Disclosure Agreement pursuant to Rule 15c2-12, promulgated by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as

amended ("Rule 15c2-12"). Failure by the Hospital Board to comply with the Continuing Disclosure Agreement and Rule 15c2-12 may adversely affect the liquidity of the Series 2021 Bonds and their market price in the secondary market. See "CONTINUING DISCLOSURE" and "APPENDIX D – FORM OF CONTINUING DISCLOSURE AGREEMENT" in this Official Statement.

Secondary Market Trading

The secondary market for the Series 2021 Bonds may be restricted or very limited at any given time, and there can be no assurance that the secondary market will provide owners of the Series 2021 Bonds with investment liquidity or will continue until final maturity of the Series 2021 Bonds. The Underwriter plans to engage in secondary market trading of the Series 2021 Bonds (subject to applicable securities laws). However, the Underwriter is not obligated to engage in secondary market trading of the Series 2021 Bonds. In addition, adverse developments with respect to the Hospital or its operations may adversely affect bid and asked prices for the Series 2021 Bonds in any secondary market.

Enforceability of the Indenture and the Lien on the Hospital's Net Pledged Revenues

The remedies available to the Trustee or the holders of the Series 2021 Bonds upon an Event of Default under the Indenture may be limited by laws relating to bankruptcy (see "Bankruptcy" above), insolvency, reorganization or moratorium and by other similar laws affecting creditors' rights, including equitable principles. In addition, the Trustee's ability to enforce such agreements will depend upon the exercise of various remedies specified by such documents which may in many instances require judicial actions that are often subject to discretion, delay and substantial costs or that otherwise may not be readily available or be limited. The various legal opinions to be delivered concurrently with the issuance of the Series 2021 Bonds will be qualified as to the enforceability of the various legal instruments by limitations imposed by State and federal laws, rulings and decisions affecting remedies, and by bankruptcy, reorganization or other laws of general application affecting the enforcement of creditors' rights, including equitable principles.

Environmental Risks

There are potential risks relating to liabilities for environmental conditions with respect to the Facilities. If hazardous substances are found to be located on property, owners of such property may be held liable for costs and other liabilities related to the presence, migration or removal of such substances, which costs and liabilities could exceed the value of the property. The Hospital Board is not aware of any pending or threatened claim, investigation or enforcement action regarding environmental issues relating to its Facilities. Any future claim, investigation or enforcement action could have material adverse consequences to the operations or financial condition of the Hospital and could impact the ability of the County or Hospital Board to pay debt service on the Series 2021 Bonds when due.

Summary

The foregoing is intended only as a summary of certain risk factors attendant to an investment in the Series 2021 Bonds. In order for potential investors to identify risk factors and make an informed decision, potential investors should be thoroughly familiar with this entire Official Statement and the appendices hereto.

CONTINUING DISCLOSURE

The Hospital Board has undertaken responsibility for continuing disclosure to Holders and Beneficial Owners of the Series 2021 Bonds pursuant to a Continuing Disclosure Agreement, dated as of

the Closing Date (the "Disclosure Agreement"), between the County, the Hospital Board and the Trustee, as dissemination agent. The provisions of the Disclosure Agreement require that the Hospital Board comply with the provisions of Rule 15c2-12 promulgated under the Securities Exchange Act of 1934 by the Securities and Exchange Commission (the "Rule").

The Hospital Board has covenanted for the benefit of Holders and Beneficial Owners of the Series 2021 Bonds to provide certain financial information and operating data relating to the Hospital on an annual and quarterly basis, and to file notices of the occurrence of certain enumerated events, if material. Any notices of material events will be filed with the Municipal Securities Rulemaking Board as set forth in the Disclosure Agreement.

The specific nature of the information to be disclosed by the Hospital Board on an annual or quarterly basis or the notices of material events is set forth in the form of Disclosure Agreement attached hereto in "APPENDIX D – FORM OF CONTINUING DISCLOSURE AGREEMENT."

Except as described in the following sentence, during the previous five years, the Hospital Board has complied in all material respects with its continuing disclosure obligations under the Rule. [Filings history to be reviewed prior to printing and any needed language to be added]

ABSENCE OF MATERIAL LITIGATION

No litigation is now pending against the County or the Hospital Board or, to the knowledge of the County or Hospital Board, threatened, (i) seeking to restrain or enjoin the issuance or delivery of any of the Series 2021 Bonds or the application of proceeds of the Series 2021 Bonds or the collection of revenues or other security pledged under the Indenture or the Resolution, (ii) in any way contesting or affecting any authority for the issuance of the Series 2021 Bonds or the validity of the Series 2021 Bonds, any proceedings of the County or Hospital Board taken concerning the issuance or sale thereof, the Indenture, the Resolutions, the Continuing Disclosure Agreement, or the Bond Purchase Agreement, (iii) in any way contesting the existence or powers of the County, or (iv) in any way contesting the completeness or accuracy of the Official Statement. There is no litigation of any nature now pending against the County or Hospital Board or, to the knowledge of the County or Hospital Board, threatened, which, if successful, would materially adversely affect the operations or financial condition of the County or Hospital Board.

TAX MATTERS

General

In the opinion of Freudenthal & Bonds, P.C., Bond Counsel, based on existing statutes, regulations, rulings and court decisions, interest on the Series 2021 Bonds is excludable from gross income for federal income tax purposes. A copy of the proposed opinion of Bond Counsel is set forth in APPENDIX F hereto.

The Internal Revenue Code of 1986 (the "Code"), imposes various restrictions, conditions and requirements relating to the exclusion from gross income for federal income tax purposes of interest on obligations such as the Series 2021 Bonds. Bond Counsel is further of the opinion that interest on the Series 2021 Bonds is not a specific preference item for purposes of the federal individual alternative minimum taxes. The County and the Hospital Board have covenanted to comply with certain restrictions designed to assure that interest on the Series 2021 Bonds will not be includable in federal gross income. Failure to comply with these covenants may result in interest on the Series 2021 Bonds being includable

in federal gross income, possibly from the date of issuance of the Series 2021 Bonds. The opinion of Bond Counsel assumes compliance with these covenants. Bond Counsel has not undertaken to determine (or to inform any person) whether any actions taken (or not taken) or events occurring (or not occurring) after the date of issuance of the Series 2021 Bonds may affect the value of, or the tax status of interest on the Series 2021 Bonds. Further, no assurance can be given that pending or future legislation or amendments to the Code, will not adversely affect the value of, or the tax status of interest on, the Series 2021 Bonds. Prospective owners are urged to consult their own tax advisors with respect to proposals to restructure the federal income tax.

Prospective purchasers of the Series 2021 Bonds should be aware that (i) with respect to insurance companies subject to the tax imposed by Section 831 of the Code, Section 832(b)(5)(B)(i) reduces the deduction for loss reserves by 15 percent of the sum of certain items, including interest with respect to the Series 2021 Bonds, (ii) interest with respect to the Series 2021 Bonds earned by certain foreign corporations doing business in the United States could be subject to a branch profits tax imposed by Section 884 of the Code, (iii) passive investment income, including interest with respect to the Series 2021 Bonds, may be subject to federal income taxation under Section 1375 of the Code for subchapter S corporations having subchapter C earnings and profits at the close of the taxable year and gross receipts more than 25% of which constitute passive investment income, and (iv) Section 86 of the Code requires recipients of certain Social Security and certain Railroad Retirement benefits to take into account, in determining gross income, receipts or accruals of interest on the Series 2021 Bonds.

Original Issue Discount. If the initial offering price to the public (excluding bond houses and brokers) at which a Series 2021 Bond is sold is less than the amount payable at maturity thereof, then such difference constitutes "original issue discount" for purposes of federal income taxes. If the initial offering price to the public (excluding bond houses and brokers) at which a Series 2021 Bond is sold is greater than the amount payable at maturity thereof, then the excess of the tax basis of a purchaser of such Series 2021 Bond (other than a purchaser who holds such Series 2021 Bond as inventory, stock in trade or for sale to customers in the ordinary course of business) over the principal amount of such Series 2021 Bond constitutes "original issue premium" for purposes of federal income taxes.

Under the Code, original issue discount is excludable from gross income for federal income tax purposes to the same extent as interest on the Series 2021 Bonds. Further, such original issue discount accrues actuarially on a constant interest rate basis over the term of each such Series 2021 Bond and the basis of such Series 2021 Bond acquired at such initial offering price by an initial purchaser of each such Series 2021 Bond will be increased by the amount of such accrued discount. The Code contains certain provisions relating to the accrual of original issue discount in the case of purchasers of the Series 2021 Bonds who purchase such Series 2021 Bonds after the initial offering of a substantial amount thereof. Owners who do not purchase such Series 2021 Bonds in the initial offering at the initial offering prices should consult their own tax advisors with respect to the tax consequences of ownership of such Series 2021 Bonds. All holders of such Series 2021 Bonds should consult their own tax advisors with respect to the allowance of a deduction for any loss on a sale or other disposition to the extent that calculation of such loss is based on accrued original issue discount.

Premium. Under the Code, original issue premium is amortized for federal income tax purposes over the term of such a Series 2021 Bond based on the purchaser's yield to maturity in such Series 2021 Bond, except that in the case of such a Series 2021 Bond callable prior to its stated maturity, the amortization period and the yield may be required to be determined on the basis of an earlier call date that results in the lowest yield on such Series 2021 Bond. A purchaser of such a Series 2021 Bond is required to decrease his or her adjusted basis in such Series 2021 Bond by the amount of bond premium attributable to each taxable year in which such purchaser holds such Series 2021 Bond. The amount of bond premium attributable to a taxable year is not deductible for federal income tax purposes. Purchasers

of such Series 2021 Bonds should consult their tax advisors with respect to the precise determination for federal income tax purposes of the amount of bond premium attributable to each taxable year and the effect of bond premium on the sale or other disposition of such a Series 2021 Bond, and with respect to the state and local tax consequences of owning and disposing of such a Series 2021 Bond.

Certain agreements, requirements and procedures contained or referred to in the Indenture and other relevant documents may be changed and certain actions may be taken or omitted under the circumstances and subject to the terms and conditions set forth in those documents, upon the advice or with the approving opinion of nationally recognized bond counsel. Bond Counsel expresses no opinion as to the effect on any Series 2021 Bond or the interest payable with respect thereto if any change occurs or action is taken or omitted upon the advice or approval of counsel other than Bond Counsel.

Although Bond Counsel has rendered an opinion that interest on the Series 2021 Bonds is excludable from federal gross income, the ownership or disposition of the Series 2021 Bonds, and the accrual or receipt of interest on the Series 2021 Bonds may otherwise affect an Owner's state or federal tax liability. The nature and extent of these other tax consequences will depend upon each Owner's particular tax status and the Owner's other items of income or deduction. Bond Counsel expresses no opinion regarding any such other tax consequences.

Future rulings, court decisions, legislative proposals, if enacted into law, or clarification of the Code may cause interest on the Series 2021 Bonds to be subject, directly or indirectly, to federal income taxation, or otherwise prevent Owners from realizing the full current benefit of the tax status of such interest. There can be no assurance that such future rulings, court decisions, legislative proposals, if enacted into law, or clarification of the Code enacted or proposed after the date of issuance of the Series 2021 Bonds will not have an adverse effect on the tax exempt status or market price of the Series 2021 Bonds.

Internal Revenue Service Audit of Tax-Exempt Issues

The Internal Revenue Service ("IRS") has initiated an expanded program for the auditing of tax-exempt issues, including both random and targeted audits. It is possible that the Series 2021 Bonds will be selected for audit by the IRS. It is also possible that the market value of the Series 2021 Bonds might be affected as a result of such an audit of the Series 2021 Bonds (or by an audit of similar obligations).

Information Reporting and Backup Withholding

Information reporting requirements apply to interest (including original issue discount) paid after March 31, 2007 on tax-exempt obligations, including the Series 2021 Bonds. In general, such requirements are satisfied if the interest recipient completes, and provides the payor with, a Form W-9, "Request for Taxpayer Identification Number and Certification," or unless the recipient is one of a limited class of exempt recipients, including corporations. A recipient not otherwise exempt from information reporting who fails to satisfy the information reporting requirements will be subject to "backup withholding," which means that the payor is required to deduct and withhold a tax from the interest payment, calculated in the manner set forth in the Code. For the foregoing purpose, a "payor" generally refers to the person or entity from whom a recipient receives its payments of interest or who collects such payments on behalf of the recipient.

If an owner purchasing a Series 2021 Bond through a brokerage account has executed a Form W-9 in connection with the establishment of such account, as generally can be expected, no backup withholding should occur. In any event, backup withholding does not affect the excludability of the interest on the Series 2021 Bonds from gross income for Federal income tax purposes. Any amounts

withheld pursuant to backup withholding would be allowed as a refund or a credit against the owner's Federal income tax once the required information is furnished to the Internal Revenue Service.

Changes in Law. From time to time, there are legislative proposals in the Congress and in the various state legislatures that, if enacted, could alter or amend federal and state tax matters referred to above or adversely affect the market value of the Series 2021 Bonds. It cannot be predicted whether or in what form any such proposal might be enacted or whether if enacted it would apply to bonds issued prior to enactment. In addition, regulatory actions are from time to time announced or proposed and litigation is threatened or commenced which, if implemented or concluded in a particular manner, could adversely affect the market value of the Series 2021 Bonds. It cannot be predicted whether any such regulatory action will be implemented, how any particular litigation or judicial action will be resolved, or whether the Series 2021 Bonds or the market value thereof would be impacted thereby. Purchasers of the Series 2021 Bonds should consult their tax advisors regarding any pending or proposed legislation, regulatory initiatives or litigation. The opinions expressed by Bond Counsel are based upon existing legislation and regulations as interpreted by relevant judicial and regulatory authorities as of the date of issuance and delivery of the Series 2021 Bonds and Bond Counsel has expressed no opinion as of any date subsequent thereto or with respect to any pending legislation, regulatory initiatives or litigation.

PROSPECTIVE PURCHASERS ARE URGED TO CONSULT THEIR OWN TAX ADVISORS TO DETERMINE THE APPLICATION OF THE CODE TO THEIR PARTICULAR CIRCUMSTANCES.

LEGAL MATTERS

The tax-exempt status of the Series 2021 Bonds and certain other legal matters are subject to the approving opinion of Freudenthal & Bonds, P.C., Bond Counsel to the County and the Hospital Board. A complete copy of the proposed form of Bond Counsel opinion is contained in APPENDIX F. Certain legal matters will be passed on for the Underwriter by its counsel, Ballard Spahr LLP, Minneapolis, Minnesota; for the County by the Laramie County Attorney; and for the Hospital Board by its Vice President and Chief Legal Officer. None of the counsel mentioned above undertakes any responsibility for the accuracy, completeness or fairness of this Official Statement.

ENFORCEABILITY OF OBLIGATIONS

While the Series 2021 Bonds are secured by the Indenture, the practical realization of such security upon any default may depend upon the exercise of various remedies, which may be dependent upon judicial actions that are subject to discretion and delay. Under existing constitutional, statutory, and judicial law, such remedies may not be readily available or may be limited. A court may decide not to order the specific performance of covenants contained in the documents. The various legal opinions to be delivered concurrently with the delivery of the Series 2021 Bonds will be qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws affecting remedies and by bankruptcy, reorganization or other laws affecting the enforcement of creditor's rights.

