OFFICIAL STATEMENT

NEW ISSUE **NOT RATED**
BOOK-ENTRY ONLY

In the opinion of Kutak Rock LLP, Bond Counsel, under existing laws, regulations, rulings and judicial decisions and assuming the accuracy of certain representations and continuing compliance with certain covenants, interest on the Series 2021 Bonds is excludable from gross income for federal income tax purposes and is not a specific preference item for purposes of the federal alternative minimum tax. Bond Counsel is also of the opinion that the Series 2021 Bonds are "qualified tax-exempt obligations" within the meaning of Section 265(b)(3) of the Internal Revenue Code of 1986, as amended. In Bond Counsel's further opinion, under existing laws, regulations, rulings and judicial decisions, the Series 2021 Bonds and the interest thereon are exempt from all Arkansas state, county and municipal taxes. See the caption "TAX MATTERS" herein.

$9,710,000
BOONE COUNTY, ARKANSAS
HOSPITAL REVENUE REFUNDING BONDS
(NORTH ARKANSAS REGIONAL MEDICAL CENTER PROJECT)
SERIES 2021

Dated: Date of Delivery **Due: May 1, as shown on inside cover**

The Hospital Revenue Refunding Bonds, Series 2021 (the "Series 2021 Bonds"), are being issued by Boone County, Arkansas (the "Issuer") pursuant to Amendment 65 to the Constitution of the State of Arkansas and the Local Government Capital Improvements Revenue Bond Act, Arkansas Code Annotated Sections 14-164-401 *et seq*. (1998 Repl. & 2019 Supp), for the purpose of providing a portion of the funds needed for (i) refunding $9,740,000 outstanding principal amount of the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2013 (the "Refunded Bonds"), (ii) funding a debt service reserve, and (iii) paying certain expenses in connection with the issuance of the Series 2021 Bonds. The Refunded Bonds were originally issued for the purpose of refinancing a portion of the costs of constructing and equipping additions and improvements to North Arkansas Regional Medical Center (the "Medical Center"). See the captions "PLAN OF REFUNDING" and "SOURCES AND USES OF FUNDS" herein.

The Series 2021 Bonds are issuable as fully registered bonds and, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company ("DTC"), New York, New York, to which principal, premium, if any, and interest payments on the Series 2021 Bonds will be made so long as Cede & Co. is the registered owner of the Series 2021 Bonds. Individual purchases of the Series 2021 Bonds will be made only in book-entry form, in denominations of $5,000 and integral multiples in excess thereof. Individual purchasers of the Series 2021 Bonds ("Beneficial Owners") will not receive physical delivery of bond certificates. See the caption "BOOK-ENTRY ONLY SYSTEM" herein.

Interest on the Series 2021 Bonds is payable each May 1 and November 1, commencing May 1, 2022. All such interest payments shall be payable to the person in whose name such Series 2021 Bond is registered on the bond registration books maintained by Regions Bank (the "Trustee"), in Little Rock, Arkansas, as of the close of business on the fifteenth day of the calendar month immediately preceding the interest payment date on which interest is due. Principal of and premium, if any, on the Series 2021 Bonds shall be payable at the designated corporate trust office of the Trustee. So long as DTC or its nominee is the registered owner of the Series 2021 Bonds, disbursement of such payments to DTC or its nominee is the responsibility of the Trustee. Disbursement of such payments to DTC Participants is the responsibility of DTC, and disbursement of such payments to Beneficial Owners is the responsibility of DTC Participants or Indirect Participants, as more fully described herein.

The Series 2021 Bonds are limited obligations of the Issuer and will not constitute an indebtedness, liability, general or moral obligation, pledge of the faith, loan of credit, or charge against the taxing power or any revenues of Boone County, Arkansas, the State of Arkansas, or any political subdivision thereof. The Series 2021 Bonds are secured by and payable solely from revenues derived from the operation of the Medical Center. Other than said revenues, the Series 2021 Bonds are <u>not</u> secured by a lien on or security interest in any real or personal property comprising the Medical Center. See the caption "SECURITY FOR THE BONDS" herein.

The Series 2021 Bonds are issued and secured on a parity basis with (i) the $4,700,000 unrefunded outstanding principal amount of the Issuer's Variable Rate Hospital Revenue Construction Bonds, Series 2006 (the "Series 2006 Bonds"), and (ii) $3,375,000 outstanding principal amount of the Issuer's Hospital Revenue Refunding Bonds, Series 2011 (the "Series 2011 Bonds"). The Series 2021 Bonds are subject to optional and extraordinary redemption prior to maturity as described under the caption "THE SERIES 2021 BONDS" herein.

This cover page contains certain information for quick reference only. It is not a summary of the terms of or the security for the Series 2021 Bonds. Investors must read the entire Official Statement to obtain information essential to making an informed investment decision.

The Series 2021 Bonds are offered, subject to prior sale, when, as, and if issued and received by the Underwriter, subject to the approval of validity by Kutak Rock LLP, Little Rock, Arkansas, Bond Counsel, and subject to certain other conditions. Certain matters will be passed upon for the Corporation by Ellis, Ellis, Hammons & Johnson, P.C., Springfield, Missouri. It is expected that the Series 2021 Bonds will be available for delivery through the facilities of DTC in New York, New York, on or about December 30, 2021.

Stephens Inc.

The date of this Official Statement is November 30, 2021.

MATURITY SCHEDULE

Year (May 1)	Amount	Interest Rate	Yield	CUSIP†
2022	$ 25,000	4.000%	1.100%	098646 CD2
2023	130,000	4.000%	1.400%	098646 CE0
2024	130,000	4.000%	1.650%	098646 CF7
2025	135,000	4.000%	1.900%	098646 CG5
2026	1,035,000	4.000%	2.100%	098646 CH3
2027	1,080,000	4.000%	2.300%	098646 CJ9
2028	1,120,000	2.375%	2.500%	098646 CK6
2029	1,145,000	2.500%	2.650%	098646 CL4
2030	1,175,000	2.625%	2.800%	098646 CM2

$3,735,000 3.000% Term Bond due May 1, 2033 - Yield: 2.950%; CUSIP† No. 098646 CN0

† CUSIP® is a registered trademark of the American Bankers Association. CUSIP data herein is provided by the CUSIP Service Bureau, operated by Standard & Poor's, a division of The McGraw-Hill Companies, Inc. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP Services Bureau. CUSIP numbers have been assigned by an independent company not affiliated with the Issuer and are included solely for the convenience of the registered owners of the Series 2021 Bonds. The Issuer and the Underwriter are not responsible for the selection or uses of these CUSIP numbers, and no representation is made as to their correctness on the Series 2021 Bonds by the Issuer or by the Underwriter. The CUSIP number for a specific maturity is subject to being changed after the issuance of the Series 2021 Bonds as a result of various subsequent actions including, but not limited to, a refunding in whole or in part or as a result of the procurement of secondary market portfolio insurance or other similar enhancement by investors that is applicable to all or a portion of certain maturities of the Series 2021 Bonds.

NO DEALER, BROKER, SALESMAN OR OTHER PERSON HAS BEEN AUTHORIZED BY THE ISSUER, THE CORPORATION OR THE UNDERWRITER TO GIVE ANY INFORMATION OR TO MAKE ANY REPRESENTATIONS, OTHER THAN THOSE CONTAINED IN THIS OFFICIAL STATEMENT; AND, IF GIVEN OR MADE, SUCH OTHER INFORMATION OR REPRESENTATIONS MUST NOT BE RELIED UPON AS HAVING BEEN AUTHORIZED BY ANY OF THE FOREGOING. THIS OFFICIAL STATEMENT DOES NOT CONSTITUTE AN OFFER TO SELL OR THE SOLICITATION OF AN OFFER TO BUY SERIES 2021 BONDS IN ANY JURISDICTION IN WHICH SUCH OFFER IS NOT AUTHORIZED OR IN WHICH THE PERSON MAKING SUCH OFFER IS NOT QUALIFIED TO DO SO, OR TO ANY PERSON TO WHOM IT IS UNLAWFUL TO MAKE SUCH OFFER. THE INFORMATION AND EXPRESSIONS OF OPINION CONTAINED HEREIN ARE SUBJECT TO CHANGE WITHOUT NOTICE, AND NEITHER THE DELIVERY OF THIS OFFICIAL STATEMENT NOR ANY SALE MADE HEREUNDER SHALL UNDER ANY CIRCUMSTANCES CREATE ANY IMPLICATION THAT THERE HAS BEEN NO CHANGE IN THE AFFAIRS OF THE ISSUER OR THE CORPORATION SINCE THE DATE HEREOF.