UNDERWRITING

Piper Sandler & Co. (the "Underwriter") has agreed, subject to the terms of a Bond Purchase Agreement, to purchase from the County the Series 2021 Bonds at an aggregate purchase price of $_____ (representing a par amount of $_____, [plus/less] [net] original issue [premium/discount] of $_____, and less Underwriter's discount of $_____). The Bond Purchase Agreement provides that the Underwriter

will purchase all Series 2021 Bonds if any are purchased, and that the obligation to make such purchase is subject to certain terms and conditions set forth in the Bond Purchase Agreement and the approval of certain legal matters by counsel. To the extent permitted by law, the Hospital Board has agreed to indemnify the Underwriter against certain civil liabilities under the Securities Act of 1933, as amended.

The Underwriter has entered into a distribution agreement ("Distribution Agreement") with Charles Schwab & Co., Inc. ("CS&Co") for the retail distribution of certain securities offerings at the original issue prices. Pursuant to the Distribution Agreement, CS&Co. will purchase the Series 2021 Bonds from the Underwriter at the original issue price less a negotiated portion of the selling concession applicable to any Series 2021 Bonds that CS&Co. sells.

THE TRUSTEE

The County and the Hospital Board have appointed Wells Fargo Bank, National Association, a national banking association organized under the laws of the United States, to serve as Trustee. The Trustee is a national banking association organized and existing under the laws of the United States of America, having all of the powers of a bank, including fiduciary powers, and is a member of the Federal Deposit Insurance Corporation and the Federal Reserve System. The Trustee is to carry out those duties assignable to it under the Indenture. Except for the contents of this section, the Trustee has not reviewed or participated in the preparation of this Official Statement and assumes no responsibility for the nature, contents, accuracy, fairness or completeness of the information set forth in this Official Statement or for the recitals contained in the Indenture or the Series 2021 Bonds, or for the validity, sufficiency, or legal effect of any of such documents.

Furthermore, the Trustee has no oversight responsibility, and is not accountable, for the use or application by the County or the Hospital Board of any of the Series 2021 Bonds authenticated or delivered pursuant to the Indenture or for the use or application of the proceeds of such Series 2021 Bonds by the County. The Trustee has not evaluated the risks, benefits, or propriety of any investment in the Series 2021 Bonds and makes no representation, and has reached no conclusions, regarding the value or condition of any assets or revenues pledged or assigned as security for the Series 2021 Bonds, or the investment quality of the Series 2021 Bonds, about all of which the Trustee expresses no opinion and expressly disclaims the expertise to evaluate.

The mailing address of the Trustee is Wells Fargo Bank, National Association, MAC 7300-107, 1740 Broadway, Denver, Colorado 80274; Attention: Corporate Trust. Additional information about the Trustee may be found on its website at https://www.wellsfargo.com. The Trustee's website is not incorporated into this Official Statement by such reference and is not a part hereof.

AUDITED FINANCIAL STATEMENTS

The financial statements of the Hospital as of and for the fiscal years ended June 30, 2020 and 2019 (the "Audited Financial Statements"), have been audited by Eide Bailly, LLP, Fargo, North Dakota (the "Auditor"), as stated in their report thereon, dated November 5, 2020. Except for the Audited Financial Statements contained in APPENDIX B, the Auditor has not reviewed or audited any financial information of the Hospital contained in this Official Statement. See "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019" in this Official Statement.

UNAUDITED INTERIM FINANCIAL INFORMATION

APPENDIX C to this Official Statement contains the unaudited interim balance sheets and income statements of the Hospital as of and for the three-month periods ending September 30, 2020 and September 30, 2019. The unaudited interim financial statements contained in APPENDIX C have not been reviewed, audited, or examined by the Auditor or any independent accounting firm. Operating results for the three-month period ended September 30, 2020 are not necessarily indicative of the results that may be expected for the entire fiscal year of the Hospital ending June 30, 2021. See "APPENDIX C – UNAUDITED INTERIM FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE THREE-MONTH PERIODS ENDED SEPTEMBER 30, 2020 AND 2019" in this Official Statement.

BOND RATING

S&P Global Ratings (the "Rating Agency"), has assigned its municipal bond rating of "A" (positive outlook) to the Series 2021 Bonds. The rating reflects the Rating Agency's current assessment of the creditworthiness of the Hospital and its ability to pay claims. Any explanation of the significance of such rating may only be obtained from the Rating Agency. The Hospital furnished certain information and material concerning the Series 2021 Bonds and the Hospital to the Rating Agency not contained herein. No application has been made to any other rating agency in order to obtain additional ratings on the Series 2021 Bonds. Generally, rating agencies base their ratings on such information and materials and on investigations, studies and assumptions made by the rating agencies themselves. There is no assurance that the credit rating mentioned above will remain in effect for any given period of time or that the rating might not be lowered or withdrawn entirely by the Rating Agency, if, in the judgment of the Rating Agency, circumstances so warrant. The Underwriter has undertaken no responsibility either to bring to the attention of the Holders of the Series 2021 Bonds any proposed change in or withdrawal of any rating or to oppose any such proposed revision or withdrawal. Any such downward change in or withdrawal of any rating might have an adverse effect on the market price or marketability of the Series 2021 Bonds.

FINANCIAL ADVISOR

The Hospital Board has retained Ponder & Co. as financial advisor in connection with the issuance of the Series 2021 Bonds. Although Ponder & Co. has assisted in the preparation of this Official Statement, Ponder & Co. is not obligated to undertake, and has not undertaken to make, an independent verification or to assume responsibility for the accuracy, completeness or fairness of the information contained in this Official Statement.

RELATIONSHIPS AMONG THE PARTIES

In connection with the issuance of the Series 2021 Bonds, the Underwriter is being represented by Ballard Spahr LLP and Freudenthal & Bonds, P.C., is acting as Bond Counsel to the County and the Hospital Board. In other transactions not related to the Series 2021 Bonds, each of these attorneys or law firms may have acted as Bond Counsel or represented the County, the Hospital Board, the Underwriter, the Trustee, or their affiliates, in capacities different from those described under "LEGAL MATTERS", and there will be no limitations imposed as a result of the issuance of the Series 2021 Bonds on the ability of any of these law firms or attorneys to act as Bond Counsel or represent any of these parties in any future transactions. Potential purchasers of the Series 2021 Bonds should assume that the County, the Hospital Board, the Trustee, and the Underwriter or their respective counsel or Bond Counsel have previously engaged in or will, after issuance of the Series 2021 Bonds, engage in, other transactions with

each other or with any affiliates of any of them, and no assurances can be given that there are or will be no past or future relationship or transactions between or among any of these parties or these attorneys or law firms.

MISCELLANEOUS

The foregoing and subsequent summaries or descriptions of provisions of the Series 2021 Bonds, the Indenture, the Continuing Disclosure Agreement, and the Bond Purchase Agreement and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof. Reference is made to said documents for full and complete statements of the provisions of such documents. The appendices attached hereto are a part of this Official Statement. Copies, in reasonable quantity, of the Indenture, the Continuing Disclosure Agreement, and the Bond Purchase Agreement may be obtained during the offering period upon request to the Underwriter and thereafter upon request to the principal corporate trust office of the Trustee.

Official Statement Certification

The preparation and issuance of this Official Statement and its distribution has been approved and authorized by the County and the Hospital Board. This Official Statement is not to be construed as an agreement or contract between the County and the Hospital Board and any purchaser, owner or holder of any Series 2021 Bond.

APPENDIX A
INFORMATION CONCERNING
CHEYENNE REGIONAL MEDICAL CENTER

APPENDIX A

INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER

[To be attached]

APPENDIX B

AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019

APPENDIX C

UNAUDITED INTERIM FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE THREE-MONTH PERIODS ENDED SEPTEMBER 30, 2020 AND 2019

APPENDIX D

FORM OF CONTINUING DISCLOSURE AGREEMENT

APPENDIX D

FORM OF CONTINUING DISCLOSURE AGREEMENT

[To be attached]

APPENDIX E

SUMMARY OF PRINCIPAL DOCUMENTS

APPENDIX E

SUMMARY OF THE PRINCIPAL DOCUMENTS

[To be provided by Bond Counsel]

APPENDIX F

FORM OF OPINION OF BOND COUNSEL

APPENDIX F

FORM OF OPINION OF BOND COUNSEL

[To be provided by Bond Counsel]

APPENDIX G

BOOK-ENTRY ONLY SYSTEM

APPENDIX G

BOOK-ENTRY ONLY SYSTEM

The information in this APPENDIX G concerning DTC (as defined below), Cede & Co. and the Book Entry System has been furnished by DTC for use in disclosure documents such as this Official Statement. The County and the Underwriter believe such information to be reliable, but neither the County nor the Underwriter takes any responsibility for the accuracy or completeness thereof.

The Depository Trust Company ("DTC"), New York, NY, will act as securities depository for the Securities. The Securities will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Security certificate will be issued for each maturity of the Securities, each in the aggregate principal amount of such maturity, and will be deposited with DTC.

DTC, the world's largest securities depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.7 million issues of U.S. and non-U.S. equity, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating: AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com and www.dtc.org.

Purchases of the Securities under the DTC system must be made by or through Direct Participants which will receive a credit for the Securities on DTC's records. The ownership interest of each actual purchaser of each Security ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Securities are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Securities, except in the event that use of the book-entry system for the Securities is discontinued.

To facilitate subsequent transfers, all Securities deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Securities with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bond; DTC's records reflect only the identity of the Direct Participants to whose accounts such Securities are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by

arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of Securities may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Securities, such as redemptions, tenders, defaults, and proposed amendments to the Security documents. For example, Beneficial Owners of the Securities may wish to ascertain that the nominee holding the Security for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of the notices be provided directly to them.

Redemption notices are required to be sent to DTC. If less than all of the Securities within an issue are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor such other DTC nominee) will consent or vote with respect to Securities unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Authority as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts Securities are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the Securities will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts, upon DTC's receipt of funds and corresponding detail information from the County or Trustee on the payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, or County, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the County or Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

A Beneficial Owner will give notice to elect to have its Security purchased or tendered, through its Participant, to Trustee, and will effect delivery of such Security by causing the Direct Participant to transfer the Participant's interest in the Series 2021 Bonds, on DTC's records, to Trustee. The requirement for physical delivery of Securities in connection with an optional tender or a mandatory purchase will be deemed satisfied when the ownership rights in the Securities are transferred by Direct Participants on DTC's records and followed by a book-entry credit of tendered Securities to Trustee's DTC account.

DTC may discontinue providing its services as depository with respect to the Securities at any time by giving reasonable notice to County or the Trustee. Under such circumstances, in the event that a successor depository is not obtained, Security certificates are required to be printed and delivered. The County may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, Security certificates will be printed and delivered to DTC.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the County believes to be reliable, but the County takes no responsibility for the accuracy thereof.

THE INFORMATION ABOVE DISCUSSING THE BOOK-ENTRY SYSTEM HAS BEEN FURNISHED BY DTC. NO REPRESENTATION IS MADE BY THE COUNTY, THE HOSPITAL BOARD OR THE UNDERWRITER AS TO THE COMPLETENESS OR ACCURACY OF SUCH INFORMATION OR AS TO THE ABSENCE OF MATERIAL ADVERSE CHANGES IN SUCH INFORMATION SUBSEQUENT TO THE DATE HEREOF. NO ATTEMPT HAS BEEN MADE BY THE COUNTY, THE HOSPITAL BOARD OR THE UNDERWRITER TO DETERMINE WHETHER DTC IS OR WILL BE FINANCIALLY OR OTHERWISE CAPABLE OF FULFILLING ITS OBLIGATIONS. THE COUNTY HAS NO RESPONSIBILITY OR OBLIGATION TO DTC PARTICIPANTS, INDIRECT PARTICIPANTS OR BENEFICIAL OWNERS, OR THE

PERSONS FOR WHICH THEY ACT AS NOMINEES WITH RESPECT TO THE BOND, OR FOR ANY PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST PAYMENT THEREON.

Sixth Draft
December 22, 2020

APPENDIX A
INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER

TABLE OF CONTENTS

APPENDIX A

INFORMATION CONCERNING CHEYENNE REGIONAL MEDICAL CENTER

INTRODUCTION

Cheyenne Regional Medical Center

Memorial Hospital of Laramie County d/b/a Cheyenne Regional Medical Center ("CRMC" or the "Hospital") is an acute care hospital located in Cheyenne, Wyoming. CRMC is a component unit of Laramie County, Wyoming (the "County"). CRMC is licensed for 206 beds, including 120 medical and surgical, 15 intensive care, 16 pediatric medical and surgical, 19 obstetric, 20 physical rehabilitation, and 16 psychiatric care. Due to COVID-19, CRMC has been granted temporary licensure for 248 beds to include 16 same day surgery, 16 additional surge beds, and 10 additional ICU beds. This temporary license is effective December 4, 2020 through March 4, 2021 and which authority may be extended in the future if required as a result of COVID-19. Designated as a sole community provider by the Centers for Medicare and Medicaid Services ("CMS"), CRMC provides comprehensive healthcare services to patients who are generally residents of the greater Laramie County, Wyoming area.

History

The roots of CRMC date back to 1867 when the Union Pacific Railroad constructed a "tent hospital" to treat workers injured while building the transcontinental railroad. One year later, the founding fathers of Cheyenne purchased the tent and established what is known today as CRMC. Since those early days, CRMC has continuously evolved and adapted to reflect the development, growth and changing medical service needs of the greater Cheyenne area and its population.

Contemporary history of CRMC essentially started in 1992 when CRMC purchased the assets of DePaul Hospital ("DePaul"). DePaul was owned and operated by the Sisters of Charity of Leavenworth and first opened its doors to serve patients in 1952. With the purchase of DePaul, CRMC became the owner and operator of both facilities. The purchased DePaul facility is known as the "East Building" and is now used for certain inpatient and outpatient services including behavioral health services, acute rehabilitation services, cardiac pulmonary rehabilitation, home health care services, financial services, i.e. patient billing and transcription, and certain other support services. CRMC's existing facility is known as the "West Building" and is used for Hospital operations. The two facilities sit approximately 1.5 miles apart and services provided within each have since been realigned to promote operating efficiency and optimize community access. Coinciding with the purchase of DePaul, the facilities operated under the d/b/a United Medical Center name. In 2006, the d/b/a name was changed to Cheyenne Regional Medical Center reflective of Cheyenne's evolving health care market and CRMC's role in providing expanded health care services.

CRMC remains a county-affiliated and community-center hospital with the mission "We inspire great health! Putting service before self, our family cares for your family with compassion, experience and innovation. We inspire great health!" CRMC serves as a regional referral center and is accredited by a private nonprofit corporation that accredits health care programs and providers in the United States (the "Joint Commission" or "TJC"). CRMC is a TJC accredited hospital with special TJC accreditations as a Chest Pain Center with PCI and a Primary Stroke Center. CRMC is one of America's 250 Best Hospitals™ designated by Healthgrades. CRMC is a CMS 5-Star rated hospital and an ANCC Magnet hospital, the only one in the State of Wyoming (the "State") to hold either designation.

OWNERSHIP AND GOVERNANCE

The County owns the Hospital facilities and the Board of County Commissioners (the "County Commissioners") appoints the governing board of CRMC (the "Hospital Board"), pursuant to the provisions of Wyo. Stat. §18-8-102. The Hospital Board is composed of nine members who serve staggered five-year terms as provided by Wyo. Stat. §18-8-104. Hospital Board members serve until June 30th of the year their term expires; their

successors having been appointed at the annual June meeting of the County Commissioners. Officers of the Hospital Board consist of a president, vice president and secretary/treasurer.

The Hospital Board constitutes a body corporate with perpetual existence with the power to sue and be sued. As required by statute, the Hospital Board has requested that the County issue its Hospital Revenue Refunding Bonds (Cheyenne Regional Medical Center Project), Series 2021 (the "Series 2021 Bonds") in order to: (i) current refund the outstanding County's Hospital Revenue Bonds (Cheyenne Regional Medical Center Project), Series 2012 (the "Series 2012 Bonds"), and (ii) pay costs of issuance for the Series 2021 Bonds. Proceeds of the Series 2012 Bonds, along with other funds of the Hospital, were originally used by the Hospital to: (i) fund a capital project for the Hospital, which included (a) the expansion and construction of emergency services facilities, (b) the construction of a freestanding cancer center building, (c) the construction of a two-story parking structure adjacent to the Hospital, (d) the financing of an information technology and software system of integrated medical records, (e) the purchase of equipment to support the expansion and the Hospital Board's facilities, and (f) the reimbursement of certain prior capital expenditures at the Hospital; and (ii) pay the costs of issuance of the Series 2012 Bonds. Although the Hospital has various affiliated entities, under the Amended and Restated Indenture of Trust, dated as of February 1, 2021, as amended by a First Supplemental Indenture of Trust, dated as of February 1, 2021 (collectively, the "Indenture"), between the County and Wells Fargo Bank, National Association, as trustee (the "Trustee"), only the Net Pledged Revenues (as defined in the Indenture) of the Hospital are pledged by the County to the repayment of the Series 2021 Bonds. See "AFFILIATED ENTITIES – Entity Organizational Chart" in this APPENDIX A.

Cheyenne Regional Medical Center Board of Trustees

Name	Business or Profession	Term Start	Term End
Jean Halpern, M.D., President	Retired Physician	2008	2022
Mel Muldrow, Vice President	Administrator Construction Management State of Wyoming	2017	2021
Mark Parsons, Secretary/Treasurer	Community Bank President/Banker	2018	2023
Robin Cooley	Attorney & Director of Workforce Services State of Wyoming	2017	2022
Rick Fortney	Deputy Director of ETS (Enterprise Technology Services) State of Wyoming	2019	2025
Denise Green	Retired Nurse	2018	2022
Jonath Jackson	Accountant/CPA	2015	2025
Kenneth Kranz, MD	Physician	2016	2024
Pete Obermueller	President, Petroleum Association of Wyoming	2019	2024

Certain Relationships of Hospital Board Members

CRMC does business and engages in transactions with firms and companies with which members of the Hospital Board are affiliated. Annually, conflict of interest statements are completed by each board member and reviewed by the Hospital Board. Pursuant to the existing policy, which is applicable to CRMC and its subsidiaries/affiliates, transactions with any entity with which a member of the applicable board is affiliated are permitted only after full disclosure of the potential conflict of interest to such board. Interested board members are required to excuse themselves from any deliberation and to refrain from voting on the proposed transaction. CRMC's management is of the opinion that these relationships do not represent material conflicts of interest.

Committees of the Hospital Board

The Hospital Board's strategic oversight and stewardship activities are further augmented by the following committees. Members of the committees include designated board members and senior management.

- Board Quality & Patient Safety Committee
- Board Finance and Audit Committee
- Board Strategic Planning Committee

- Board Community Health & Benefit and Community Partnerships Committee
- Board Nominating Committee
- Board Governance/Compliance Committee
- Board CEO Performance Review/Executive Compensation Committee
- Board CEO Search Committee
- Medical Staff Executive Committee

Strategic Review of Hospital Operations

CRMC regularly conducts strategic reviews of its operations, including but not limited to whether it is appropriate to consider investments, joint ventures, affiliations, divestures, or the acquisition of other healthcare related entities. In addition, CRMC has also received offers and will likely receive offers in the future from healthcare-related entities with respect to investments, joint ventures, affiliation, divestures, or acquisitions. In February 2018, CRMC entered into a Management Services Agreement with the University of Colorado Health ("UCHealth"). See "AFFILIATED ENTITIES – Affiliations" in this APPENDIX A.

The County considers the Hospital a vital community asset and at this time affirmed its belief that the Hospital should continue to be owned and operated by the County as a county memorial hospital under public ownership. The County and Hospital will continue to evaluate strategic options, partnerships and ventures in the future.

Senior Management

Timothy Thornell, FACHE President and Chief Executive Officer. Mr. Thornell is the President and CEO of Cheyenne Regional Health System in Wyoming. Mr. Thornell joined Cheyenne Regional in April 2019. The system is comprised of Cheyenne Regional Medical Center (CRMC), 206 licensed acute care beds across two campuses, the free-standing Davis Hospice Center, Cheyenne Regional Cancer Center, Wyoming Institute of Population Health, and Cheyenne Regional Medical Group, the state's largest medical group. Prior to his role at Cheyenne Regional, Mr. Thornell served as Chief Executive Officer of Lea Regional Medical Center in Hobbs, New Mexico for nearly eight years. Mr. Thornell also previously held Chief Operating Officer positions at MountainView Regional Medical Center in Las Cruces, New Mexico and Yakima Regional Medical Center in Yakima, Washington. In addition, Mr. Thornell has ten years of experience in physician practice management with Ventura County Medical Center and Health Management Associates. Mr. Thornell is a Fellow of the American College of Healthcare Executives and a Diplomat of the American College of Medical Practice Executives. Mr. Thornell holds undergraduate degrees in Physiology and French from University of California, Davis and a Master's in Health Administration from University of Southern California. Mr. Thornell is currently pursuing his doctorate degree in Public Health at Johns Hopkins University.

Neil Bertrand, CPA, Vice President & Chief Financial Officer. Mr. Bertrand began his healthcare career in 1974. His first five years he was an auditor with Coopers & Lybrand at Lutheran Medical Center in Wheat Ridge, Colorado. The next 20 years, he was employed as a controller, VP/Controller, VP Finance, CFO and CFO/Treasurer at Lutheran Medical Center (a Top 100 hospital 3 years while there as CFO). He worked for Exempla for one year as the SVP of Finance. He worked for 4 years at New West Physicians (a primary care physician owned corporation with 54 physicians) as CFO in Lakewood, Colorado. He worked for 15 years at Longmont United Hospital as CFO before coming to CRMC in 2016. Mr. Bertrand has served on numerous boards including Mountain States Risk Retention Reciprocal General and Malpractice Liability Company as a founding member and Board member/Treasurer for many years, Hospital Cooperative Laundry Finance Committee and Board and served as Board Chair, Live Well Colorado Board Corporate Treasurer for the 10 years on the Board, Antero Health Plan HMO as a Board member, Ed and Ruth Lehman YMCA in Longmont Colorado for 10 years as Treasurer and Board Chair for 2 years, Live Well Longmont as a Board member, HFMA Colorado Board member, President of Lutheran Medical Office Building Corporation, and Board member of LMCJV a joint contracting business with Lutheran and its organized medical staff. Mr. Bertrand's entire career has been related to healthcare and has been in very successful organizations. He has a wealth of experience and expertise which added great value to the integration discussions based on his merger and acquisition experience while at Lutheran, Exempla and Longmont. Mr. Bertrand brings to CRMC more than four decades of quality experience and a great track record of performance.

Mr. Bertrand earned a Bachelor of Science Business Administration with an emphasis in Accounting from Colorado State University.

Jeffrey Chapman, MD, Vice President & Chief Medical Officer. Dr. Chapman joined CRMC in 2015. Prior to joining CRMC, Dr. Chapman started his clinical experience in research and emergency medicine and then moved into general surgery and plastic surgery and was in private practice in North Dakota and Colorado for over twenty years. Dr. Chapman became a Board-certified plastic surgeon with a specialty certification in hand surgery. Dr. Chapman has held various physician led positions all through his tenure; including Vice Chair and Chairman of Surgery, Chairman of the Medical Staff Quality Committee, the Surgery Physician Champion for the Epic Implementation (an electronic medical record program), Vice Chief of Staff and Chief of Staff. Dr. Chapman earned a Bachelor of Science and Doctor of Medicine from the University of North Dakota and completed a Master's in Medical Management at the University of Southern California in 2015. Dr. Chapman completed residencies in emergency medicine and general surgery at Wright State University, plastic surgery residency at the University of Wisconsin and a hand surgery and microvascular surgery at the University of Minnesota.

Tracy Garcia, Vice President of Clinical Care Services & Chief Nursing Officer. Ms. Garcia has been with CRMC since 1989. Ms. Garcia began her career at CRMC as a Licensed Practical Nurse (LPN) and then became a Registered Nurse. Throughout her tenure at CRMC, Ms. Garcia has held various nursing positions, including as a staff nurse, a charge nurse, a special projects nurse, an educator, a manager, a director and now as the Chief Nursing Officer. As the Chief Nursing Officer, Ms. Garcia is responsible for all nursing practice within the organization. Ms. Garcia received her Master of Science, Nursing-Leadership in Health Care Systems from Regis University. In 2018, Ms. Garcia was honored to receive the Wyoming Woman of Influence award in Healthcare. Ms. Garcia has served on the Laramie County Community College Nursing Advisory Committee since 2016 and was a Board member for the Cheyenne/Laramie County Emergency Medical Services Joint Power Board and a Laramie County Community College Paramedic Program Board member from 2009-2016. Ms. Garcia is a member of the American College of HealthCare Executives, American Organization of Nurse Executives and the Emergency Nurses Association.

Robin Roling, Vice President & Chief Operating Officer. Ms. Roling has served as Chief Operating Officer at CRMC since June 2016. Ms. Roling has over 30 years of healthcare experience having served in the U.S. Army and various hospitals in the western region of the United States. Ms. Roling is a Fellow in the American College of Healthcare Executives, graduate of Leadership Cheyenne, and serves on various boards including serving as Treasurer for Cheyenne LEADS (economic development). Ms. Roling earned a Bachelor of Science in Nursing from the University of Wyoming and completed her Master of Science degree in Healthcare Informatics from the University of Colorado Health Sciences Center.

Kerry Slater, President Cheyenne Regional Medical Group. Ms. Slater joined Cheyenne Regional Medical Group ("CRMG") in June 2017 as the President of CRMG. Prior to joining CRMG, Ms. Slater was the Director of Volunteer Services at Presbyterian Healthcare Services in Albuquerque, NM and then became Director of Practice Operations. As Director of Practice Operations, Ms. Slater oversaw the clinic operations for multiple clinic sites and gained experience in primary care, urgent care, pediatric specialties, adult medical specialties and pain management. Ms. Slater relocated to Colorado and became Executive Director for Banner Medical Group in Northern Colorado and was accountable for the oversight of over 150 providers spread over fourteen specialty areas including cardiology, oncology, orthopedics, general surgery, neurosciences, gastroenterology, anesthesia, endocrinology, pulmonary/critical care, cardiac surgery and infectious disease. In addition to her clinic operations experience, Ms. Slater has also participated in quality and process improvement initiatives achieving Juran Institute Lean Six Sigma Green Belt certification. Ms. Slater earned a Master of Business Administration from the University of New Mexico.

Joanna Vilos, JD, Vice President & Chief Legal & Human Resources Officer. Ms. Vilos joined CRMC in 2017. Prior to joining CRMC, Ms. Vilos was a partner with the law firm of Holland & Hart LLP, where she focused primarily on employment law and handled a wide variety of matters for clients in industries including healthcare and energy. From 2010-2016, Ms. Vilos was selected as a Tier One labor and employment attorney by *Chambers USA: America's Leading Lawyers for Business*. She was also featured in the August 2016 issue of *Working Mother Magazine* for her success as a working mother in the legal profession. Ms. Vilos' role at CRMC is to advise the hospital and board of trustees on all aspects of legal and regulatory compliance. Ms. Vilos received her

Bachelor of Arts degree in Sociology and Government from the University of Maryland and her Juris Doctorate from Harvard Law School.

Licensed Beds in Service

CRMC has a licensed bed complement of 206 beds inclusive of 170 acute care beds, 20 rehabilitation beds, and 16 behavioral health beds. As of June 30, 2020, all licensed beds were available for service with a year-to-date occupancy rate of 50%. As of September 30, 2020, the year to date occupancy rate was 48.3%. Due to COVID-19, CRMC has been granted temporary licensure for 248 beds to include 16 same day surgery, 16 additional surge beds, and 10 additional ICU beds. This temporary license is effective December 4, 2020 through March 4, 2021 and which authority may be extended in the future if required as a result of COVID-19.

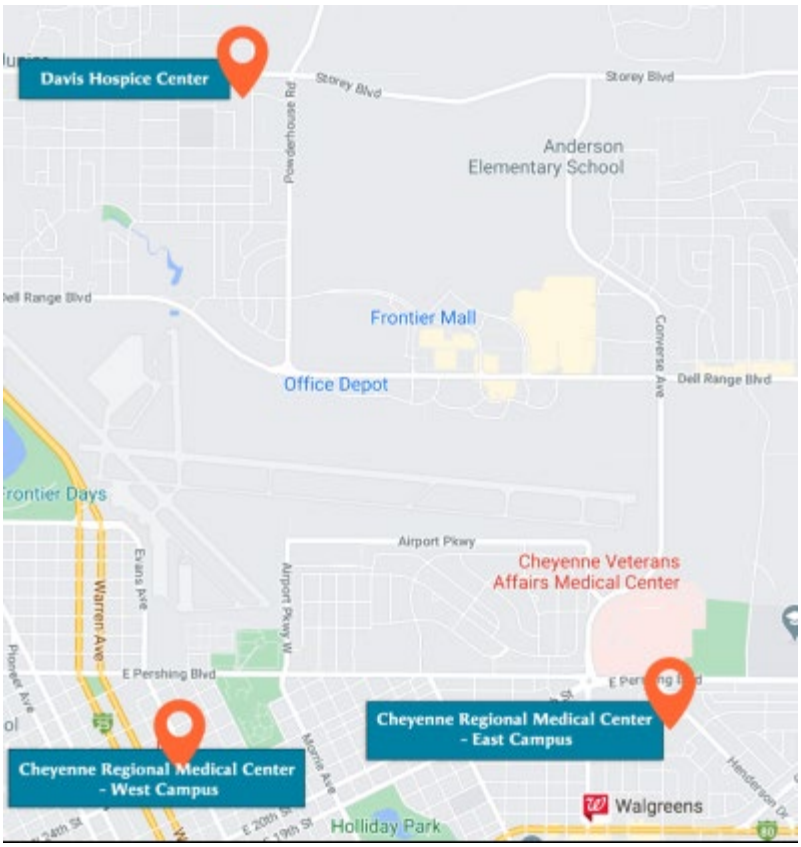
HOSPITAL FACILITIES AND SERVICES

CRMC is one of Wyoming's largest healthcare systems. Serving as a regional referral center, it serves the healthcare needs of patients from southeast Wyoming, northern Colorado, western Nebraska and communities from throughout Wyoming.

CRMC's facilities are currently divided into three primary components:

- Main campus consists of the West and East Buildings
- West Building
  - Acute care inpatient services including cardiology, neurosurgery, obstetrics, orthopedics, physical therapy and pediatrics
  - Outpatient services including emergency, cardiac, medical imaging, oncology, outpatient surgery, trauma, wound care and hyperbaric
- East Building
  - Inpatient acute rehabilitation services and behavioral health
  - Outpatient behavioral health services and cardiopulmonary rehabilitation
- Davis Hospice Center
  - Inpatient and outpatient hospice services
  - Located 3.6 miles from the main campus

Below is a map reflecting the locations of each of the CRMC's facilities:


Davis Hospice Center
Storey Blvd
Storey Blvd
Powderhouse Rd
Anderson
Elementary School
Frontier Mall
Converse Ave
Office Depot
Dell Range Blvd
Airport Pkwy
Cheyenne Veterans
Affairs Medical Center
Evans Ave
Warren Ave
Airport Pkwy W
E Pershing Blvd
Cheyenne Regional Medical Center
- East Campus
Cheyenne Regional Medical Center
- West Campus
Morrie Ave
Walgreens
Holliday Park

Source: CRMC.