CERTAIN INFORMATION CONTAINED HEREIN HAS BEEN OBTAINED FROM THE ISSUER, THE CORPORATION, THE DEPOSITORY TRUST COMPANY AND OTHER SOURCES WHICH ARE BELIEVED TO BE RELIABLE. THE UNDERWRITER HAVE REVIEWED THE INFORMATION IN THIS OFFICIAL STATEMENT IN ACCORDANCE WITH, AND AS PART OF, THEIR RESPONSIBILITIES TO INVESTORS UNDER THE FEDERAL SECURITIES LAWS AS APPLIED TO THE FACTS AND CIRCUMSTANCES OF THIS TRANSACTION, BUT THE UNDERWRITER DOES NOT GUARANTEE THE ACCURACY OR COMPLETENESS OF SUCH INFORMATION.

THE SERIES 2021 BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, NOR HAS THE TRUST INDENTURE BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACTS. THE SERIES 2021 BONDS HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SECURITIES AND EXCHANGE COMMISSION, NOR HAS THE COMMISSION PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFICIAL STATEMENT.

IN CONNECTION WITH THIS OFFERING, THE UNDERWRITER MAY OVERALLOT OR EFFECT TRANSACTIONS WHICH STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2021 BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

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SUMMARY STATEMENT

This Summary Statement is subject in all respects to the more complete information contained in this Official Statement. The offering of the Series 2021 Bonds to potential investors is made only by means of the entire Official Statement, including the cover page and Appendices hereto. No person is authorized to detach this Summary Statement or otherwise to use it without the entire Official Statement. Definitions of certain words and terms used in this Summary Statement are set forth in Appendix B to this Official Statement.

The Offering

The offering consists of $9,710,000 principal amount of Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2021 (the "Series 2021 Bonds") to be issued by Boone County, Arkansas (the "Issuer"). The Issuer is a political subdivision of the State of Arkansas with full power and authority to issue the Series 2021 Bonds pursuant to the laws of the State of Arkansas.

Purpose

The proceeds of the sale of the Series 2021 Bonds will be loaned to North Arkansas Regional Medical Center, an Arkansas nonprofit corporation (the "Corporation"), pursuant to a Loan Agreement dated as of May 1, 1999, as supplemented and amended by a Supplemental Loan Agreement dated as of March 1, 2006, by a Second Supplemental Loan Agreement dated as of November 1, 2010, by a Third Supplemental Loan Agreement dated as of December 1, 2011, by a Fourth Supplemental Loan Agreement dated as of March 1, 2013, and by a Fifth Supplemental Loan Agreement dated as of December 1, 2021 (as supplemented and amended, the "Loan Agreement"), each by and between the Issuer and the Corporation. See the caption "SUMMARY OF PORTIONS OF THE LOAN AGREEMENT" herein.

The Corporation leases and operates North Arkansas Regional Medical Center (the "Medical Center") and will use the proceeds of the Series 2021 Bonds, along with other available moneys, (i) to refund $9,740,000 outstanding principal amount of the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2013 (the "Refunded Bonds"), originally issued to refinance capital improvements to the Medical Center, (ii) to fund a debt service reserve, and (iii) to pay the costs of issuing the Series 2021 Bonds. See the captions "SOURCES AND USES OF FUNDS" and "PLAN OF REFUNDING" herein.

North Arkansas Regional Medical Center and the Corporation

The Medical Center is a 174 licensed bed acute-care hospital owned by the Issuer and located in Harrison, Arkansas. The Medical Center is leased to and operated by the Corporation pursuant to an Assignment and Lease Agreement dated as of March 1, 1997, as amended by an Amendment to Assignment and Lease Agreement dated as of November 1, 2010 (as amended, the "Lease Agreement"). See Appendix A hereto for a description of the Medical Center and the Corporation. The term of the Lease Agreement expires on December 31, 2041. See the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT" herein.

The Corporation, a nonprofit corporation organized and existing under Arkansas law since 1996, has been recognized by the Internal Revenue Service as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and is thus exempt from federal income taxation under the Code. The Corporation presently staffs 130 of the Medical Center's 174 licensed beds.

For a more detailed description of the Corporation and the Medical Center, see Appendix A attached hereto.

Security for the Bonds

The Series 2021 Bonds are limited obligations of the Issuer, payable solely from amounts due from the Corporation under the Loan Agreement and a Bond Guaranty Agreement dated as of

December 1, 2021 (the "Bond Guaranty Agreement"), by and between the Corporation and the Trustee (as defined below). See the caption "SUMMARY OF PORTIONS OF THE BOND GUARANTY AGREEMENT" herein.

The Series 2021 Bonds are secured by an assignment of the Issuer's interest in the Loan Agreement, including a pledge of and security interest in the Pledged Revenues generated from operation of the Medical Center. The Series 2021 Bonds are issued and secured on a parity basis with (i) $4,700,000 outstanding principal amount of the Issuer's Variable Rate Hospital Revenue Construction Bonds (North Arkansas Regional Medical Center Project), Series 2006 (the "Series 2006 Bonds"), and (ii) $3,375,000 outstanding principal amount of the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2011 (the "Series 2011 Bonds"). The Corporation presently intends to evaluate the refunding of the Series 2006 Bonds and the Series 2011 Bonds in the first quarter of 2022. **Other than the lien on Pledged Revenues, the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds are not secured by a lien on or security interest in any real or personal property comprising the Medical Center.**

The Series 2021 Bonds do not constitute general obligations of the State of Arkansas, Boone County, Arkansas, or any other political subdivision or body politic or corporate of the State of Arkansas. Neither the faith and credit nor the taxing power of the State of Arkansas, Boone County, Arkansas, nor any other political subdivision is pledged to the payment of the principal, redemption premium, if any, or interest on the Series 2021 Bonds. See the caption "SECURITY FOR THE BONDS" herein.

In the Trust Indenture dated as of May 1, 1999, as supplemented and amended by a Supplemental Trust Indenture dated as of March 1, 2006, by a Second Supplemental Trust Indenture dated as of November 1, 2010, by a Third Supplemental Trust Indenture dated as of December 1, 2011, by a Fourth Supplemental Trust Indenture dated as of March 1, 2013, and by a Fifth Supplemental Trust Indenture dated as of December 1, 2021 (as supplemented and amended, the "Indenture"), each by and between the Issuer and Regions Bank, Little Rock, Arkansas, as trustee (the "Trustee"), pursuant to which the Series 2021 Bonds are issued and secured, the Issuer has reserved the power to issue Additional Bonds on a parity of security with the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds. See the caption "SUMMARY OF PORTIONS OF THE INDENTURE" herein.

Redemption

The Series 2021 Bonds are subject to optional, mandatory and extraordinary redemption as set forth in the Official Statement under the caption "THE SERIES 2021 BONDS."

Special Considerations

Payment of principal of, premium, if any, and interest on the Series 2021 Bonds is dependent on, among other things, revenues derived by the Corporation from the operation of the Medical Center. Certain risks are inherent in the production of such revenues. See the captions "RISK FACTORS" and "REGULATION OF THE HEALTH CARE INDUSTRY" herein and "APPENDIX A – NORTH ARKANSAS REGIONAL MEDICAL CENTER" attached hereto.

Pending Litigation and Other Potential Liability

There is not now pending, nor to the knowledge of the Issuer or the Corporation, threatened, any litigation restraining or enjoining the validity of the Series 2021 Bonds or the proceedings or authority under which they are to be issued.

The Corporation has no litigation or proceedings pending, or, to its knowledge, threatened, against it which may not be adequately covered by the Corporation's reserves and insurance policies, or which, in the opinion of the Corporation and its defense counsel, could have a material adverse effect on the Corporation's business or financial position.

OFFICIAL STATEMENT

$9,710,000
Boone County, Arkansas
Hospital Revenue Refunding Bonds
(North Arkansas Regional Medical Center Project)
Series 2021

INTRODUCTION

The purpose of this Official Statement, including the cover page and the Appendices hereto, is to provide certain information concerning the $9,710,000 Boone County, Arkansas Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2021 (the "Series 2021 Bonds"). Definitions of certain words and terms used in this Official Statement are set forth in Appendix B to this Official Statement.

Boone County, Arkansas (the "Issuer") is a political subdivision of the State of Arkansas authorized in furtherance of the public purposes described in Arkansas Code Annotated Sections 14-164-401 *et seq*., as amended (1998 Repl. & 2019 Supp.), known as the Local Government Capital Improvements Revenue Bond Act (the "Act"), to finance and refinance one or more projects as defined in the Act, including health care facilities, through the issuance of its revenue bonds. The Series 2021 Bonds are being issued pursuant to the Act and a Trust Indenture dated as of May 1, 1999, as supplemented and amended by a Supplemental Trust Indenture dated as of March 1, 2006, by a Second Supplemental Trust Indenture dated as of November 1, 2010, by a Third Supplemental Trust Indenture dated as of December 1, 2011, by a Fourth Supplemental Trust Indenture dated as of March 1, 2013, and by a Fifth Supplemental Trust Indenture dated as of December 1, 2021 (as supplemented and amended, the "Indenture"), each by and between the Issuer and Regions Bank, Little Rock, Arkansas, as trustee and paying agent (the "Trustee"). See the caption "SUMMARY OF PORTIONS OF THE INDENTURE" herein.

The Issuer will lend the proceeds of the Series 2021 Bonds to North Arkansas Regional Medical Center, an Arkansas not-for-profit corporation (the "Corporation"), pursuant to a Loan Agreement dated as of May 1, 1999, as supplemented and amended by a Supplemental Loan Agreement dated as of March 1, 2006, by a Second Supplemental Loan Agreement dated as of November 1, 2010, by a Third Supplemental Loan Agreement dated as of December 1, 2011, by a Fourth Supplemental Loan Agreement dated as of March 1, 2013, and by a Fifth Supplemental Loan Agreement dated as of December 1, 2021 (as supplemented and amended, the "Loan Agreement"). See the caption "SUMMARY OF PORTIONS OF THE LOAN AGREEMENT" herein.

The Issuer owns the Medical Center and leases it to the Corporation pursuant to an Assignment and Lease Agreement dated as of March 1, 1997, as amended by an Amendment to Assignment and Lease Agreement dated as of November 1, 2010 (the "Lease Agreement"). The Lease Agreement has a term expiring December 31, 2041. See the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT" herein.

The proceeds of the Series 2021 Bonds will be used, along with other available moneys, (i) to refund $9,740,000 outstanding principal amount of the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2013 (the "Refunded Bonds"), (ii) to fund a debt service reserve, and (iii) to pay costs related to the issuance of the Series 2021 Bonds. See the captions "SOURCES AND USES OF FUNDS" and "PLAN OF REFUNDING" herein.

Pursuant to the terms and provisions of a Bond Guaranty Agreement dated as of December 1, 2021 (the "Bond Guaranty Agreement"), by and between the Corporation and the Trustee, the Corporation has covenanted to make payments to the Trustee as necessary to assure payment of principal of, premium, if any, and interest on the Series 2021 Bonds when due, whether upon maturity or earlier redemption. Such covenant is not a general obligation of the Corporation, but is a special obligation enforceable only to the extent of Pledged Revenues within the control of the Corporation. See the caption "SUMMARY OF PORTIONS OF THE BOND GUARANTY AGREEMENT" herein.

The Series 2021 Bonds are issued and secured on a parity basis with the Issuer's (i) $4,700,000 outstanding principal amount of Variable Rate Hospital Revenue Construction Bonds (North Arkansas Regional Medical Center Project), Series 2006 (the "Series 2006 Bonds"), (ii) $3,375,000 outstanding principal amount of Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2011 (the "Series 2011 Bonds"), and (iii) any Additional Bonds issued in accordance with the provisions of the Indenture. See the caption "THE SERIES 2021 BONDS – Additional Bonds" herein. The Series 2006 Bonds, the Series 2011 Bonds, the Series 2021 Bonds and any such Additional Bonds (collectively, the "Bonds") are limited obligations of the Issuer payable as provided in the Indenture from the revenues and receipts derived by the Issuer pursuant to the Loan Agreement and all other funds held by the Trustee and available for such payment. The Corporation presently intends to evaluate the refunding of the Series 2006 Bonds and the Series 2011 Bonds in the first quarter of 2022. The Loan Agreement requires that payments be made by the Corporation to the Trustee for the account of the Issuer in amounts and at times sufficient to pay the principal, premium, if any, and interest requirements on the Bonds. To secure its payments due under the Loan Agreement and the Bond Guaranty Agreement, the Corporation has pledged and granted a security interest in the Pledged Revenues generated from the operation of the Medical Center. **Other than the lien on Pledged Revenues, the Bonds are <u>not</u> secured by a lien on or security interest in any real or personal property comprising the Medical Center.**

The Series 2021 Bonds do not constitute general obligations of the State of Arkansas, Boone County, Arkansas, or any other political subdivision or body politic or corporate of the State of Arkansas. Neither the faith and credit nor the taxing power of the State of Arkansas, Boone County, Arkansas, nor any other political subdivision is pledged to the payment of the principal, redemption premium, if any, or interest on the Series 2021 Bonds.

This Official Statement contains brief descriptions of, among other things, the Issuer, the Corporation, the Medical Center, the Series 2021 Bonds, the Lease Agreement, the Loan Agreement, the Indenture, the Bond Guaranty Agreement and the Continuing Disclosure Agreement. Such descriptions do not purport to be comprehensive or definitive. All references in this Official Statement to documents are qualified in their entirety by reference to such documents, and references to the Series 2021 Bonds herein are qualified in their entirety by reference to the form of Series 2021 Bond contained in the Indenture. Information concerning the Issuer and concerning the Corporation and Medical Center has been supplied by the Issuer and the Corporation, respectively. Until the issuance and delivery of the Series 2021 Bonds, copies of the Lease Agreement, Loan Agreement, Indenture, Bond Guaranty Agreement and Continuing Disclosure Agreement may be obtained at the offices of Stephens Inc., 111 Center Street, Little Rock, Arkansas 72201. Copies of these documents may be obtained from the Trustee after delivery of the Series 2021 Bonds at the expense of the requesting party.

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THE SERIES 2021 BONDS

Description

The Series 2021 Bonds are being issued as fully registered bonds in minimum denominations of $5,000 or any integral multiple thereof. The Series 2021 Bonds will bear interest from their date at the rates and mature in the amounts and on the dates as set forth on the inside cover page of this Official Statement. Interest on the Series 2021 Bonds is payable semiannually on May 1 and November 1 of each year, commencing May 1, 2022. Interest shall be paid by the Trustee by check or draft mailed on such Interest Payment Date. Principal of and premium, if any, on the Series 2021 Bonds are payable at the designated corporate trust office of the Trustee in Little Rock, Arkansas, or at the offices of any additional or successor paying agent.

All of the Series 2021 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company ("DTC"), to which principal, premium and interest payments on the Series 2021 Bonds will be made so long as DTC or its nominee is the registered owner of the Series 2021 Bonds. See the caption "BOOK-ENTRY ONLY SYSTEM" herein.

Optional Redemption

The Series 2021 Bonds maturing on and after May 1, 2028 are subject to redemption prior to maturity at the option of the Issuer, as a whole or in part, in any order of maturity as directed by the Corporation, without restriction as to source of payment, on May 1, 2027, and on any date thereafter, at a redemption price equal to 100% of the principal amount to be redeemed, plus accrued interest to the date fixed for redemption.

Extraordinary Redemption

(1) The Series 2021 Bonds are subject to redemption, at the direction of the Issuer, in whole or in part, at any time, at a price of par plus accrued interest to the date of redemption, upon the prepayment of the Series 2021 Note by the Corporation, in whole or in part, in the event the Lease Agreement is terminated by either the Issuer or the Corporation prior to its expiration in accordance with the provisions thereof. In said event, the Bond Guaranty Agreement requires the Series 2021 Note to be prepaid by the Corporation to the extent of available Pledged Revenues in excess of one month's operating expenses (based on the average monthly operating expenses of the Medical Center for the preceding Fiscal Year). See the captions "SUMMARY OF PORTIONS OF LEASE AGREEMENT – Events of Termination" and "SUMMARY OF PORTIONS OF THE BOND GUARANTY AGREEMENT" herein.

(2) To the extent insurance proceeds are not utilized for replacement or restoration of the Medical Center, and the Lease Agreement is terminated because of damage to or destruction of the Medical Center as a result of fire or other casualty, said proceeds shall be used to prepay the Series 2021 Note. In addition, in said event, the Bond Guaranty Agreement requires the Series 2021 Note to be prepaid by the Corporation to the extent of available Pledged Revenues in excess of one month's operating expenses (based on the average monthly operating expenses of the Medical Center for the preceding Fiscal Year). Such prepayment shall be applied to the redemption of the Series 2021 Bonds, in whole or in part, at the direction of the Issuer, at any time, at a price of par plus accrued interest to the date of redemption.