The table below provides a list of the specialties and practice areas offered at CRMC:

- 24-hour Nurse Triage
- Acute Rehabilitation
- Allergy/Immunology
- Ambulance Services
- Anesthesiology/Pain Medicine
- Behavioral Health Services:
  - Adolescent Psychiatry
  - Adult Psychiatry
- Blood Bank
- Cheyenne Regional Cancer Center
  - Medical Oncology
  - Radiation Oncology
  - Ambulatory Infusion
  - Cancer Rehabilitation
  - Clinical Trials
  - Genetic Counseling
  - Navigation Services
  - Lymphedema Therapy
- Cheyenne Regional Heart & Vascular Institute:
  - Coronary Angiography
  - Stenting
  - Congestive Heart Failure Treatment
  - Cardiac Electrophysiology (device-based therapies and catheter ablations)
  - Cardiothoracic Surgery
  - Vascular Surgery
  - Cardiac Rehabilitation
- Critical Care
- Dentistry/Oral Surgery
- Dermatology
- Diabetes Education
- Emergency Care
- Ear, Nose & Throat (ENT)
- Emergency Medicine
- Emergency Response Systems
- Family Practice
- Food and Nutrition Services Outpatient Nutrition Center
- Gastroenterology
- Home Health Care
- Hospice/Palliative Care
- Hyperbaric Oxygen Wound Care
- Infectious Disease
- Internal Medicine
- Laboratory
- Metabolic Diseases/Endocrinology
- Nephrology/Hemodialysis
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedics & Sports Medicine
  - Joint Replacements
  - Arthroscopic Surgery of the Joints
  - Fracture Management
  - Treatment of Sports and Job-related injuries
  - Physical Therapy
  - MAKO® Robotic Arm Technology for Total/Partial Knee and Total Hip replacements
- Otolaryngology
- Pain Medicine Clinic
- Pathology
- Pediatrics
- Personal Care and Support Services
- Plastic Surgery
- Podiatry
- Pulmonary Medicine
- Radiation Oncology
- Radiology:
  - Bone Densitometry
  - CT Scanning
  - General X-ray
  - Intervention Radiology
  - Magnetic Resonance Imaging
  - Mammography
  - Nuclear Medicine
  - Ultrasound
- Respiratory Therapy
- Rheumatology
- Skilled Nursing
- Sleep Lab/EEG
- Speech Therapy
- Surgery:
  - Bariatric Surgery
  - General Surgery
  - Neurosurgery & Spine
  - Otolaryngology
  - Plastic Surgery
  - Vascular Surgery
  - Da Vinci Xi® Surgical System for Minimally Invasive Surgeries
  - Invasive Surgeries
  - Mazor X™ Robotic Guidance System for Spine Surgeries
- Telehealth Outreach
- Therapies (inpatient and outpatient):
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
- Trauma Center
  - American College of Surgeons verified Level III Trauma Center
  - Designated Regional Trauma Center
- Transfer Center (24/7)
- Urology
- Wellness
- Wound Care Services
- Wyoming Institute of Population Health
- Wyoming Program of All-Inclusive Care for the Elderly (PACE)

Specialized Programs

CRMC is recognized for both its personalized approach to patient care and its expertise in providing health care to a region that includes southeastern Wyoming, western Nebraska and northern Colorado. The following services, programs and technology have contributed to CRMC's regional reputation:

The **Cheyenne Regional Heart and Vascular Institute** includes surgeons, physicians, nurses, clinical dietitians, therapists and other specialists with extensive experience using the latest tools and technologies to diagnose and treat a wide variety of cardiovascular conditions and diseases.

- **The coronary intervention team** performs a full range of interventional procedures, including heart catheterization, invasive evaluation of pulmonary hypertension, coronary angiography and coronary interventions (angioplasty and stenting, laser atherectomy, Impella® and intra-aortic balloon devices, intravascular ultrasound, fractional flow reserve and optical coherence tomography).
- **The cardiac electrophysiology team** specializes in evaluating and treating patients with a variety of cardiac arrhythmias. The team offers expertise in diagnostic studies, treatments and procedures using best practices and innovative technologies. Treatments include the use of device-based therapies and catheter ablations.
- **The vascular surgery team** uses the latest techniques and tools to diagnose and surgically treat narrowing or blockages of the peripheral arteries and defects or damage in the peripheral veins. This includes both traditional and minimally invasive techniques.
- The Cheyenne Regional Heart and Vascular Institute also offers expert treatment **of congestive heart failure and cardiac rehabilitation.**

The **Cheyenne Regional Cancer Center** offers a comprehensive and compassionate treatment, prevention and research program that delivers high-quality oncology care to patients. Services include the diagnosis, management and treatment of cancer and hematopoietic diseases, in addition to a variety of resources that support our patients and their families. The Cheyenne Regional Cancer Center's vision is to ensure that each patient achieves the highest quality of life possible, while also holding onto hope. This vision is fulfilled by caring for the mind, body and spirit of the patient and the patient's family by utilizing:

- State-of-the-art, advanced technology designed specifically for cancer treatment
- An expert team of cancer treatment providers, nurses and other specialists
- Diagnostic technologies and treatments that reduce the symptoms and side effects of cancer treatment

CRMC'S **Orthopedic and Sports Medicine program** offers treatment for sports injuries, job-related injuries, joint replacement and muscle and tendon damage. CRMC's orthopedic surgeons are board-certified by the American Board of Orthopedic Surgery. CRMC's clinical team of nurses, technologists, trainers and therapists all hold certifications and/or college degrees in their specialty areas.

CRMC's **Trauma Center** is verified by the American College of Surgeons (ACS) as a Level III Trauma Center and is also designated as a Regional Trauma Center by the State of Wyoming. As a Level III Trauma Center, staffing is available 24 hours a day within the emergency, surgery, respiratory therapy, radiology, critical care, nursing, rehabilitation, security, and pastoral care departments. ACS-verified Trauma Centers are required to offer a full spectrum of care that starts with community education and injury prevention that continues through trauma treatment and patient rehabilitation.

CRMC's **Neurosurgery Services** treats brain, peripheral nerve and spine-related injuries and diseases demanding the highest level of patient care. From diagnosing a disorder to helping a patient recover post-surgery, this program provides services dedicated to treating and improving the quality of life for patients. Conditions treated include central and peripheral nervous system disorders, spine related disorders, movement disorders, cerebral vascular disease, aneurysms, traumatic brain injury, and Parkinson's disease. Ultrasound 3-D and 4-D imagery are two of the diagnostic technologies used to scan the brain. Magnetic Resonance Imaging and ultra-fast CT scanners also help physicians detect and diagnose neurological conditions. In 2018, CRMC was the first hospital in Wyoming to add the Mazor X™ robotic surgical assistance and guidance system to its spinal surgery program. This system

combines pre-operative planning tools and analytics with intra-operative guidance, providing patients with the most advanced spinal surgery options available. In 2003, CRMC was also the first medical center in the United States to use the Stealth Treon system to remove a brain tumor. The system provides the surgeon with an exact, 3-D view of the surgical area and allows for less-invasive procedures and decreases the risk of brain and nerve damage during surgery. CRMC has continued to upgrade its technology with the addition of intraoperative CT scanning and the latest upgrade to the Stealth navigational technologies.

The **Weight Loss Center** at CRMC offers surgical weight loss options that include gastric banding, gastric sleeve resection and gastric bypass. The Weight Loss Center also offers a non-surgical medical weight loss program.

Continued Investments in Technology

CRMC continues to invest in electronic medical records (EMR) and information technology (IT) updates. Examples of recent investments in EMR and IT include the following:

- Currently on February 2020 version of Epic EMR and are preparing for August 2020 upgrade January 2021.
- Installed Epic native video visits telemedicine software. Telemedicine was well adopted during COVID-19 utilizing this technology.
- Installed Epic MyChart Bedside for CRMC patients that utilizes iPads for patients to view their care related information.
- Installed Epic Rover mobile device software on iPhones to allow nurses and physicians more flexibility in documenting on patients as well as secure text.
- Expanded Epic Community Connect presence in Wyoming. We have now extended our EMR to seven locations.
- Completed conversion to Cisco VOIP Telephony, installed new Cisco Network Infrastructure and Cisco's cyber security software suite.
- Migrated most application and database servers to virtual running VMWare on Cisco UCS servers.
- Installed Cohesity backup and recovery system for advanced ransomware protected backups.
- Oracle Human Capital Management was replaced with Kronos Full Suite in January 2020 for Human Resources and Payroll functions.

AFFILIATED ENTITIES

CRMC's subsidiaries, controlled entities and joint ventures include the following affiliated entities. *None of the affiliated entities listed below are a party to the Indenture and such entities are not obligated with respect to the Series 2021 Bonds.*

Cheyenne Regional Medical Center Foundation (the "Foundation"), was established to assist in the development, growth, and operations of CRMC. Through fundraising, the Foundation provides grants primarily to help support the purchased property, equipment, supplies, and fund research primarily for CRMC. In accordance with GASB Statement No. 39, Determining Whether Certain Organizations Are Component Units, the Foundation has been determined to be a component unit and is presented as a discretely presented component unit in CRMC's financial statements.

Cheyenne Physician Group, LLC d/b/a Cheyenne Regional Medical Group ("CRMG") was established in 2005 and formed to assist in the development of an integrated health care delivery network and operates multi-specialty physician medical practices in the greater Cheyenne, Wyoming area. CRMG is a 100-percent-owned subsidiary of CRMC and is an approved disregarded entity for tax purposes. CRMG is the largest physician/provider group in the State with 75+ providers. CRMG has a governance and operational structure that is provider driven. Consisting of 17 specialties and a full-time executive staff, CRMG is integrated with Cheyenne Regional's service lines, including cardiology/vascular/cardiothoracic surgery, hematology-oncology, orthopedics, neurology,

pulmonology, endocrinology/diabetes, nephrology, rheumatology, infectious disease, neurosurgery, pain management, internal medicine and primary care.

Cheyenne Surgical Center, LLC d/b/a High Plains Surgery Center was established to operate a surgery center as a joint venture with independent physicians. The surgery center is 25% owned by CRMC.

Cheyenne Women's Imaging Pavilion, LLC ("CWIP, LLC") was established to provide women's imaging services as a joint venture between Cheyenne Radiology Group and CRMC. CWIP is 16% owned by CRMC.

S. Spindle, LLC d/b/a Wyoming Sleep Disorders Center was established to provide outpatient sleep studies. The Sleep Center is 25% owned by CRMC.

Cheyenne Regional Health Services Corporation ("CRHSC") is a Wyoming for-profit corporation that was established to facilitate CRMC's development, operation and maintenance of a medical office building and for the delivery of health services generally. CRHSC is 100% owned by CRMC and its bylaws require that CRMC's tax exempt policies and practices be followed in all activities.

Gold's Gym at Cheyenne Regional, LLC was established to operate a health and fitness center in Cheyenne, Wyoming as a joint venture with CRHSC. The Gym is 19% owned by CRHSC. An area of the gym is used exclusively by Cheyenne Regional's Cardiac Rehabilitation and Medical Fitness programs.

Affiliations

UCHealth Management Services Agreement. In February 2018, CRMC entered into a Management Services Agreement with UCHealth (the "UCHealth MSA"). The UCHealth MSA has an initial term of three years with an automatic extension for one successive three-year renewal term. One of the purposes of the UCHealth MSA is to bring resources and access to services that would otherwise not typically be available to the Hospital's primary service area, strengthening the already solid business position. The UCHealth MSA provides CRMC access to and the benefits of the UCHealth System's management expertise as well as economies of scale, medical staff collaboration and recruitment, quality assurance efforts, and strategic planning capabilities all of which serve to strengthen CRMC's overall economic profile. Some of the early tangible benefits for CRMC of the UCHealth MSA have included expense savings through group purchasing and other supply cost reductions. In addition, CRMC recently announced that beginning January 2021, UCHealth will be providing air ambulance services to CRMC. Savings of this change in air ambulance provider for CRMC are estimated at $500,000 annually.

Under the terms of the UCHealth MSA, UCHealth employs the CEO of CRMC and provides a variety of management services through recommendations of efficiencies, strategic planning, key performance metrics and other initiatives in the primary, secondary, and tertiary service areas. In addition, CRMC can engage specific consultative services for a negotiated fee as needed. Other than the CEO compensation and consulting fees, no payments are necessary between UCHealth and CRMC. The CEO, who joined CRMC last year, is an employee of UCHealth but is accountable to CRMC's board of directors and the local community.

The UCHealth MSA included an initial 120-day assessment performed by UCHealth of several key operational areas, resulting in some new strategic initiatives focused on the cost and management of the physician group, quality metrics and better engagement with medical staff and patients. The UCHealth MSA is cancelable by either party during the renewal term without cause with 180 days' written notice. The UCHealth MSA allows UCHealth to extend and solidify its footprint in southern Wyoming which is a key tertiary service area for the system, along with Colorado and western Nebraska.

HCA-HealthONE. In the fall of 2011, CRMC expanded its emergency care across the region with the addition of an AIRLIFE Denver medical helicopter service in Cheyenne. The service is a partnership between CRMC and HCA-HealthONE, which operates AIRLIFE Denver. In addition, CRMC partners with HealthONE for telestroke services. The partnership with HealthONE Telestroke includes exclusivity throughout CRMC's extended service areas. This partnership includes bringing the latest telemedicine technology and services to CRMC's emergency department to allow for the remote examination of stroke patients by physicians at HealthONE stroke facilities.

Laramie County Community Partnership. CRMC is a founding member of the Laramie County Community Partnership. This 65-member collaborative is dedicated to optimizing community resources in support of improved social and environmental well-being for Laramie County residents.

Healthier Laramie County. CRMC is a member of this collaborative county effort to make preventable healthcare services more accessible and affordable. Those efforts include expanding emergency prescription services, strengthening vaccination delivery, establishing a county-wide cancer coalition and increasing tobacco cessation assistance throughout the State.

University of Wyoming Family Practice Residency Program. CRMC partners with the University of Wyoming to educate and place physicians in Wyoming. This training program provides residents the skills necessary to practice in rural and frontier areas.

Children's Hospital of Colorado. CRMC collaborates with Children's Hospital Colorado ("Colorado Children's") in certain programs and activities to provide pediatric patients with access to the highest quality, most cost-effective pediatric care. This collaboration is governed by a steering committee of officials of CRMC and Colorado Children's. The term of this collaboration between CRMC and Colorado Children's currently expires on May 21, 2021 but may be renewed. [PROVIDE A SENTENCE ON CRMC INTENDS TO EXTEND?]

Community Programs and Affiliations

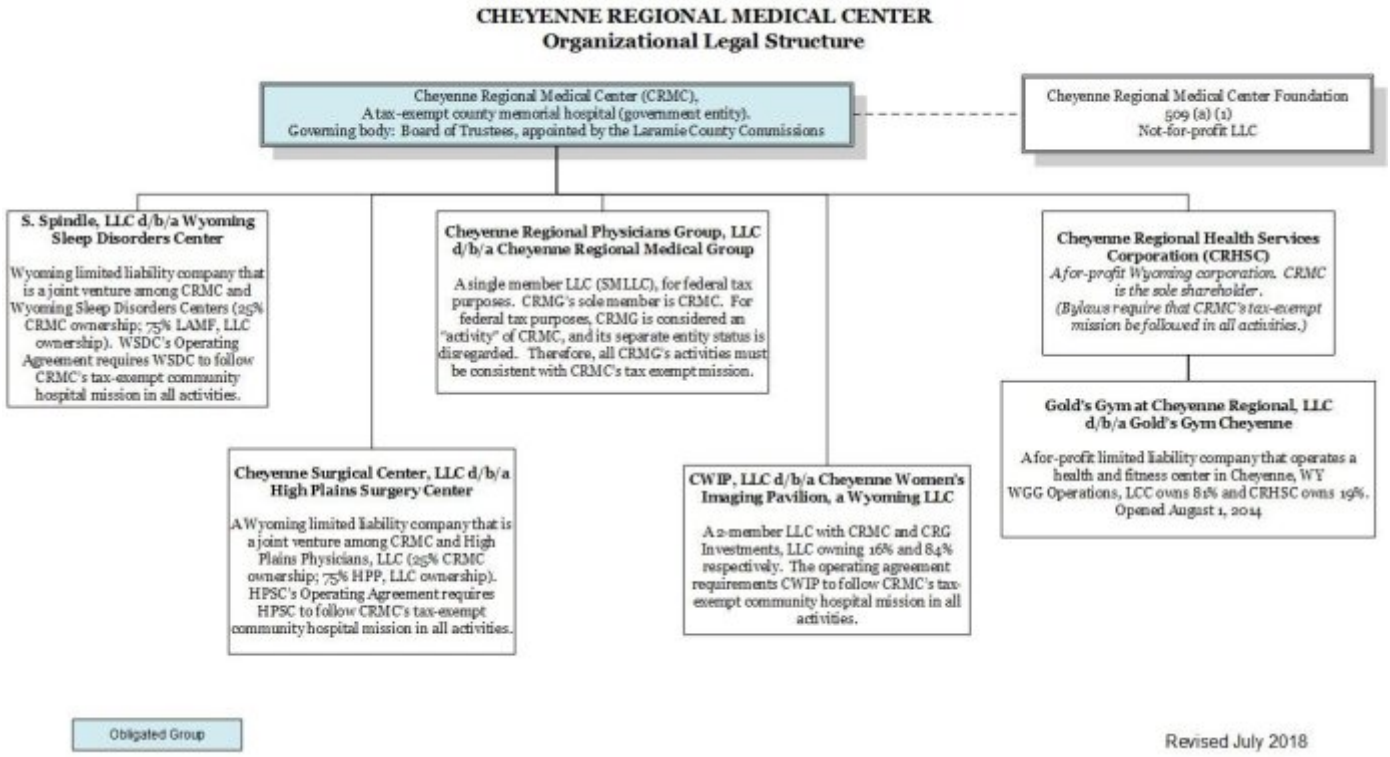
- HealthWorks (federally qualified health center)
- Children's Hospital Colorado and the University of Colorado School of Medicine – Care Alliance formed to enhance local infant and pediatric care
- American Joint Replacement Registry
- Vizient
- Premier Partnership for Care Transformation Project (PACT)
- University of Wyoming – College of Health Sciences
- United Way of Laramie County
- WWAMI Chronic Care Clerkship Site
- WWAMI Psychiatry Care Clerkship Site
- WWAMI Doctor of Psychiatric Nurse Practitioner Internship Site
- CMS and Joint Commission's Zero Suicide in Healthcare Program: Cheyenne Regional Medical Center Behavioral Health Services and Peak Wellness Community Mental Health Center sponsored by Wyoming Department of Health to be the Wyoming model partnership agencies for the Wyoming adoption of this program
- Partnership with Peak Wellness to support Laramie County law enforcement-to provide officers with 40 hours of Behavioral Health Crisis Intervention Training biannually
- Partnership for Youth Success (PaYS) program – partnership with the U.S. Army that offers priority hiring status to soldiers participating in the PaYS program
- Wyoming Department of Health, Office of Rural Health and Wyoming Hospital Association – partnership with Wyoming Institute of Population Health to meet Patient Protection and Affordable Care Act (PPACA) needs assessment/health planning requirements in 12 critical access hospital communities across Wyoming
- Wyoming Health Matters: www.wyominghealthmatters.org
- DAISY Award for Extraordinary Nurses – international program to recognize outstanding nurses at Cheyenne Regional; nurses are nominated by patients, peers and providers; award given to three nurses each quarter
- Women, Infants, and Children (WIC) – March of Dimes partnership; WIC is also a joint venture between Cheyenne Regional and the Wyoming Department of Health
- Partnership with Laramie County Community College to provide sports medicine coverage for the college's student athletes, including training and education on concussions and nutrition.
- Partnership with Laramie County School District #1 high schools to provide them with certified athletic trainers

Educational Programs

CRMC has a new graduate Nurse Residency Program. It is designed to effectively support new graduate nurses as they transition into their first professional roles as caregivers in the acute care hospital setting.

Entity Organizational Chart

The diagram below reflects the organization structure of CRMC and its affiliated entities:



Source: CRMC.

ACCREDITATIONS

CRMC is licensed by the Wyoming Department of Health and has received the following accreditations:

- CRMC is accredited by the Joint Commission with most recent survey occurring and completed during July 2017 and was awarded a three-year accreditation (re-certification survey is pending).
- Primary Stroke Center (March 2019; the Joint Commission and American Heart Association/American Stroke Association; two-year accreditation)
- American College of Surgeons Commission on Cancer
- Verified Level III Trauma Center by the American College of Surgeons (June 2018)
- Commission on Accreditation for Rehabilitation Facilities (three-year CARF Accreditation for ARU and specialty accreditation for the ARU's stroke program, June 2018)
- Chemical Dependency Program Certification
- American Association of Cardiovascular and Pulmonary Rehabilitation Certification
- Inter-societal Commission for the Accreditation of Echocardiography Labs
- College of American Pathologists (CAP)
- American Association of Blood Banks (AABB)

- Mammography Quality Standards Act and Program/Certified Mammography Facility (CWIP, LLC)
- American College of Radiology
- Nuclear Regulatory Commission
- Home Care Medicaid Waiver for Long Term Care, Comprehensive and Support Services Certification (annual)
- Wyoming PACE (Program for All-Inclusive Care for the Elderly)-certified by the Centers for Medicare & Medicaid Services (CMS) and the Wyoming Department of Health
- Medicare/Medicaid-certified Home Care
- Medicare/Medicaid-certified Hospice (Outpatient and Inpatient)
- American Society of Health-System Pharmacists (ASHP) accreditation of CRMC's postgraduate year one Pharmacy Residency Program (accredited through 2024 with a midterm program report due to 2021)

AWARDS/ACHIEVEMENTS

Grant Awards to the Institute of Population Health: Fiscal Year 2021

CRMC's Institute of Population Health was awarded the following large grants, which will be utilized by CRMC to work toward improving the health and well-being of the community:

- **Marketplace Navigator Grant** – CRMC was granted $100,000 and is the only grantee for marketplace navigators in the State. CRMC's navigators travel across the state to help people enroll in health insurance during open enrollment and when they experience other qualifying events.
- **Consumer Product Safety Commission** – The Consumer Product Safety Commission randomly selected CRMC to participate in a sample of ED admissions for injuries due to products. Participation for CRMC gives CRMC up to date and local information about products that may be causing injury in the area that CRMC can use to inform CRMC's injury prevention efforts. CRMC was awarded $21,093 in Fiscal Year 2021.
- **U.S. Department of Health and Human Services, Health Resources and Services Admin Pass through from University of Wyoming** – This grant in the amount of $51,859 is in partnership with the University of Wyoming to improve the health status and health education of older adults, and the education and training of health professionals throughout Wyoming. The overall intent is to improve the health outcomes for older adults by developing a healthcare workforce that strives to achieve the Triple Aim by maximizing patient and family engagement and integrating geriatrics and primary care.
- **University of Colorado Public Health Training Center –** Rocky Mountain Public Health training center Award in the amount of $9,816.
- **Laramie County Prevention –** This two-year grant in the amount of $900,492 with the County is to help provide prevention services. ($450,246 each year).
- **Wyoming Cancer Resources Program –** This grant in the amount of $89,100 funds education around cancer prevention, cancer prevention activities, and efforts to link individuals to cancer screening.
- **Hospital Preparedness Program Cooperative Agreement (Southeastern Wyoming Healthcare Coalition) Grant** – CRMC is a subrecipient who will provide Lead Hospital and fiscal agent services to Southeastern Wyoming Healthcare Coalition ($220,000).

Grant Awards (CARES Act): Fiscal Year 2021

- **State of Wyoming State Loan and Investment Board -** CRMC Capital Projects between March 15 – December 15, 2020 for $2.2 million
- **State of Wyoming State Loan and Investment Board –** CRMC Payroll and Operating Costs between March 15 – December 15, 2020 for $3.4 million
- **State of Wyoming State Loan and Investment Board -** CRMG Capital Equipment – Point of Care Testing equipment for $101.5 thousand
- **CARES Act/Enroll Wyoming Assistance Grant -** This Grant provides additional temporary personnel to assist Enroll Wyoming, the state network working to assist Wyoming citizens in enrolling in health

insurance, during the Open Enrollment period, as well as assisting those individuals who were given a Special Enrollment Period exceptions because of COVID-19 and job loss ($600.0 thousand)
- **FCC COVID-19 Telehealth program funding –** Federal assistance for increase telehealth services ($87.3 thousand)

Awards and Achievements for Fiscal Years 2020 and 2019

2020 and 2019 Healthgrades Awards

Healthgrades, a national hospital and health system quality ratings organization:

- Presented CRMC with the America's 250 Best Hospitals Award™ for both 2019 and 2020. (The distinction places CRMC in the top 5 percent of more than 4,500 hospitals assessed nationwide for its superior clinical performance.)
- Recognized CRMC as one of America's 100 Best Hospitals for General Surgery for 2020.
- Recognized CRMC as being among the top 5% of hospitals in the nation for overall pulmonary services for 2019-2020 and for being among the top 10% in the nation for overall pulmonary services for 2017-2020.
- Recognized CRMC as being among the top 10% of hospitals in the nation for cardiology services, stroke treatment, gastrointestinal services and general surgery for 2019-2020.
- Awarded CRMC the following specialty awards:
    - Pulmonary Care Excellence Award™ for 4 Years in a Row (2017-2020)
    - Stroke Care Excellence Award™ for 2 Years in a Row (2019-2020)
    - Gastrointestinal Care Excellence Award™ for 2 Years in a Row (2019-2020)
        - General Surgery Excellence Award™ for 2 Years in a Row (2019-2020)
    - Recognized CRMC as a top five-star recipient for the following:
        - Treatment of stroke (2018-2020)
        - Coronary interventional procedures (2020)
        - Treatment of heart attack (2019-2020)
        - Treatment of heart failure (2015-2020)
        - Treatment of sepsis (2011-2020)
          Treatment of pneumonia (2012-2020)
        - Treatment of respiratory failure (2013-2020)
        - Colorectal surgeries (2017-2020)
        - Esophageal/stomach surgeries (2019-2020)
        - Treatment of pulmonary embolism (2019-2020)
        - Treatment of bowel obstruction (2020)
        - Treatment of pancreatitis (2020)
        - Hip fracture treatment (2019-2020)

Other Awards and Achievements for 2020

- **CRMC earned a top five-star overall quality rating** from the federal Centers for Medicare & Medicaid Services in January 2020. Out of 4,500 rated hospitals, only 407 received five stars during this rating period. CMS reviews more than 50 quality measures grouped into give categories to evaluate hospitals.
- **CRMC received Chest Pain Certification** from The Joint Commission, the national's oldest and largest standards-setting and accrediting organization in healthcare. Being Chest Pain Certified means that CRMC has earned The Joint Commission's Gold Seal of Approval for diagnosing and treating patients with chest pain, including heart attacks and other acute coronary syndromes. CRMC is the first and only hospital in Wyoming to receive this certification.
- **CRMC was the first hospital in Wyoming to earn the prestigious Magnet designation.** The American Nurses Credentialing Center's **Magnet Recognition Program®** is the highest national honor for professional nursing practice and distinguishes healthcare organizations that meet very rigorous standards for nursing excellence. Just 520 healthcare organizations throughout the United States have achieved Magnet recognition. The recognition was announced in April 2020.

- **CRMC was presented with the American Heart Association/American Stroke Association's 2020 Get With The Guidelines® - Heart Failure Gold Plus with Target: Type 2 Diabetes Honor Roll Achievement Award.** This award recognizes CRMC's commitment to ensuring heart failure patients receive the most appropriate treatment according to nationally recognized, research-based guidelines, with the goal of speeding recovery and reducing hospital readmissions for heart failure patients. This is the third year in a row that CRMC has received a Get With The Guidelines award for heart failure care.
- **CRMC was presented with the American Heart Association/American Stroke Association's 2020 Get With The Guidelines®- Stroke Gold Plus with Honor Roll and Target: Type 2 Diabetes Honor Roll Achievement Award .** The goal of the Get With The Guidelines stroke program is to speed recovery and reduce death and disability for stroke patients. This was the fifth year for CRMC to receive a stroke care award.
- **CRMC was presented with the American Heart Association/American Stroke Association's 2020 Get With The Guidelines®-2020 Get With The Guidelines® - Resuscitation Adult Gold Plus Achievement Award.** This award recognizes CRMC's commitment to ensuring patients receive the most appropriate resuscitation treatment according to nationally recognized, research-based guidelines, following an in-hospital or out-of-hospital event. This was the second year in a row for CRMC to receive a resuscitation award. According to the American Heart Association/American Stroke Association, the Get With The Guidelines awards are given to "an elite group of hospitals" for their "commitment to guideline adherence and quality improvement" for the heart failure and stroke patient populations and for those patients suffering cardiac arrest. The "Target" recognitions additionally highlight efforts to help heart failure and stroke patient populations with Type 2 diabetes better manage their conditions.
- **Cheyenne Regional's Marketing Department received nine national Aster marketing awards,** including five gold, three silver and a bronze, for work created in the 2019 calendar year.

Innovative Care: 2020

- **CRMC opened its all-new MRI Suite, Radiology Care Unit and Ultrasound Department, designed to enhance patient care and comfort. A new state-of-the-art Philips Ingenia Ambition 1.5T X MRI machine was also installed.** The new machine is the first and only one of its kind in Wyoming and includes a wide-bore opening, an audio-visual experience to help patients relax, feet-first entry for most scans, more detailed images and complex scans in less time.
- **CRMC opened it newly remodeled Wound Care & Hyperbaric Medicine Clinic.** The clinic was expanded and remodeled to provide for a more comfortable patient experience and to improve staff workflows.
- **CRMG began providing video visits to their patients via CRMC's health system's MyChart patient portal**. This new service is expected to be widely available to CRMG patients in the fall.
- **CRMC was recognized as an early adopter of Cosmos, an Epic platform** that analyzes data to support evidence-based patient care research and enhanced clinical workflows. CRMC is among the first Epic-based organizations to participate in Cosmos, placing CRMC in the top 10% in the Epic Community.
- **CRMC received American College of Radiology (ACR) accreditation** in Nuclear Medicine and for its PET/CT, MRI, Ultrasound and CT. CRMC was also designated by the ACR as a Designated Lung Cancer Screening Center (for its CT). ACR accreditation is recognized as the gold standard in Medical Imaging.
- **The Robert Wood Johnson Foundation announced in April that the County's overall health ranking jumped from 17th to 12th** (out of 23 Wyoming counties) in just one year. Cheyenne Regional's Institute of Population Health is digging into the data to determine which factors had the most impact on this increase, with the goal of helping the County make even more health gains in the future.
- **CRMC's Emergency Department began offering virtual visits** for patients with symptoms of COVID-19 or who needed emergency care for non-life-threatening conditions.
- **The Leona M. and Harry B. Helmsley Charitable Trust funded the purchase of eight LUCAS mechanical chest compression devices for CRMC**. This donation was part of the Trust's multimillion-dollar effort to save the lives of COVID-19 patients and protect frontline workers caring for them.
- **CRMC's Laboratory was accredited** by the College of American Pathologists on January 11, 2020, the American Association of Blood Banks on January 16, 2020, and the Joint Commission on February 12, 2020.