(3) To the extent condemnation of all or any portion of the Medical Center results in a termination of the Lease Agreement, any available condemnation award shall be used to prepay the Series 2021 Note. In addition, in said event, the Bond Guaranty Agreement requires the Series 2021 Note to be prepaid by the Corporation to the extent of available Pledged Revenues in excess of one month's operating expenses (based on the average monthly operating expenses of the Medical Center for the preceding Fiscal Year). Such prepayment shall be applied to the redemption of the Series 2021 Bonds, at

the direction of the Issuer, in whole or in part, at any time, at a price of par plus accrued interest to the date of redemption.

(4) In the event any action by the Issuer or the Corporation causes any interest on the Series 2021 Bonds to become taxable to the owners thereof pursuant to the Code, and in the judgment of the Trustee or its counsel such effect cannot be remedied within a reasonable period of time, the Bond Guaranty Agreement requires the Series 2021 Note to be prepaid by the Corporation to the extent of available Pledged Revenues in excess of one month's operating expenses (based on the average monthly operating expenses of the Medical Center for the preceding Fiscal Year). At the direction of the Issuer, such prepayment shall be applied to the redemption of the Series 2021 Bonds, in whole or in part, at any time, at a price of par plus accrued interest to the date of redemption.

Any extraordinary redemption of the Series 2021 Bonds in part under the conditions described above shall be in inverse order of maturity.

Mandatory Sinking Fund Redemption

The Series 2021 Bonds maturing on May 1, 2033 are subject to mandatory sinking fund redemption prior to maturity on May 1 in the years and amounts set fourth below at a redemption price equal to the principal amount thereof and accrued interest to the date of redemption, and without premium, as follows:

Year	Principal Amount
2031	$1,210,000
2032	1,245,000
2033 (maturity)	1,280,000

Selection of Bonds to be Redeemed

If fewer than all of the Series 2021 Bonds of any one maturity shall be called for redemption, the particular Series 2021 Bonds or portions thereof to be redeemed from such maturity shall be selected by lot by the Trustee in such manner as it shall determine; provided, however, that so long as DTC or its nominee is the sole registered owner of the Series 2021 Bonds, the particular Series 2021 Bonds or portions thereof to be redeemed within a maturity shall be selected by lot by DTC in such manner as DTC shall determine. Portions of a Series 2021 Bond may be redeemed only to the extent the remaining unredeemed portion of such Series 2021 Bond equals or exceeds the minimum authorized denomination ($5,000).

Notice of Redemption

In the event any of the Series 2021 Bonds or portions thereof are called for redemption as aforesaid, notice thereof identifying the Series 2021 Bonds or portions thereof to be redeemed and the date on which they shall be presented for payment shall be given by Trustee by mailing a copy of the redemption notice by first class mail (or, so long as DTC or its nominee is the sole registered owner of the Series 2021 Bonds, by any other means acceptable to DTC, including facsimile), at least thirty (30) days but not more than sixty (60) days prior to the date fixed for redemption to the Owner of each Series 2021 Bond to be redeemed in whole or in part at the address shown on the registration books. Failure to give any such notice by mailing, or any defect therein, shall not affect the validity of the proceedings for the redemption of any Series 2021 Bond or portion thereof with respect to which no such failure has occurred. Any notice so mailed shall be conclusively presumed to have been duly given, whether or not the Owner receives the notice.

After the date specified in such notice, the Series 2021 Bonds so called for redemption will cease to bear interest, provided funds for their payment have been deposited with the Trustee; and, except for

the purpose of such payment, shall no longer be protected by the Indenture and shall not be deemed to be outstanding under the provisions of the Indenture.

Additional Bonds

(1) The Issuer may issue Additional Bonds for the purpose of paying the cost of any Improvements to the Medical Center, together with incidental expenses and payments in connection therewith, if there shall be deposited with the Trustee, among other things, a report by the Accountants stating that the Historical Debt Service Coverage Ratio of the Corporation for the two most recently completed Fiscal Years was not less than 1.30:1.

(2) The Issuer may issue Additional Bonds for the purpose of refunding any Outstanding Bonds if prior to the incurrence thereof either (i) an Officer's Certificate of the Corporation is delivered to the Trustee stating that, taking into account the issuance of the proposed Additional Bonds and the application of the proceeds thereof and any other funds available to be applied to such refunding, the Maximum Annual Debt Service Requirement of the Corporation will not be increased, or (ii) if there shall be deposited with the Trustee a report by the Accountants stating that the Historical Debt Service Coverage Ratio of the Corporation for the two most recently completed Fiscal Years was not less than 1.30:1.

Any Additional Bonds issued as permitted in the Indenture shall be secured by and shall be payable from the Bond Fund, Debt Service Reserve Fund and Pledged Revenues on a parity basis with the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds.

The Corporation may incur other indebtedness as permitted under the Loan Agreement. See the captions "SUMMARY OF PORTIONS OF THE LOAN AGREEMENT – Permitted Indebtedness of Corporation" and "SUMMARY OF PORTIONS OF THE INDENTURE – Improvement Bonds" and "SUMMARY OF PORTIONS OF THE INDENTURE – Refunding Bonds" herein.

SECURITY FOR THE BONDS

The Bonds do not constitute general obligations of the State of Arkansas, Boone County, Arkansas, or any other political subdivision or body politic or corporate of the State of Arkansas. Neither the faith and credit nor the taxing power of the State of Arkansas, Boone County, Arkansas, or any other political subdivision is pledged to the payment of the principal, redemption premium, if any, or interest on the Bonds.

The Bonds are limited obligations of the Issuer, payable solely from (i) amounts due under the Loan Agreement, and (ii) amounts due under the Bond Guaranty Agreement. Under the Loan Agreement and the Notes, the Corporation has agreed to make payments in amounts sufficient to pay the principal of, premium, if any, and interest on the Bonds when due. Under the Bond Guaranty Agreement, the Corporation has agreed to make payments to the Trustee as necessary to assure payment of the principal of, premium, if any, and interest on the Bonds when due, whether upon maturity or earlier redemption. The payment obligations of the Corporation under the Loan Agreement and Bond Guaranty Agreement are secured by a security interest in Pledged Revenues. **The Bonds will not be secured by a lien on the Medical Center or by any other real or personal property (other than Pledged Revenues) now owned by, or subsequently conveyed to, the Issuer or the Corporation.**

"Pledged Revenues" are defined in the Loan Agreement as all money, earnings, rents, issues, profits, income, revenues, investment earnings, receipts and proceeds or rights to the payment of money, receivables, accounts, contract rights and judgments derived in any fashion from the use and operation of the Medical Center at any time; and all proceeds from chattel paper, instruments, accounts and contract rights; but *excluding* gifts, donations, bequests, devises, legacies, contributions, pledges and grants restricted to an inconsistent purpose, proceeds from the Notes and the Bonds, unrealized gains and losses

from investments, and proceeds from life insurance; all determined in accordance with generally accepted accounting principles.

The Issuer has entered into the Indenture in order to secure the Bonds. Under the Indenture, the Issuer has assigned to the Trustee all of the Issuer's interests under the Notes and the Loan Agreement, and all of the property and revenues pledged thereunder.

The Medical Center is owned by the Issuer and leased to the Corporation pursuant to the terms of an Assignment and Lease Agreement dated as of March 1, 1997, as amended by an Amendment to Assignment and Lease Agreement dated as of November 1, 2010 (as amended, the "Lease Agreement"). The Lease Agreement has a term expiring December 31, 2041. See the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT" herein.

The Lease Agreement is subject to early termination upon the occurrence of any of the events described herein under the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT – Events of Termination". In such event, although the obligations of the Corporation under the Loan Agreement, the Notes and the Bond Guaranty Agreement shall continue, it is unlikely that the Corporation will possess sufficient assets to fulfill said obligations, and because the sole security for the payments by the Corporation pursuant to the Loan Agreement, the Notes and the Bond Guaranty Agreement is the Pledged Revenues, it is unlikely that any attempt to enforce the Corporation's obligations would result in payment in full of principal of and interest on the Bonds.

Pursuant to the Indenture, the Issuer has covenanted that, whether or not the Lease Agreement or any successor lease is then in effect, it will use its best efforts to operate the facilities constituting the Medical Center, or to cause such facilities to be operated, as a "hospital" or other "health care facilities" within the meaning of the Act. The Issuer has also covenanted that it will use its best efforts to ensure that Pledged Revenues are deposited with the Trustee in sufficient amounts at all times to pay the principal of, premium, if any, and interest on the Bonds when due.

In the event of early termination of the Lease Agreement, there can be no assurance that the Issuer could operate the Medical Center in such a manner, or would be successful in locating a successor lessee that could operate the Medical Center in such a manner, as would produce sufficient Pledged Revenues to pay the principal of, premium, if any, and interest on the Bonds when due.