- **CRMC entered into a partnership with the University of Wyoming's Fay W. Whitney School of Nursing.** The partnership will create a nursing faculty position at the University of Wyoming that will focus on expanding the growth of nurses throughout Wyoming. The partnership will also emphasize making higher education available to CRMC nurses.

Grant Awards to the Institute of Population Health: 2020

CRMC's Institute of Population Health was awarded the following large grants, which will help CRMC work toward improving the health and well-being of the community:

- **Comprehensive Opioid Abuse Program (COAP) –** CRMC received the Comprehensive Opioid Abuse Program award in the amount of $200,000 to work with local law enforcement agencies to implement Law Enforcement Assisted Diversion (LEAD) as the next step to formalize effective diversion within the County. Award notification was on October 19, 2019 and the budget was approved on March 26, 2020.
- **U.S. Department of Health and Human Services, Health Resources and Services Admin Pass through from University of Wyoming -COVID** – In partnership with the University of Wyoming this grant in the amount of $41,865 is to improve the health status of older adults and assist in the development, strategy, and evaluation for all CRMC specific COVID telehealth trainings.
- **Childhood Injury Prevention** – This grant in the amount of $7,000 will provide for car seat safety activities and drowning prevention in partnership with the municipal pool.
- **Injury Prevention Opioid** – This grant in the amount of $7,000 will fund the one-time connection of Epic to the Prescription Drug Monitoring Program (PDMP). This will help prescribers comply with the new law that requires checking.

Awards and Achievements for 2019

In addition to the 2020 and 2019 Healthgrades Awards noted above, CRMC also received the following in 2019:

- **CRMC was designated as a Primary Stroke Center** by the Joint Commission and the American Heart Association/American Stroke Association. CRMC earned the Joint Commission's Gold Seal of Approval and the American Heart Association/American Stroke Association's Heart-Check mark for Advanced Certification for Primary Stroke Centers.
- **CRMC's Cardiovascular service line was jointly recognized by the American Heart Association/American Stroke Association and U.S. News & World Report** for superior cardiac and stroke care in the magazine's 2019 edition of Best Hospitals.
- **CRMC was presented with the American Heart Association/American Stroke Association's Get With The Guidelines®-Target: Stroke Honor Roll Elite Gold Plus Quality Achievement Award.** The goal of the Get With The Guidelines stroke program is to speed recovery and reduce death and disability for stroke patients. This was the fourth year for CRMC received a stroke care award.
- **CRMC received the American College of Cardiology's National Cardiovascular Data Registry (NCDR) Chest Pain – MI Registry Platinum Performance Achievement Award.** CRMC was one of only 225 hospitals nationwide to receive this honor. The award recognizes CRMC's commitment and success in implementing a higher standard of care for heart attack patients and signifies that CRMC has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology and the American Heart Association clinical guidelines and recommendations.
- **CRMC received the American Heart Association's Get With The Guidelines®-Heart Failure Gold Plus Quality Achievement Award.** This award recognizes CRMC's commitment to ensuring heart failure patients receive the most appropriate treatment according to nationally recognized, research-based guidelines, with the goal of speeding recovery and reducing hospital readmissions for heart failure patients. This is the second year in a row that CRMC has received a Get With The Guidelines award for heart failure care.
- **CRMC was presented with the American Heart Association's Get With The Guidelines®-Resuscitation Silver Quality Achievement Award.** The award recognizes CRMC's commitment to

ensuring patients receive the most appropriate resuscitation treatment according to nationally recognized, research-based guidelines, following an in-hospital or out-of-hospital event.

- **CRMC earned "Most Wired" recognition from the College of Healthcare Information Management for the sixth consecutive year.** CRMC also received Most Wired awards for its ambulatory services and its affiliated CRMG for the first time ever.

Innovative Care: 2019

- **CRMC was the first hospital in Wyoming to implant the Micra,** the world's smallest pacemaker.
- **CRMC was the first hospital in Wyoming to implant the Inspire sleep therapy device.**
- **CRMC was the first hospital in Wyoming to perform the Intracept procedure** for lower back pain.
- **CRMC was the first hospital in Wyoming to implant a CardioMems™ HF device**, a small pulmonary artery pressure sensor that can be used to treat a select group of heart failure patients.
- **CRMC launched its first-ever remote patient monitoring system for congestive heart failure patients**.
- **CRMC began offering genicular nerve radiofrequency ablation,** a non-surgical procedure to relieve chronic knee pain.
- **CRMC began offering a real-time nerve monitoring system** shown to significantly improve outcomes related to continence and sexual function after robotic prostatectomies.
- **Million Hearts® Cardiovascular Disease Reduction Model:** Cheyenne Cardiology Associates (CCA) was one of 516 medical clinics from across the nation selected by the Centers for Medicare & Medicaid Services (CMS) to participate in a five-year initiative focused on decreasing the incidence of heart attacks and strokes through prevention. (Initiative began in 2016.)
- **CRMC was the first hospital in Wyoming to offer the DATscan and Axumin medical imaging procedures** that can help confirm parkinsonian syndrome and suspected prostate cancer recurrence.
- **CRMC was the first hospital in Wyoming to offer a virtual care option for Cheyenne area adults through a program called SmartExam**.
- **CRMC was the first hospital in Wyoming to launch MyChart Bedside**, a mobile and tablet-based application to provide patients with information about their treatment, condition and hospital stay.
- **CRMC moved its PACE (Program of All-Inclusive Care for the Elderly) program to a larger, renovated facility** due to the program's growth since its inception in January 2013.
- **CRMC installed a Mamava breastfeeding pod to** offer visiting moms a secure, clean space to nurse their babies or pump breast milk in private. CRMC was the first facility in Wyoming to install a Mamava pod.

MEDICAL STAFF AND EMPLOYEES

General

As of June 30, 2020, CRMC employed 2,135 individuals for a total of approximately 1,878 full-time equivalent employees. CRMC offers a comprehensive range of benefit programs for its eligible employees which management believes is similar and competitive with other area employers. These programs include hospital/medical benefits, life and disability insurance, tuition assistance, tax-sheltered annuity programs, and a pension program for eligible employees. CRMC has no collective bargaining agreements, considers its relationship with employees to be good, and strategically strives to be a "Best Place to Work" employer.

As of June 30, 2020, there were 168 physicians on the active and associate medical staff, including 24 physicians employed by CRMC and 50 employed by CRMG. Active and associate staff members are the principal sources of admissions to CRMC.

Retention

CRMC has a formal retention program for its medical staff and physicians. This retention plan was developed based on feedback from physician and medical staff focus groups. CRMC uses Fair Market Value up to the 75th percentile when establishing providers base salary, along with incentives including relocation allowance, sign-on bonus, and student loan reimbursement. Provider contracts are three-year contracts that can also include a

productivity and quality bonus structure. CRMC believes, based upon medical staff feedback, that the number one thing physicians desire is feeling they are part of a collegial group of caregivers and have a voice in the governance of the hospital and clinic. CRMC has also started a "mentorship" program that pairs new physicians with peers established in the Cheyenne community. An example of this mentorship activity is hosting social events to allow medical staff to socialize. As of November 2020, 66.2% of CRMC employed physicians have been employed three years or more. 17.6% of employed physicians have been employed by CRMC for 10-15 years.

Recruiting

CRMC recruits physicians under the following circumstances: (i) CRMC plans to offer needed services and there are no existing physician specialists to assist with such services; (ii) CRMC plans to expand an existing service but the existing compliment of physicians cannot serve the expansion; (iii) physician vacancies resulting from relocation, retirement or death and the need for replacement; (iv) demand for physician services exceeding availability; or, (v) physicians in practice request assistance in recruiting.

Physician recruitment is critical to maintain and grow service lines in both the inpatient and outpatient arenas. CRMC has a fulltime dedicated recruiter to assist in sourcing candidates as well coordinating all recruitment efforts and tailoring recruitment itineraries to candidates' individual needs. CRMC both employs physicians and supports independent practices in recruitment through Stark allowable practices of income guarantees and/or recruitment support.

CRMC reimburses physician candidates for reasonable interviewing expenses and may also pay reasonable relocation expenses to successfully recruited physicians. CRMC may also provide financial assistance to physicians being recruited when this type of incentive is necessary to compete. While CRMC has a standardized recruitment package, the recruitment packages are customizable to meet the needs of individual candidates.

The Hospital Board does not approve individual physician hiring decisions. The Hospital Board sets compensation guidance parameters for administration to follow. The Hospital Board does act on contracts for employed physicians if there is a need to go above the 75th percentile of fair market value ("FMV") in order to successfully recruit the physician. The Hospital Board does approve all compensation arrangements above the 75th percentile of FMV. The Hospital Board is kept apprised of all decisions to provide assistance with the recruitment of independent physicians but does not formally vote on offering recruitment packages.

Calendar year 2020 has been a successful year for recruiting physicians. Even with the challenges of the COVID-19 pandemic, as of November 30, 2020, CRMC successfully recruited 23 physicians to join the CRMC team. Thirteen (13) recruited physicians are employed in our subsidiary medical group CRMG and ten (10) recruited physicians have been placed into private practices. Six recruited were primary care physicians, seven were surgeons or proceduralists (such as orthopedic surgeons and EP cardiologists) and ten were medical specialists (such as psychiatrists and general cardiologists). The successful recruiting of an EP cardiologist in 2020 means that CRMC has the only two EP cardiologists in Wyoming affiliated with CRMC.

Medical Staff Profile

The following tables set forth the specialties or subspecialties of CRMC's medical staff represented within each clinical department and certain information regarding the active and associate medical staff members within each department as of June 30, 2020.

Active and Associate Medical Staff Profile

Department	Number of Physicians	Average Age	% Board Certified	% Pending (Recently completed training)
Medicine	75	44	93%	4%
Surgery	81	50	88	11
Special Clinical Services	12	54	92	8

Source: CRMC.

Active and Associate Medical Staff by Practice Area

Specialty	Number of Physicians	Specialty	Number of Physicians
Anesthesiology	16	OB/GYN	11
Cardiology	5	Oral & Maxillofacial Surgery	3
Cardiology/Electrophysiology	2	Orthopedic Surgery	7
Cardiothoracic Surgery	2	Otolaryngology	6
Emergency Medicine	17	Pain Management	3
Endocrinology	1	Pathology	3
Family Medicine	13	Pediatric Dentistry	1
Family Medicine/Hospitalist	4	Pediatrics	12
Gastroenterology	6	Plastic Surgery	1
General Surgery	5	Podiatric Surgery	2
Geriatric Medicine	1	Psychiatry	6
Hematology/Oncology	3	Pulmonary Medicine	3
Infectious Disease	1	Radiation Oncology	1
Internal Medicine	2	Radiology, Diagnostic	8
Internal Medicine/Hospitalist	11	Rheumatology	2
Nephrology	2	Urology	2
Neurology	1	Vascular Surgery	2
Neurosurgery	2	Wound Care/Hyperbaric Medicine	1
		TOTAL:	168

Source. CRMC records.

The following chart shows CRMC's top admitting physicians for 2020.

Top Ten Admitting Physicians – 2020[(1)]

Specialty	FY 2020 Admissions	% of Total Admissions
Internal Medicine[(2)]	383	4.2%
Family Medicine[(2)]	373	4.1
Internal Medicine[(2)]	347	3.8
Internal Medicine[(2)]	327	3.6
Family Medicine[(2)]	307	3.4
Internal Medicine[(2)]	297	3.3
Family Medicine[(2)]	293	3.2
Internal Medicine[(2)]	289	3.2
Internal Medicine[(2)]	288	3.1
Internal Medicine[(2)]	283	3.1
Top Ten Total	3,187	
Total Admissions	9,102	35.0%

[(1)] Includes those physicians on staff as of September 30, 2020.
[(2)] Physicians employed by CRMC.
Source: CRMC.

PROFESSIONAL LIABILITY, GENERAL AND OTHER INSURANCE CONSIDERATIONS

Effective January 1, 2018, CRMC joined UMIA (via Mountain States Group) for its professional and general liability insurance coverage.

CRMC has malpractice insurance coverage to provide protection for professional liability losses on a claims-made basis subject to a limit of $1.0 million per claim with an annual aggregate limit of $3.0 million and $25,000 deductible. CRMC participates in two additional layers of excess coverage with UMIA. The first layer is $20.0 million each claim/$40.0 million professional aggregate/$40.0 million general aggregate/$80.0 million total aggregate. The second layer is $13.0 million each claim/$13.0 million aggregate.

SERVICE AREA

CRMC's primary service area is Laramie County, Wyoming. The County is spread over 2,688 square miles and is Wyoming's most populous county with an estimated 2019 population of 99,540. Its secondary service area includes the following counties: Albany, Carbon, Goshen and Platte in Wyoming, as well as Kimball, Banner, Morrill, and Scottsbluff Counties in Nebraska. Although northern Colorado is shown in the map below, CRMC does not have a material number of patients from Colorado.

The map below depicts CRMC's primary service area.

Source: CRMC.

During the fiscal year ended June 30, 2020, CRMC's primary service area accounted for 87.0% of its total discharges. The secondary service area accounted for 7.6% of total discharges. The remaining 5.4% of total discharges were from a broader geographic area defined as the tertiary service area, consisting of 0.7% from Wyoming counties outside the primary and secondary service areas and 4.7% from other locations. CRMC does not draw a meaningful number of patients from Colorado, and as a result Colorado is not part of the CRMC service area and CRMC does not consider Colorado hospitals to be competitors. See "MARKET COMPETITION AND UTILIZATION" below for further discussion of the market.

CRMC Service Area	% Total Discharges	Counties
Primary Service Area	87.0%	Laramie
Secondary Service Area	7.6	Albany, Carbon, Goshen and Platte Wyoming and Kimball, Banner, Morrill and Scottsbluff, Nebraska
Tertiary Service Area	5.4	Converse, Niobrara and Sweetwater, Wyoming and Cheyenne, Nebraska

Source: CRMC.

Service Area Population

The following table sets forth certain population statistics for CRMC's primary service area and the State of Wyoming generally:

	1990	2000	2010	2019
Primary Service Area (Laramie County)	73,142	81,607	91,738	99,540 (projected)
% change		11.2%	12.4%	1.2%
State of Wyoming	453,588	493,783	563,626	578,360 (projected)
% change		10.9%	14.1%	0.2%

Source: 1990, 2000, 2010 and 2019 from U.S. Census Bureau.