In addition to the security provided by the Pledged Revenues, the Bonds are secured by the Debt Service Reserve Fund held by the Trustee. The Series 2021 Account of the Debt Service Reserve Fund will be funded with $971,000 of proceeds of the Series 2021 Bonds and will be maintained in an amount equal to the lesser of (i) the maximum annual Debt Service Requirement with respect to the Series 2021 Bonds, (ii) 125% of the average annual Debt Service Requirement with respect to the Series 2021 Bonds, or (iii) 10% of the initial stated principal amount of the Series 2021 Bonds.

BOOK-ENTRY ONLY SYSTEM

The Series 2021 Bonds will be issued only as one fully registered Series 2021 Bond for each maturity, in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York ("DTC"), as registered owner of all the Series 2021 Bonds. The fully registered Series 2021 Bonds will be retained and immobilized in the custody of DTC.

DTC (or any successor securities depository) or its nominee will be considered by the Issuer, the Corporation and the Trustee to be the owner or holder of the Series 2021 Bonds for all purposes under the Indenture.

Owners of any book entry interests in the Series 2021 Bonds (the "book entry interest owners") described below, will not receive or have the right to receive physical delivery of the Series 2021 Bonds,

and will not be considered by the Issuer, the Corporation and the Trustee to be, and will not have any rights as, owners or holders of the Series 2021 Bonds under the bond proceedings and the Indenture except to the extent, if any, expressly provided thereunder.

CERTAIN INFORMATION REGARDING DTC AND DIRECT PARTICIPANTS IS SET FORTH BELOW. THIS INFORMATION HAS BEEN PROVIDED BY DTC. THE ISSUER, THE CORPORATION, THE UNDERWRITERS AND BOND COUNSEL ASSUME NO RESPONSIBILITY FOR THE ACCURACY OF SUCH STATEMENTS.

DTC, the world's largest 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 3.6 million issues of U.S. and non-U.S. equity issues, 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 among 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, the National Securities Clearing Corporation and the Fixed Income Clearing Corporation, all of which are registered 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"). The DTC Rules applicable to its Direct and Indirect Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of Series 2021 Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Series 2021 Bonds on DTC's records. The ownership interest of each actual purchaser of each Series 2021 Bond ("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, but Beneficial Owners are 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 Series 2021 Bonds 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 Series 2021 Bonds, except in the event that use of the Book-Entry System for the Series 2021 Bonds is discontinued.

To facilitate subsequent transfers, all Series 2021 Bonds 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 Series 2021 Bonds with DTC and their registration in the name of Cede & Co. or such other nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Series 2021 Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Series 2021 Bonds 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. Redemption notices shall be sent to DTC. If less than all of the Series 2021 Bonds within a maturity are to be redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such maturity to be redeemed.

Neither DTC nor Cede & Co. (nor such other DTC nominee) will consent or vote with respect to the Series 2021 Bonds unless authorized by a Direct Participant in accordance with DTC's Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the City as soon as possible after the Record Date. The Omnibus Proxy will assign Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Series 2021 Bonds are credited on the Record Date (identified in a listing attached to the Omnibus Proxy).

Payment of debt service and redemption proceeds with respect to the Series 2021 Bonds 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 Issuer or the Trustee on 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, the Trustee or the Issuer, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds and debt service to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Issuer or the 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.

BENEFICIAL OWNERS SHOULD CONSULT WITH THE DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS FROM WHOM THEY PURCHASE A BOOK ENTRY INTEREST TO OBTAIN INFORMATION CONCERNING THE SYSTEM MAINTAINED BY SUCH DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS TO RECORD SUCH INTERESTS, TO MAKE PAYMENTS, TO FORWARD NOTICES OF REDEMPTION AND OF OTHER INFORMATION.

THE ISSUER, THE CORPORATION AND THE TRUSTEE HAVE NO RESPONSIBILITY OR LIABILITY FOR ANY ASPECTS OF THE RECORDS OR NOTICES RELATING TO, OR PAYMENTS MADE ON ACCOUNT OF, BOOK ENTRY INTEREST OWNERSHIP, OR FOR MAINTAINING, SUPERVISING OR REVIEWING ANY RECORDS RELATING TO THAT OWNERSHIP.

The Trustee and the Issuer, so long as a book entry method of recording and transferring interest in the Series 2021 Bonds is used, will send any notice of redemption or of any Indenture amendment or supplement or other notices to Bondholders under the Indenture only to DTC (or any successor securities depository) or its nominee. Any failure of DTC to advise any Direct Participants, or of any Direct Participants or Indirect Participants to notify any Beneficial Owner, of any such notice and its content or effect will not affect the validity of the redemption of the Series 2021 Bonds called for redemption, the Indenture amendment or supplement, or any other action premised on notice given under the Indenture.

The Issuer, the Corporation and the Trustee cannot and do not give any assurances that DTC, Direct Participants, Indirect Participants or others will distribute payments of debt service on the Series 2021 Bonds made to DTC or its nominee as the registered owner of the Series 2021 Bonds, or any redemption or other notices, to the Beneficial Owners, or that they will do so on a timely basis, or that DTC will serve and act in a manner described in this Official Statement.

DTC may discontinue providing its services as securities depository with respect to the Series 2021 Bonds at any time by giving reasonable notice to the Issuer or the Trustee. Under such circumstances, in the event that a successor securities depository is not obtained, bond certificates are required to be printed and delivered.

In addition, the Issuer may decide to discontinue use of the system of book-entry transfers through DTC (or a successor securities depository). In that event, bond certificates will be printed and delivered.

SOURCES AND USES OF FUNDS

The proceeds of the Series 2021 Bonds and other available moneys will be used as described below:

Sources of Funds	
Par Amount of the Series 2021 Bonds	$ 9,710,000
Net Reoffering Premium	167,759
Series 2013 Bond Fund and Debt Service Reserve Fund Moneys	1,090,645
Total:	$10,968,404
Uses of Funds	
Deposit to Series 2013 Escrow Fund	$9,809,870
Deposit to Debt Service Reserve Fund	971,000
Underwriter's Discount and Costs of Issuance	186,665
Contingency	869
Total:	$10,968,404

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DEBT SERVICE REQUIREMENTS

The following table sets forth the amounts required to pay scheduled principal and interest on the Bonds during the Fiscal Years ending March 31 indicated below:

	Series 2006 Principal and Interest[1][2]	Series 2011 Principal and Interest[2]	Refunded Series 2013 Bonds	Series 2021 Principal[3]	Series 2021 Interest	Total Debt Service
2022	$ 188,000	$920,175	$524,653	$ --	$ --	$1,632,828
2023	188,000	916,403	--	25,000	249,931	1,379,334
2024	188,000	914,797	--	130,000	295,919	1,528,716
2025	188,000	915,668	--	130,000	290,719	1,524,387
2026	188,000	914,019	--	135,000	285,419	1,522,438
2027	188,000	--	--	1,035,000	262,018	1,485,018
2028	188,000	--	--	1,080,000	219,719	1,487,719
2029	188,000	--	--	1,120,000	184,819	1,492,819
2030	188,000	--	--	1,145,000	157,206	1,490,206
2031	188,000	--	--	1,175,000	127,472	1,490,472
2032	188,000	--	--	1,210,000	93,900	1,491,900
2033	188,000	--	--	1,245,000	57,075	1,490,075
2034	188,000	--	--	1,280,000	19,200	1,487,200
2035	535,000	--	--	--	--	535,000
2036	1,531,100	--	--	--	--	1,531,100
2037	1,534,500	--	--	--	--	1,534,500
2038	1,545,300	--	--	--	--	1,545,300
Totals:	$7,589,900	$4,581,062	$524,653	$9,710,000	$2,243,397	$24,649,012

(1) Assuming for the purpose of this Official Statement an average annual all-inclusive interest rate on the Series 2006 Bonds of 4.00% per annum.

(2) The Corporation currently intends to evaluate the refunding of the Series 2006 Bonds and the Series 2011 Bonds in the first quarter of 2022.

(3) Including mandatory sinking funds redemptions.

ESTIMATED DEBT SERVICE COVERAGE

	Fiscal Year 2021
Net Income Available to Pay Debt Service[1]	$9,483,178
Estimated Maximum Annual Debt Service on Bonds[2]	$1,528,716
Estimated Coverage	6.20X

(1) Excess of Corporation revenues and contributions (excluding contributions for property, plant and equipment) over Corporation expenses, adding back depreciation, amortization and interest expenses. Does not include revenues and expenses attributable to North Arkansas Medical Foundation or North Arkansas Medical Services. Includes COVID-19 related funding. See "FINANCIAL INFORMATION – Management Discussion of Fiscal Year 2020 and Fiscal Year 2021 Operating Results" in Appendix A to this Official Statement.

(2) See the bond year ending May 1, 2024, under the caption "DEBT SERVICE REQUIREMENTS" herein.

PLAN OF REFUNDING

A portion of the proceeds of the Series 2021 Bonds and other available moneys will be used to accomplish a current refunding of $9,740,000 outstanding principal amount of the Series 2013 Bonds (the "Refunded Bonds"). The Series 2013 Bonds were originally issued to refund a portion of the Series 2006 Bonds. The Series 2006 Bonds were originally issued to finance the acquisition, construction and equipping of various capital improvements to the Medical Center.

Upon the delivery of the Series 2021 Bonds, a portion of the proceeds thereof will be deposited with the Trustee, and will be utilized, together with available bond fund and debt service reserve fund moneys relating to the Refunded Bonds, to redeem the Refunded Bonds on the date of closing at 100% of the principal amount thereof plus accrued interest. The proceeds derived from the Series 2021 Bonds and other such available moneys to be deposited with the Trustee will be held uninvested in trust for the holders of the Refunded Bonds, and will be sufficient to pay the principal and interest due on the Refunded Bonds on the redemption date. After such deposit, the Refunded Bonds will no longer be deemed to be outstanding under the Indenture and will be secured solely by the amounts held by the Trustee for such purposes. See the caption "SOURCES AND USES OF FUNDS" herein.

THE ISSUER

Boone County, Arkansas (the "Issuer") is a political subdivision of the State of Arkansas authorized in furtherance of the public purposes described in Arkansas Code Annotated Sections 14-164-401 *et seq*., as amended (1998 Repl. & 2019 Supp.), known as the Local Government Capital Improvements Revenue Bond Act (the "Act"), to finance and refinance projects as defined in the Act, including health care facilities, by issuance of its revenue bonds.

The Issuer is located in northern Arkansas, approximately 140 miles north of Little Rock. The City of Harrison is the County Seat of the Issuer. The County is served by U.S. Highways 62 and 65 and by State Highways 7, 43 and 412.

The Issuer is governed by the Quorum Court of Boone County, Arkansas. The current County Judge and Quorum Court members of the Issuer and the years in which their terms expire are as follows:

Name	Term Expires
Robert Hathaway, County Judge	December 31, 2022
Jim Milum, District 1	December 31, 2022
Glenn Redding, District 2	December 31, 2022
Heath Kirkpatrick, District 3	December 31, 2022
Bryan Snavely, District 4	December 31, 2022
Fred Woehl Jr., District 5	December 31, 2022
Bobby Woods, District 6	December 31, 2022
Rodney Sullins, District 7	December 31, 2022
Jim Harp, District 8	December 31, 2022
Ralph H. Guynn, District 9	December 31, 2022
James C. Widner, District 10	December 31, 2022
David Thompson, District 11 & 12	December 31, 2022

Population figures for the Issuer, according to the United States Bureau of the Census, are as follows:

Year	Boone County Population
2015	37,119
2016	37,259
2017	37,459
2018	37,385
2019	37,432
2020	37,625

RISK FACTORS

THE PURCHASE OF THE SERIES 2021 BONDS IS SUBJECT TO CERTAIN INVESTMENT RISKS AND MAY NOT BE SUITABLE FOR SOME INVESTORS. PROSPECTIVE INVESTORS ARE ENCOURAGED TO READ THIS OFFICIAL STATEMENT IN ITS ENTIRETY, INCLUDING THE APPENDICES HERETO. PARTICULAR ATTENTION SHOULD BE GIVEN TO THE FACTORS DESCRIBED BELOW WHICH, AMONG OTHERS, COULD AFFECT THE PAYMENT OF THE PRINCIPAL OF AND INTEREST ON THE SERIES 2021 BONDS, AND COULD ALSO AFFECT THE MARKET PRICE OF THE SERIES 2021 BONDS TO AN EXTENT THAT CANNOT BE DETERMINED. THE FOLLOWING LIST OF RISK FACTORS IS NOT INTENDED TO PROVIDE AN EXHAUSTIVE LIST OF THE GENERAL OR SPECIFIC RISKS RELATING TO THE PURCHASE OF THE SERIES 2021 BONDS. ADDITIONAL RISK FACTORS RELATING TO AN INVESTMENT IN THE SERIES 2021 BONDS ARE DESCRIBED THROUGHOUT THIS OFFICIAL STATEMENT, INCLUDING THE APPENDICES HERETO, WHETHER OR NOT SPECIFICALLY DESIGNATED AS RISK FACTORS. ALL OR ANY OF THE FOLLOWING RISKS COULD BE EXACERBATED BY THE COVID PANDEMIC (DEFINED BELOW).

General

The Series 2021 Bonds are limited obligations of the Issuer and will not constitute an indebtedness, liability, general or moral obligation, pledge of the faith, loan of credit, or charge against the taxing power or any revenues of Boone County, Arkansas, the State of Arkansas, or any political subdivision thereof. The Series 2021 Bonds are secured by and payable solely from revenues derived from the operation of the Medical Center. Other than said revenues, the Series 2021 Bonds are <u>not</u> secured by a lien on or security interest in any real or personal property comprising the Medical Center. See the caption "SECURITY FOR THE BONDS" herein.

Except as otherwise noted herein, the Series 2021 Bonds are payable from the payments to be made by the Corporation under the Loan Agreement. No representation can be made or assurance given that revenues will be realized by the Corporation in amounts sufficient to pay maturing principal of and interest on the Series 2021 Bonds. Payments due under the Loan Agreement will be general corporate obligations of the Corporation. The ability of the Corporation to make such payments is dependent upon its general financial condition and upon many other factors and conditions which may change in the future to an extent and with effects that cannot be determined at this time. Such factors include, in addition to those mentioned below, the capabilities of the management of the Corporation, the confidence of physicians in the Corporation and the Medical Center, the relationship between the Corporation and other health care providers, changes in the economic conditions of the Corporation's service area, the demand for and utilization of inpatient and outpatient medical services, levels of and restrictions on federal reimbursement under Medicare and federal and State reimbursement under Medicaid, reimbursement from other third-party payors, competition, rates, the availability of physicians and trained support staff, demographic changes, malpractice claims, natural disasters, government legislation,

regulation and licensing requirements, and future economic and other conditions (including the impact of inflation) which may change in the future and which are not quantified or determinable at this time. **There can be no assurance given that the financial condition of the Corporation and/or utilization of the Corporation's services will not be adversely affected by any of such factors and conditions.**

The Corporation is a health care provider which derives a significant portion of its revenues from Medicare, Medicaid, Blue Cross and Blue Shield of Arkansas and other third-party payor programs. See the caption "SOURCES OF PATIENT SERVICE REVENUE" in Appendix A to this Official Statement. Federal and State health care legislation and regulatory and judicial actions are profoundly changing many aspects of operations and finances of health care providers, including the Corporation. The receipt of future revenues by the Corporation is therefore subject to, among other factors, federal and State policy changes affecting the health care industry and other conditions which are impossible to predict. Such conditions may include difficulties in maintaining, increasing and collecting fees and charges in amounts sufficient to maintain the scope and quality of health services and changes in reimbursement or prospective payment policies. The effect on the Corporation of recently enacted laws and regulations and of changes in federal and State laws and policies cannot be fully or accurately determined at this time.

This caption should be read in conjunction with the information concerning the Corporation and the Medical Center contained in Appendix A hereto, and with the financial statements of North Arkansas Medical System (the "System") and the Corporation attached hereto as Appendices C and D, respectively.

The following factors should be considered by prospective purchasers of the Series 2021 Bonds in evaluating the ability of the Corporation to meet its obligations under the Loan Agreement with respect to the Series 2021 Bonds. The discussion of risk factors is not, and is not intended to be, exhaustive.

COVID-19 Pandemic

General. In February 2020, the Centers for Disease Control and Prevention (the "CDC") confirmed the spread of COVID-19 to the United States. In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic (the "COVID-19 Pandemic"), and the United States federal government declared COVID-19 a national emergency. The COVID-19 Pandemic has had, and continues to have, numerous and varied medical, economic and social impacts, any and all of which may adversely affect the Corporation's business and financial condition. National, state and local governments have taken, and may continue to take, various actions, including the passage of laws and regulations, on a wide array of topics, in an attempt to control the spread of COVID-19 and to address the health and economic consequences of the COVID-19 Pandemic. Many of these government actions have caused substantial changes to the way health care is provided and how society in general functions. It is not clear how long such measures will remain in place or what any new measures will require.