Service Area Unemployment Rates

Unemployment rates for CRMC's primary service area have historically been comparable with the unemployment rate for the State of Wyoming generally. The unemployment rates for the primary service area, the State of Wyoming and the United States as of June 2020 are as set forth below:

	2009	2010	2011	2019	2020
Cheyenne MSA	7.7%	7.1%	6.5%	3.4%	6.6%
State of Wyoming	6.5	7.0	5.8	3.5	7.6
United States	9.3	9.4	9.1	3.7	11.1

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Cheyenne's Largest Employers

The City of Cheyenne is both the county seat of the County and the capital of the State. The County and the region have benefited from historical stability of employment through State and local government employment as well as the F.E. Warren Air Force Base, which is home to the 90th missile wing and Minuteman intercontinental ballistic missiles. The region has also benefitted from extensive energy resources, which has led to recent business development and investment. The largest employers in the City of Cheyenne by employed headcount are shown on the table on the following page:

Employer	Product/Service	Employees as of 2018
F.E. Warren AFB	Military	4,177
State of Wyoming	Government Services	3,755
Laramie County School District #1	Education K-12	2,289
Cheyenne Regional Medical Center	Health Care	1,900
Federal Government	Government Services	1,728
Wyoming National Guard	Military	1,130
Veterans' Affairs Medical Center	Health Care	980
Sierra Trading Post	Outlet Catalog/Retail	878
Union Pacific Railroad	Transportation, Rail	660
City of Cheyenne	Government Services	568
Lowe's Companies, Inc.	Distribution Center	450
Laramie County Government	Government Services	387
Dish/EchoStar Broadcasting Corporation	Satellite Uplink Center	380
Laramie County Community College	Education	359
HollyFrontier Oil	Oil Refinery	292
Crete Carrier Corp.	Transportation	286
Simon Contractors	Heavy Construction	250
Allstate Call Center	Insurance	240
Laramie County School District #2	Education K-12	219
Blue Cross/Blue Shield	Health Plans	213
United States Postal Service	Government Services	198
Life Care Cheyenne	Long-Term Care	196
Dyno Nobel	Fertilizer & Nitrate Mfg.	180
Reiman Construction	Construction	173
Blue Federal Credit Union	Credit Union	169
Empress Health & Rehabilitation (formerly Mountain Towers)	Long-Term Care	160
Little America	Hotel & Resort	149
Magpul Industries	Firearms	136
Magic City Enterprises	Rehabilitation Facility	121
Charter Business	Communications	117
Halladay Motors	Automobile Sales and Service	111
Taco Johns International	Food Service Headquarters	102

Source: Wyoming Center for Business & Economic Analysis & Cheyenne LEADS employer interviews January 2018.

MARKET COMPETITION AND UTILIZATION

CRMC is one of the largest health systems in the State and is the largest in its service area. With the exception of the VA Hospital in Cheyenne, which is not considered a competitor, there is no other hospital in CRMC's primary service area. Within the last three years, CRMC has held steady at an 85% market share in its primary service area across major service lines which includes inpatient and outpatient available services (Wyoming Hospital Association/Colorado Hospital Association/CMS data sources). The nearest healthcare providers (which are primarily critical access hospitals) are shown on the table on the following page:

Hospital	City	Distance from CRMC	Average Daily Census	Admissions
CRMC	Cheyenne	n/a	103	9,102
Ivinson Memorial	Laramie	50 miles	23	2,282
Memorial Hospital of Carbon County	Rawlins	152 miles	5	572
Platte County Memorial Hospital	Wheatland	70 miles	4	398
Kimball Health	Kimball, Nebraska	65 miles	*Not available*	*Not available*

Source: CRMC Data (FY20) and WHA data FY2019.

Competition from outside the primary and secondary service area comes from hospitals in Fort Collins (46 miles south of Cheyenne) and Greeley, Colorado (53 miles southeast of Cheyenne) and Scottsbluff, Nebraska (116 miles northeast of Cheyenne). As described above, the CRMC service area does not include any portion of Colorado because of historical patient statistics. However, outmigration, primarily for services not provided at CRMC, does occur to hospitals in Colorado, Wyoming, and other states for very specialized care. Based on Wyoming and Colorado Hospital Association data, the majority of this outmigration from CRMC is to healthcare facilities operated by UCHealth which CRMC management believes is reflective of the value of the UCHealth MSA described above in this Appendix A.

Historical Utilization Data

The table below summarizes certain operating statistics of the Hospital for Fiscal Years 2018–2020.

	FY 2018	FY 2019	FY 2020	3 Months ended 9/30/20	3 Months ended 9/30/19
Admissions (excluding newborns)	9,955	9,807	9,102	2,160	2,438
Observation Hours	100,297	116,981	118,481	25,181	35,663
Adjusted Admissions	21,477	22,822	21,719	5,158	5,916
Average Length of Stay (Days)	4.70	4.50	4.14	4.24	4.18
Patient Days (excluding newborns)	46,801	44,087	37,701	9,163	10,191
Births	1,203	1,191	1,106	288	301
Outpatient Visits	135,421	138,385	130,651	32,393	34,665
Physician Relative Value Units	453,320	462,095	440,468	114,386	117,472
Emergency Department Visits	40,759	41,630	38,162	8,449	10,671
Surgeries:					
Main Operating Room	2,214	2,584	2,427	598	678
Same Day Surgery	2,786	3,163	3,077	766	835
Total Surgeries	5,000	5,747	5,504	1,364	1,513

Source: CRMC Data.

Payor Mix

The table below shows the revenue payor mix for the Hospital for Fiscal Years 2018–2020.

	FY 2018	FY 2019	FY 2020	3 Months ended 9/30/20	3 Months ended 9/30/19
Medicare	46.1%	47.3%	45.9%	47.2%	46.1%
Medicaid	8.3	7.7	7.3	7.6	7.7
Blue Cross	14.2	14.6	15.5	14.2	15.4
Commercial and other	23.5	23.1	23.4	23.6	22.3
Patient self-pay	7.9	7.3	7.9	7.4	8.5
	100.0%	100.0%	100.0%	100.0%	100.0%

Source: CRMC Data.

COVID-19 AND THE HOSPITAL

For a general discussion of COVID-19 and its impact on the health care industry generally, as well as a summary of the federal response to COVID-19, see "BONDHOLDERS' RISKS – General Health Care Risk Factors – *COVID-19 and Infectious Disease Outbreak*" in this Official Statement.

COVID-19 Operational Impact and Response

Prior to the Wyoming Governor, Mark Gordon, declaring a State of Emergency, CRMC created an incident command center comprised of key management and care delivery leaders for the purpose of responding to the COVID-19 health threat. This effort included responses designed to address a comprehensive list of issues including care delivery, staffing, supply chain management, telehealth and virtual care, as well as protocols for testing, treating and isolating patients directly affected by COVID-19. Through the incident command center, briefings are conducted three times per week or more frequently as needed, and key messages, policies and protocols are disseminated throughout CRMC. These messages are supported by email, video messaging, and a designated COVID-19 web page on the Hospital's intranet, as well as the external facing CRMC website. In addition, communications with patients, parents and families are addressed through social media, the secure patient portal, and a designated call center that was established to provide information to the Hospital's communities.

On March 13, 2020, the Governor of the State, Mark Gordon, declared a State of Emergency due to the COVID-19 outbreak. Pursuant to an executive order, such State of Emergency remains in effect until such time it is rescinded and is in effect as of this date. Pursuant to guidance from the Wyoming Department of Health dated April 24, 2020, hospitals and other healthcare providers in Wyoming were encouraged to follow guidance from CMS and CDC asking providers to postpone non-essential elective surgeries to conserve supplies of personal protective equipment ("PPE"). The Hospital complied with this guidance and CRMC formed a surge planning committee and named site-based surge planning coordinators to finalize phased surge plans that would allow for a significant increase in hospital bed capacity, including ICU beds and ventilators. The Hospital also redeployed staff to address changes in volumes and patient care needs. In order to meet the routine ongoing healthcare needs of patients, the Hospital also began conducting telephonic health assessments, telemedicine visits and treatments, and screening of patients, visitors and staff prior to entry to facilities. Telehealth services peaked at 30% of clinic visits in April 2020 and have since stabilized to approximately 10-15% of clinic visits. In our Behavioral Health Services, we continue to be 100% telehealth visits. In addition, the Hospital established COVID-19 testing locations throughout its service area to allow for testing of patients while minimizing the infection risk and conserving PPE.

Since March 2020, CRMC has tracked key volume indicators (admissions, surgical cases and outpatient or clinic visits and emergency department visits) to monitor the impact of COVID-19 on the Hospital. In April 2020, key volume indicators were significantly (roughly 50%) below fiscal year 2019 levels. Volumes began to recover in May 2020 but remained below fiscal year 2019 levels. Admissions, surgical cases and outpatient or clinic visits returned to levels approximately equal to or above fiscal year 2019 volumes for the same period by August 2020, with the exception of emergency department visits which have continued to trail slightly below fiscal year 2019 levels, ending fiscal year 2020 at 5% below fiscal year 2019 volume.

CRMC has worked to avoid a shortage of critical supplies. The Hospital's Materials Management department has dedicated a team to sourcing PPE outside of the CRMC group purchasing organization as the traditional supply chain continues to be challenged. In addition, the Hospital implemented PPE conservation protocols, limited the number of staff and visitors within the facilities to reduce PPE use, and received thousands of donated items of PPE from the community and local businesses. In addition, the Hospital has adopted a centralized control, distribution and tracking mechanism for key supplies such as N95 respirators, surgical masks, gowns, gloves, hand sanitizer, laboratory supplies, and disinfectant wipes. The Hospital's supply of each of these items is tracked regularly as is the average utilization of the items in the past seven days, so that CRMC can understand, for each item, its usage rate and project the supply (number of days) the Hospital has on hand.

COVID-19 Financial Impact and Response

As of September 30, 2020, cash and unrestricted investments totaled $347.3 million, which resulted in a days' cash on hand calculation of 391 which includes approximately $12.1 million of federal grant funding received through July 2020 under the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), and approximately $48.6 million under the expanded Accelerated and Advance Payment Program under the CARES Act (the "APP Program"). Under the APP Program, providers and health systems can receive advanced or accelerated Medicare disbursements in the form of a liability which must be paid back from earned Medicare fee for service payments. The U.S. Congress and CMS have extended the repayment of these accelerated/advance payments on multiple occasions and repayment terms remain subject to additional congressional and regulatory action. Repayments for the approximately $48.6 million the Hospital received under the APP Program are currently expected to begin in April and May 2021, one year after the Hospital received the APP Program payments, and outstanding balances are currently not required to be paid in full for 29 months from the date the first payment under the APP Program was received by the Hospital.

For the year ended June 30, 2020, the Hospital recognized non-operating revenue of approximately $800 thousand of grant funding from the approximately $12.1 million the Hospital has received from the initial $100 billion grant authorization to hospitals and health care providers under the CARES Act Provider Relief Fund. During the quarter ended September 30, 2020, the Hospital recognized an additional $165 thousand from the CARES Act Provider Relief Fund. The Hospital expects to recognize the remaining approximately $11.1 million from the CARES Act Provider Relief Fund during the fiscal year ending June 30, 2021.

On November 18, 2020, the U.S. Department of Health and Human Services ("HHS") released updated guidance regarding reporting requirements for health care providers that received payments from the CARES Act Provider Relief Fund. CRMC believes the amounts recognized as non-operating revenue in the consolidated financial statements of CRMC as of June 30, 2020 and for the fiscal year then ended, included in APPENDIX B to this Official Statement, and the amounts deferred for recognition in future periods, are consistent with the guidance available from HHS as of the date of this Official Statement. HHS has stated that it intends to offer additional information to aid in future reporting, which may require adjustments in treatment of payments from the CARES Act Provider Relief Fund; however, management of CRMC does not expect any such changes to have a material impact on the consolidated financial statements contained in this Official Statement.

In addition, the Hospital has undertaken a volume management strategy that ensures elective surgeries and other deferred care is scheduled promptly. Margin preservation steps taken by CRMC include cost saving measures such as : (i) productivity compliance organization wide; development of a shared labor pool, compensation reductions for the Hospital's executive team, mandatory flex paid time off required to match expenses to compressed net revenue; and reductions in discretionary spending such as travel. Liquidity preservation measures include, decreased capital expenditures to emergency projects only, and applying for and receiving Medicare Accelerated Payments. So far, the ultimate liquidity impact of COVID has been nominal for CRMC.

For more information regarding the CARES Act, the APP Program and other state and federal legislative responses to the COVID-19 pandemic, see "BONDHOLDERS' RISKS – General Health Care Risk Factors – *COVID-19 and Infectious Disease Outbreak*" in this Official Statement.

Incidence of COVID-19 in Service Area

Data concerning the incidence of COVID-19 in the Hospital's service area is changing daily. The Wyoming Department of Health updates its COVID-19 data on a daily basis and Wyoming healthcare organizations are self-reporting COVID cases in their respective hospitals. In late 2020, this information can be found at the following website: https://datastudio.google.com/u/0/reporting/1ubVORkCavAiRJS_DD4lz-cNFK6u15YuA/page/ir5KB. CRMC adopted a "no visitor" policy effective November 1, 2020 with certain exceptions such as guardians for pediatric patients, outpatient procedures, end-of-life patients, special needs patients, and other special circumstances. All visitors are required to wear face coverings for the duration of their visit at the Hospital and submit to visitor screening. At one point in late November/early December 2020, over 110 CRMC staff were self-quarantined due to possible COVID-19 exposure and 63 COVID-19 positive patients were being

treated at the Hospital. As of December 31, 2020, CRMC self-reported actively treating __ inpatients for COVID-19 with __ of those patients in ICU and ___ CRMC staff members were self-quarantining.

As mentioned above in this Appendix A, CRMC is licensed for 206 beds, including 120 medical and surgical, 15 intensive care, 16 pediatric medical and surgical, 19 obstetric, 20 physical rehabilitation, and 16 psychiatric care. Due to COVID-19, CRMC has been granted temporary licensure for 248 beds to include 16 same day surgery, 16 additional surge beds, and 10 additional ICU beds. This temporary license is effective December 4, 2020 through March 4, 2021 and may be extended in the future if necessary.

During 2020, CRMC has not had to restrict its acceptance or admission of transferred patients. CRMC has not exceeded its capacity limitations during 2020. In addition, CRMC believes that it has on hand an adequate level of personal protective equipment (PPE) to enable CRMC to respond to any future surge in COVID-19 incidence in and around the service area of CRMC.

On December 15, 2020, from the allocated COVID-19 vaccination, CRMC began vaccinating its medical staff. CRMC's vaccination efforts are starting with the ICU staff and the medical staff that deal with the most at-risk patients. As of December 31, 2020, [360] staff members of CRMC had received the initial dose of a COVID-19 vaccination from the vaccine allocation that CRMC has received from the State.

FINANCIAL INFORMATION

Summary of Financial Information

The following summary of revenues and expenses of CRMC for the three fiscal years ended June 30, 2018, 2019 and 2020 which has been derived from audited financial statements of CRMC. CRMC is financially self-sufficient and does not receive funds from the County.

This summary should be read in conjunction with the financial statements and accompanying notes appended thereto and attached to this Official Statement as "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019." The unaudited interim financial summaries for the three-month periods ended September 30, 2020 and 2019 have not been examined by independent accountants; however, in the opinion of Hospital management, it reflects all adjustments (consisting of normal recurring accruals) necessary for a fair presentation of the results of operations of the Hospital for these periods. The results of operations for the three-month period ended September 30, 2020 may not necessarily be indicative of the operating results to be expected for the entire fiscal year ending June 30, 2021. See "APPENDIX C – UNAUDITED INTERIM FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE THREE-MONTH PERIODS ENDED SEPTEMBER 30, 2020 AND 2019" in this Official Statement.