It is generally expected that the overall impact of the COVID-19 Pandemic on the U.S. economy will continue to be broad- based and materially adverse. The full impact of the COVID-19 Pandemic on the operations and financial condition of the Corporation cannot be fully determined at this time due to the evolving nature of the COVID-19 Pandemic, including uncertainties relating to its duration and severity, and the future actions of governmental authorities to contain or to mitigate its impact, though such effect could be material and adverse. Management is continuously monitoring the situation and will adjust its response in concert with federal, state and local health officials and government authorities. See "APPENDIX A – NORTH ARKANSAS REGIONAL MEDICAL CENTER THE MEDICAL CENTER – Financial Information - Impact of COVID-19 Pandemic."

Operational Disruption. The COVID-19 Pandemic has affected the Corporation's ability to conduct normal business operations and, as a result, the operations, financial condition and financial performance of the Corporation has been, and may continue to be, materially adversely affected. As with nearly all industries and companies, the Corporation expects to encounter further disruption in its operations as a result of the COVID-19 Pandemic. As the COVID-19 Pandemic continues and new variants emerge or the COVID-19 Pandemic increases in severity or experiences intermittent surges,

capacity and acuity of patients may vary significantly from time to time and the Corporation's ability to conduct its operations may be materially adversely affected.

In order to reduce the spread of the virus, many state and local governments previously issued general "stay at home" or "shelter in place" orders that mandated social distancing, suspended elective surgeries and other non-emergency medical services, closed school systems and closed or limited non-essential business activities. In recent months, many states, including Arkansas, have begun the process of easing or eliminating such restrictions to allow more economic activity to take place only to partially reimplement portions of such restrictions due to a rise in numbers of positive COVID-19 cases and hospitalizations. The self-quarantines, stay-at-home or shelter-in-place orders, and suspension of voluntary procedures and surgeries have had an adverse impact on the operations and financial position of health care provider systems due to increased costs, potential reduction in overall patient volume and shifts in payor mix.

The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (*"*CMS*"*) issued guidance in March 2020 that all elective surgeries and procedures, including medical and dental, should be postponed nationwide to mitigate the burden on health systems due to increasing COVID-19 incidence and to preserve necessary facilities, equipment, supplies (including personal protective equipment), and personnel needed to treat COVID-19 patients. Several state and local governments, including Arkansas and its political subdivisions, subsequently issued directives, in varying forms, mandating such postponement. Although the restrictions on elective procedures have gradually been lifted, including in Arkansas, the restrictions have adversely affected revenues of health care providers. It cannot be predicted whether progression of the COVID Pandemic will require that similar or new restrictions be implemented in the future.

Developments with respect to COVID-19 and the State's responses thereto (including governmental mandates) occurred (and may occur in the future) at a rapid pace. Vaccinations for the COVID-19 virus became available to the general public (individuals 12 years of age or older) in spring 2021 and to children 5 to 11 years of age in fall 2021. Such vaccinations are now widely available to all individuals 5 years of age or older. The State has had a high degree of vaccine hesitancy, and per capita vaccinations in the State have lagged vaccinations in many other states. It is impossible to predict the continued effectiveness of the various vaccines, or the percentage of the general population who will opt to receive the vaccine. Accordingly, the spread of the virus may continue for an unknown period of time.

In spring 2021, the CDC eased its face covering recommendation. On April 28, 2021, the Arkansas General Assembly passed Act 1002 of 2021 ("Act 1002"), which prohibits a State agency or entity, a political subdivision of the State, or a State or local official from mandating the use of face coverings. In early August 2021, the Arkansas General Assembly met in special session for the purpose of considering amendments to Act 1002, but the session was adjourned with no amendments having been approved. On August 6, 2021, a circuit judge in Pulaski County, Arkansas entered an order granting a preliminary injunction that prohibits enforcement of Act 1002. The State has appealed such order to the Arkansas Supreme Court. On September 30, 2021, the Arkansas Supreme Court denied a request to stay the preliminary injunction issued by the lower court, which means that Act 1002 cannot be enforced at this time. The Corporation unable to anticipate the effect of continued litigation on the enforceability of Act 1002, and the Corporation is unable to anticipate the effect on the Medical Center and other Corporation facilities if face covering mandates are invalidated.

On September 9, 2021, President Biden announced a COVID-19 Action Plan (the "Action Plan") that, among other things, will require vaccinations for federal workers and contractors, as well as healthcare workers in hospitals, nursing facilities and other institutions that receive Medicare and Medicaid reimbursement. Failure to comply with these vaccination mandates may result in the loss of federal contracts and in exclusion from the Medicare and/or Medicaid programs. Unless an exemption is received, the Corporation may be subject to the Action Plan's requirements as a Medicare and Medicaid provider. Compliance with the Action Plan's vaccine mandates may increase operating costs of the

Medical Center or impact its ability to recruit and retain employees. Failing to agree to the Action Plan requirements may also result in the loss of Medicare and Medicaid reimbursements. These new federal requirements run counter to recent laws passed by the Arkansas General Assembly. In 2021, the Arkansas General Assembly passed Act 977 ("Act 977") (in April 2021) and Act 1115 ("Act 1115") (in October 2021), both of which include State limitations on vaccine mandates. Act 1115, which was adopted after the Action Plan was released, requires, among other things, employers that require or are mandated to require a COVID-19 vaccine to also provide a reasonable exemption process for employees. At this time, the System anticipates that it will review these requirements, along with additional information that may be received from the federal agencies, and take a measured approach to allow the Corporation to comply the Action Plan without violating State law. The Action Plan is the subject of multiple legal challenges from various states, including Arkansas. On November 6, 2021, the U.S. 5th Circuit Court of Appeals granted an emergency stay of the Action Plan's vaccine requirement with respect to businesses with one hundred or more employees. The Corporation is unable to predict the ultimate outcome of any legal challenges or whether enforcement of the Action Plan will be deferred or continued while any legal challenges are subject to litigation. At this time, the Corporation is unable to predict how it will be affected by the Action Plan's mandates. In addition, the Corporation is unable to predict the enforceability of Act 977 and Action 1115 if such legislation is challenged.

The treatment of COVID-19 or another highly contagious disease at the Corporation's facilities, as well as governmental and commercial entity responses to the COVID-19 Pandemic and resulting economic conditions, may adversely affect the Corporation's operations and financial performance in various ways, including but not limited to (1) an overburdening of facilities, (2) a quarantine, temporary shutdown or diversion of patients, (3) a disruption in the production or supply of pharmaceuticals, medical supplies and protective equipment and increases in the costs of such products, (4) professional or non-professional staff shortages or illnesses, (5) an increase in overhead costs due to additional costs incurred related to adjustments to the use of various facilities and to staffing, including overtime wages, mandated sick pay, and the use of more expensive contract staff to provide care, (6) significantly delayed payments from third party payors, (7) increased numbers of professional liability lawsuits, (8) a larger number of uninsured patients due to increased unemployment rates, or (9) reduced patient volumes and operating revenues due to unaffected individuals deferring elective procedures or otherwise avoiding medical treatment. As the effects of, and responses to, the COVID-19 Pandemic are far reaching and rapidly changing, the Corporation cannot predict the impacts or costs of the COVID-19 Pandemic, which could be material and adverse.

Economic and Market Disruption. The COVID-19 Pandemic 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. Additionally, it has resulted in volatility in the United States and global financial markets, and at times 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.

Governmental Relief. A variety of federal efforts have been initiated in response to the economic disruption caused by the COVID-19 Pandemic. On March 13, 2020, President Trump declared a "national emergency" under both the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, which allowed access to disaster relief funds to address the COVID Pandemic and related economic dislocation, and the National Emergencies Act, which allowed the U.S. Department of Health and Human Services (*"*DHHS*"*) to waive certain guidelines related to Medicare, Medicaid and the Children's Health Insurance Program to address the COVID-19 Pandemic. The U.S. Congress followed by passing a series of federal relief packages to address the COVID-19 Pandemic, including (1) the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (the "CPRSA Act"), (2) the Families First Coronavirus Response Act (the "Families First Act"), (3) the Coronavirus Aid, Relief, and Economic Security Act (the *"*CARES Act*"*), (4) the Paycheck Protection Program and Health Care Enhancement Act (the *"*Enhancement Act*"*), (5) the COVID-19 response and relief portions of the

Consolidated Appropriations Act, 2021 (the "Appropriations Act of 2021"), and (6) the American Rescue Plan Act the ("American Rescue Plan," and together with collectively, the CPRSA Act, the Families First Act, the CARES Act, the Enhancement Act and the Appropriations Act of 2021, the "COVID-19 Relief Acts"). The COVID-19 Relief Acts were largely designed to help fund COVID-19 testing, tracing and treatment and to provide economic relief and other support for individuals and businesses, including hospitals and other health care providers. COVID-19 Relief Act measures that may alleviate some of the financial strain on hospitals and other health care providers include, among others: (1) a $178 billion "Public Health and Social Services Emergency Fund" to reimburse eligible health care providers for "health care related expenses or lost revenues that are attributable to coronavirus" (the *"*Provider Relief Fund*"*), (2) an increase in the Federal Medicaid Assistance Percentage for state Medicaid program, and (3) various other Medicare and Medicaid policy changes that temporarily boost Medicare and Medicaid reimbursement or provide for additional flexibility in patient care during the COVID-19 emergency period.