(The remainder of this page is intentionally left blank.)

Historical Financial Information

Balance Sheet

The following is a summary of balance sheet data for CRMC for the fiscal years ended 2018, 2019, and 2020 and for three-month period ended September 30, 2020 with a comparison to the same three-month period ended September 30, 2019. The information for the fiscal years ended June 30, 2018, 2019, and 2020 has been derived from the audited financial statements of CRMC and the information for the three-month period ended September 30, 2020 is from internal CRMC records.

	FY 2018	FY 2019	FY 2020	3 Months ended 9/30/20	3 Months ended 9/30/19
Cash and cash Equivalents	$38,696,603	$ 42,691,907	$100,162,488	$125,498,156	$ 41,523,073
Other current assets	60,242,644	63,708,698	67,028,403	71,089,002	65,310,071
Total current assets	98,939,247	106,400,605	167,190,891	196,587,158	106,833,144
Unrestricted investments	188,513,183	210,393,495	230,974,932	221,839,233	214,549,627
Restricted investments	6,331,554	6,623,441	17,320,766	15,849,977	6,656,024
Total non-current investments	194,844,737	217,016,936	248,295,698	237,689,210	221,205,650
Total capital assets	188,646,854	193,770,929	197,968,907	195,582,003	196,939,296
Total other assets	11,550,444	11,403,608	12,262,192	12,084,066	11,594,044
Total assets	493,981,282	528,592,078	625,717,688	641,942,436	536,572,134
Pension related deferred outflows	843,654	6,981,525	-	-	6,981,525
	$494,824,936	$535,573,603	$625,717,688	$641,942,436	$543,553,659
Total current liabilities	27,840,231	33,755,669	45,060,570	57,763,711	33,408,578
Long-term debt	91,287,599	88,579,757	107,424,619	106,469,374	88,220,670
CMS advances payments	-	-	43,523,649	38,501,689	-
Net pension liability	1,326,918	11,315,473	2,635,675	2,635,675	11,315,473
Pension related deferred inflows	21,971	-	3,017,723	3,017,723	-
Unrestricted net assets	272,814,407	291,822,689	320,312,839	331,167,050	295,400,273
Other	101,533,810	110,100,015	103,742,613	102,387,214	115,208,666
Total liabilities and net position	$494,824,936	$535,573,603	$625,717,688	$641,942,436	$543,553,659

(The remainder of this page is intentionally left blank.)

Income Statement

The following is a summary of statement of operations and changes in net assets for CRMC for the fiscal years ended 2018, 2019, and 2020 and for three-month period ended September 30, 2020 with a comparison to the same three-month period ended September 30, 2019. The information for the fiscal years ended June 30, 2018, 2019, and 2020 has been derived from the audited financial statements of CRMC and the information for the three-month period ended September 30, 2020 is from internal CRMC records.

	FY 2018	FY 2019	FY 2020	Actual 3 Months ended 9/30/20	Actual 3 Months ended 9/30/19
Net Patient Revenue	$329,886,072	$344,675,889	$348,831,796	$90,682,007	$90,032,312
Other Operating Revenue	14,180,993	14,517,426	14,436,901	4,032,231	3,308,200
Total Operating Revenue	344,067,065	359,193,315	363,268,697	94,714,238	93,340,512
Salaries, wages and employee benefits	183,956,773	189,779,637	190,371,471	47,973,759	48,258,782
Purchased Services	44,172,305	47,839,862	47,877,169	11,391,322	11,900,088
Supplies and other	75,100,022	78,786,776	78,181,317	21,210,042	20,044,849
Depreciation Expense	25,456,032	25,565,818	26,824,392	6,752,997	6,695,538
Total Operating expenses	328,685,132	341,972,093	343,254,349	87,328,120	86,899,257
Operating Income (loss)	15,381,933	17,221,222	20,014,348	7,386,118	6,441,255
Nonoperating Revenues (Expenses)					
Investment income and other	(3,869,419)	13,768,925	5,783,819	3,243,540	3,106,956
Interest Expense	(4,298,871)	(4,241,963)	(4,237,842)	(1,130,847)	(1,046,631)
Excess of Revenues Over (less than) Expenses Before Contributions and other Changes in Net Assets	7,213,643	26,748,184	21,560,325	9,498,811	8,501,580
Foundation Capital Contributions	740,284	826,303	572,423	-	184,655
Increase (decrease) in Net Assets	$7,953,927	$27,574,487	$22,132,748	$9,498,811	$8,686,235

(The remainder of this page is intentionally left blank.)

Select Financial Ratios

Liquidity

The table below represents CRMC's unrestricted Days Cash on Hand for the Hospital's last three (3) fiscal years ended June 30, 2018, 2019, and 2020 and for the three-month period ended September 30, 2020. The information for the fiscal years ended June 30, 2018, 2019, and 2020 has been derived from the audited financial statements of CRMC and the information for the three-month period ended September 30, 2020 is from internal CRMC records.

Days Cash on Hand

	FY 2018	FY 2019	FY 2020	3 Months ended 9/30/2020
Total Unrestricted Cash and Investments	$227,209,786	$253,085,402	$331,137,421	$347,337,389
Total Operating Expense	332,984,000	346,214,056	347,492,191	88,458,967
Less: Depreciation and Amortization	25,456,032	25,565,818	26,824,392	6,752,997
Net Operating Expense	$307,527,968	$320,648,238	$320,667,799	$81,705,970
Daily Operating Expense	842,542	878,488	876,142	888,108
Days cash on hand	269.7	288.1	377.9	391.1

Debt Service Coverage

The table below shows CRMC's historical Net Revenue Available for Debt Service and the ratio of such Net Revenue to Maximum Annual Debt Service Requirements ("MADS") for the fiscal years ending June 30, 2018, 2019 and 2020 along with pro-forma debt service coverage for the proposed Series 2021 Bonds. The information for the fiscal years ended June 30, 2018, 2019, and 2020 has been derived from the audited financial statements of CRMC.

Debt Service Coverage

	FY 2018	FY 2019	FY 2020
Excess of Revenues of (Less Than) Expenses	$17,715,767	$39,267,246	$27,109,588
Add: Interest Expense	4,298,871	4,241,963	4,237,842
Add: Depreciation and Amortization	23,709,170	23,844,418	25,421,156
Less: Unrealized gains (losses) on investments	222,585	5,522,157	(5,424,209)
Less: (Gain) loss on disposal of assets	74,745	9,109	(212,555)
Net Income Available for Debt Service	$45,426,479	$61,822,361	$62,405,350
Annual Debt Service[(1)]	$7,685,788	$7,822,494	$8,038,294
Annual Debt Service Coverage	5.91x	7.90x	7.76x
Pro Forma Maximum Annual Debt Service[(2)]*	$9,617,386	$9,617,386	$9,617,386
Pro Forma Maximum Annual Debt Service Coverage*	4.72x	6.43x	6.49x

(1) For Fiscal Year 2020 includes the debt service associated with the Equipment Leases previously entered into by the Hospital Board discussed in the forepart of this Official Statement under the heading "INTRODUCTORY STATEMENT – Current and Possible Future Equipment Financing Leases" prior to the date of issuance of the Series 2021 Bonds.

(2) This calculation includes the debt service associated with the Equipment Leases previously entered into by the Hospital Board and the proposed $10,000,000 Equipment Lease that is anticipated to be entered into by the Hospital Board in February 2021.

** Preliminary, subject to change.*

Capitalization

The table below sets forth the actual and pro forma capitalization of CRMC for the fiscal years ending June 30, 2018, 2019 and 2020 and pro-form fiscal year 2020 with the assumed Series 2021 Bonds:

Capitalization (Including Current Maturities)

	FY 2018	FY 2019	FY 2020	Pro Forma FY 2020*
Long Term Debt (including current maturities)[(1)]	$94,490,649	$91,353,383	$112,591,837	$120,608,062
Divided by:				
Long Term Debt (including current maturities)	94,490,649	91,353,383	112,591,837	120,608,062
Add: Unrestricted net assets and Net Inv in Cap Assets	366,970,612	394,240,235	405,689,909	405,689,909
Total Capitalization	$461,461,261	$485,593,618	$518,281,746	$526,297,971
Debt to Capitalization	20.5%	18.8%	21.7%	22.9%

[(1)] *For Fiscal Year 2020 includes the debt associated with the Equipment Leases previously entered into by the Hospital Board discussed in the forepart of this Official Statement under the heading "INTRODUCTORY STATEMENT – Current and Possible Future Equipment Financing Leases" prior to the date of issuance of the Series 2021 Bonds plus the proposed $10,000,000 Equipment Lease that is anticipated to be entered into by the Hospital Board in February 2021.*

***** *Preliminary, subject to change.*

Management Discussion and Analysis of the Fiscal Year Ended June 30, 2020 and 2019

For a discussion and analysis of the financial performance of CRMC and overall review of CRMC's financial activities and balances as of and for the fiscal year ended June 30, 2020 and 2019, see "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 and 2019 – Management's Discussion and Analysis" in this Official Statement.

Management Discussion and Analysis of Three-Month Periods Ended September 30, 2020 and 2019

This discussion and analysis of the financial performance of CRMC provides an overall review of CRMC's financial activities and balances as of and for the three-months ended September 30, 2020. See also "'APPENDIX C - UNAUDITED INTERIM FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE THREE-MONTH PERIODS ENDED SEPTEMBER 30, 2020 AND 2019" in this Official Statement.

Financial Highlights - Financial Statements.

- CRMC recorded an increase in net position by approximately $22.9 million from September 2019 and an increase of approximately $9.5 million from fiscal year ended June 30, 2020.
- CRMC's operating income was approximately $7.4 million for the three-months ended September 30, 2020 and approximately $6.4 million for the three-months ended September 30, 2019.
- Total assets and deferred outflows of resources were approximately $641.9 million at September 30, 2020, $625.7 million at June 30, 2020 and $543.6 million at September 30, 2019.
- Total liabilities and deferred inflows of resources were approximately $208.4 million at September 30, 2020, which included $83.1 million of outstanding revenue bond; $201.7 million at June 30, 2020, which included $83.1 million of outstanding revenue bond; and $132.9 million at September 30, 2019, which included $85.2 million of outstanding revenue bond.
- CRMC's (hospital only) net days revenue in accounts receivable as of September 30, 2020 was 42.3 compared to 49.8 at September 30, 2019.

Overview of the Financial Statements

The statement of net position at September 30, 2020 indicated total assets and deferred outflows of resources of $641.9 million, total liabilities and deferred inflows of resources of $208.4 million, and net position of $433.6 million. Total current assets were $196.6 million and total current liabilities were $57.8 million resulting in a current ratio of 3.4.

The statements of revenues, expenses, and changes in net position for the three-months ending September 30, 2020 indicated total operating revenues of $94.7 million and operating expenses of $87.3 million, resulting in operating income of $7.4 million, and a gain from nonoperating revenues (expenses) and capital contributions from the Foundation of $2.1 million. The net position increased $9.5 million, from $424.1 million at June 30, 2020 to $433.6 million at September 30, 2020.

Cash and cash equivalents increased $25.3 million from $100.2 million at June 30, 2020 to $125.5 million at September 30, 2020, which when added to long-term investments of $221.8 million equated to 391 Days Cash on Hand.

CRMC - Hospital-only Information

Total patient service revenue, prior to deduction for charity care, was approximately $238.6 million for the three-months ending September 30, 2020 as compared to $234.6 million for three-months ended September 30, 2019. Total charity care, contractual adjustments, and provision for bad debts were approximately $155.1 million for the three-months ending September 30, 2020 and $151.7 million for the three-months ended September 30, 2019. Medicare and Medicaid contractual adjustments and other adjustments expressed as a percentage of total patient service revenue including charity care was 58.4% as of the three-months ending September 30, 2020 compared to 57.4% for the year ended September 30, 2019. Provision for bad debts as a percentage of total patient service revenue including charity care was 5.3% for the three-months ending September 30, 2020 compared to 5.7% for the three-months ended September 30, 2019.

Inpatient admissions during the three-months ending September 30, 2020 were 2,160 compared to 2,438 for the three-months ending September 30, 2019. Outpatient registrations for the three-months ending September 30, 2020 decreased 6.6% over the same three-months of 2019. The decrease is a result of the current COVID-19 pandemic.

Operating expenses for the three-months ended September 30, 2020 totaled approximately $77.2 million. The largest component of operating expenses is salaries, wages, and employee benefits. Salaries, wages, and employee benefits expenses for employees of CRMC for the three-months ended September 30, 2020 and 2019 accounted for approximately 51.1% and 51.3% of total operating expenses. The total full-time equivalents (FTEs) at CRMC for the three-months ended September 30, 2020 were 1,654 compared to 1,644 for the year ended June 30, 2020.

Operating income for the three-months ended September 30, 2020 was $9.9 million or 11.4% of operating revenues as compared to $9.0 million or 10.5% of operating revenues for the three-months ended September 30, 2019. Fiscal year 2021 year-to-date operating income substantially equates to CRMC's annual budgeted operating margin of 11.4%.

Nonoperating revenues and expenses consist primarily of investment income, gain on joint venture, loss on disposal of property and equipment, provider relief funds, and interest expense.

Investment income generated a gain of $3.1 million and $3.4 million for the three-month periods ending September 30, 2020 and 2019.

Interest expense increased $84,000 from the three-month period ending September 30, 2019 to September 30, 2020.

OTHER MATTERS

Pension Plan

CRMC is the administrator of the Memorial Hospital of Laramie County Pension Plan (the "Plan"), a single-employer defined benefit noncontributory pension plan covering substantially all its employees who have met the Plan's eligibility requirements. The most recent actuarial valuation of the Plan was made as of January 1, 2020. The Plan has been closed to new employees since January 1, 2004. As of January 1, 2020, membership in the Plan consisted of 1,194 people. The unfunded actuarial accrued liability for the Plan is amortized over a six-year period. See the "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 and 2019 – Note 9 – Pension and Retirement Benefits" for additional information related to the Hospital's Pension Plan.

Investment Policy and Management

The Hospital Board has established an investment policy (the "Investment Policy"), to guide the investment of CRMC's funds with a goal to maximize income and growth, given the risk tolerances established by the Hospital Board. Pursuant to the Investment Policy, CRMC has established two main pools of funds. The first pool is targeted in very short-term fixed income obligations to provide 60 to 100 days of operating cash reserves. The second pool consists of long-term investments, invested in a balanced approach with a goal to achieve higher returns. CRMC's investments must also comply with the Wyoming Uniform Prudent Investor Act and all other regulations. Pursuant to the Investment Policy, the Hospital Board will review its Investment Policy and strategies annually. CRMC utilizes an outside professional investment advisor to assist in investment management. See the "APPENDIX B – AUDITED FINANCIAL STATEMENTS OF THE HOSPITAL FOR THE FISCAL YEARS ENDED JUNE 30, 2020 and 2019" in this Official Statement for the investment allocation at June 30, 2020 and 2019.

Litigation

Medical Malpractice Litigation. The nature of CRMC's business generates claims and litigation against CRMC arising in the ordinary course of its activities. At any given time, CRMC has a number of lawsuits pending based on alleged medical malpractice. Given CRMC's medical malpractice insurance coverage and consultations with counsel, it is CRMC's management opinion that resolution of such suits now pending will not materially adversely affect CRMC's financial condition.

Other Litigation. As of October 2020, CRMC has no knowledge of any suits (exclusive of worker's compensation claims) against it, which did not involve claims based on alleged medical malpractice.

(The remainder of this page is intentionally left blank.)