Additionally, CMS allowed hospitals and other Medicare providers and suppliers to request an immediate advance of their future Medicare payments under its Accelerated and Advance Payment Program. For hospitals, such advanced payments are subject to recoupment commencing one year after the payment is received, with 25% of claims being withheld as recoupment for the first eleven months of repayment and 50% of claims being withheld as recoupment for the next six months of repayment. Thereafter, CMS may require the entire outstanding balance to be paid in full, or CMS can determine the percent of claims to be withheld until payment in full (plus a 4% interest rate). This program provided additional liquidity, but was not a grant or an additional source of revenue. For the fiscal year ended March 31, 2021, the Corporation received approximately $10,500,000 in advanced/accelerated Medicare reimbursements under this program. None of this amount was recorded as income. In April 2021, recoupment of the advance began. At September 30, 2021, the outstanding balance was $8,121,416 and is held in cash reserves and reflected as a liability on the Corporation's balance sheet.

The timing, adequacy and other ultimate effects of the COVID-19 Relief Acts or other federal or state stimulus relief programs on the Corporation, or the economy generally, cannot be predicted at this time. Although the federal government may consider future COVID-19 emergency response and relief legislation, the content and passage of any such legislation is uncertain. See "APPENDIX A – NORTH ARKANSAS REGIONAL MEDICAL CENTER THE MEDICAL CENTER – Financial Information - Impact of COVID-19 Pandemic" for a discussion of Pandemic Relief obtained by the Corporation to date.

The acceptance of funds from certain COVID-19 stimulus programs, including the Provider Relief Fund, is conditioned on eligibility and the acceptance of terms and conditions, and may be subject to other guidelines or requirements that may change from time to time. Additional guidance or clarifications concerning COVID-19 stimulus programs, including reporting, recordkeeping and repayment requirements, may be announced from time to time. Failure to comply with such guidelines or requirements could result in recoupment, False Claims Act liability, or other penalty.

Matters Relating to the Security for the Bonds

The obligation of the Corporation to make payments under the Loan Agreement and the Notes is secured by a first security interest in the Pledged Revenues, which security interest is assigned by the Issuer to the Trustee in the Indenture. See the caption "SECURITY FOR THE BONDS" herein. The effectiveness of the security interest in the Pledged Revenues may be limited by a number of factors, including: (1) provisions of the Social Security Act that may limit the ability of the Trustee to enforce directly the security interest in any of the Pledged Revenues in the form of reimbursement due under the Medicare or Medicaid programs and any other statutory or contractual provisions, grant award conditions, regulations or judicial decisions which may have a comparable effect with respect to any of the Pledged Revenues in the form of governmental appropriations, or governmental or private research services; (2) commingling of some or all of the Pledged Revenues and other moneys of the Corporation; (3) present and future statutory liens; (4) rights arising in favor of the United States of America or any agency

thereof; (5) rights of third parties in revenues not yet expended; (6) constructive trusts, equitable or other rights impressed or conferred by Federal or State courts in the exercise of equitable jurisdiction; (7) rights of third parties in Pledged Revenues converted to cash and not in possession of the Trustee; and (8) claims that might arise if appropriate financing or continuation statements are not filed in accordance with the Arkansas Uniform Commercial Code, as in effect from time to time.

In addition, in the event of the bankruptcy of the Corporation pursuant to the United States Bankruptcy Code, any receivables coming into existence and any Pledged Revenues received on or after the date which is 90 days (or, in some circumstances, one year) prior to the commencement of the case in bankruptcy court might not be subject to the pledge of the Corporation, and, under certain circumstances, a court of equity may have power to direct the use of the Pledged Revenues to meet expenses of the bankrupt entity before providing for the payment of the Bonds. With respect to Pledged Revenues subject to such security interest, the Issuer would occupy the position of an unsecured creditor.

The effect of insolvency, fraudulent transfer and bankruptcy laws relating to the enforceability of guaranties or obligations issued by one corporation in favor of the creditors of another or the obligation of one corporation to make debt service payments on behalf of another corporation is unsettled and the ability to enforce the Indenture against any transferee corporation which would be rendered insolvent thereby could be subject to challenge. In particular, such obligations may be voidable under the United States Bankruptcy Code or applicable state fraudulent conveyance statutes if the obligation is incurrence without "fair consideration" or "reasonably equivalent value" to the obligor and if the incurrence of the obligation thereby renders the corporation insolvent. The standards for determining the fairness of consideration and the manner of determining insolvency are not clear and may vary under the under the United States Bankruptcy Code, state fraudulent transfer statutes and applicable cases.

The remedies available to the Trustee and the owners of the Series 2021 Bonds upon an event of default under the Indenture, the Loan Agreement or the Series 2021 Note are in many respects dependent upon judicial actions that are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including specifically the United States Bankruptcy Code, the remedies provided in the Indenture, the Loan Agreement and the Series 2021 Note may not be readily available or may be limited and a court may decide to order the specific performance of covenants contained in such documents. The various legal opinions 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 general principles of equity and by bankruptcy, reorganization, insolvency or other similar laws affecting the rights of creditors generally.

All legal opinions with respect to the enforceability of the Loan Agreement, the Notes, the Indenture and any other financing documents are and will be expressly subject to a qualification that enforceability thereof may be limited by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium and other similar laws affecting the rights of creditors generally, and by general principles of equity.

General Economic Conditions: Bad Debt, Indigent Care and Investment Performance

Global economic conditions could have a number of negative impacts on the Corporation and on the health care industry generally. The COVID-19 Pandemic has, and continues to, adversely impact the economy of the United States.

Health care providers are economically influenced by the environment in which they operate. Any national economic difficulties may constrain corporate and personal spending, limit the availability of credit and increase the national debt and any federal and state government deficits. To the extent that unemployment rates are high, employers reduce their workforces and their budgets for employee health care coverage and private and public insurers may seek to reduce payments to health care providers or curb utilization of health care services, causing health care providers to experience decreases in insured patient volume and reductions in 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 health care

providers to increase uncompensated care. Economic downturns and lower funding of federal Medicare and state Medicaid (a significant source of income for the Corporation) and other state health care programs may increase the number of patients who are unable to pay for their medical and hospital services. These conditions may give rise to increases in health care providers' uncollectible accounts, or "bad debt," uninsured discount and charity care and, consequently, to reductions in operating income.

Although the Corporation has and will continue to maximize payment or reimbursement for the care it provides, it also recognizes its obligation to provide uncompensated care to the medically indigent. Obligations to provide uncompensated care can be derived from anti-dumping, emergency care, continuity of care and other laws that might apply to the Corporation. Many nonprofit hospitals have been and are subject to litigation attempting to establish obligations to provide uncompensated care based on the tax-exempt status of the hospital under federal or state law.

Investments provide the Corporation an important source of funds to support programs and services. Periodic market declines may adversely affect the Corporation's investment portfolio, including unrealized investment portfolio losses and reduced investment income, although the Corporation has experienced portfolio gains in recent years. Declines in investment portfolio values may reduce or eliminate non-operating revenues. Investment losses (even if unrealized) may trigger debt covenant violations and may jeopardize economic security. See Note 2 to the consolidated financial statements of the System attached as Appendix C to this Official Statement for a description of the System's investment return for the past two fiscal years. No assurances can be given that the market value of the Corporation's investments will not decline in the future. Any such decline could adversely affect the financial condition of the Corporation and its ability to satisfy its payment obligations with respect to the Series 2021 Bonds. Market declines could also limit the Corporation's access to the credit markets and increase its borrowing costs.

Legislative and Regulatory Changes; Health Care Reform

In recent years, health care reform at both the federal and state levels has been identified as a priority by political leaders and candidates, business leaders and public advocates. In 2010, H.R. 3590, the Patient Protection and Affordable Care Act, amended by H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") was enacted. Various aspects of the Affordable Care Act are described below.

A significant component of the Affordable Care Act is reformation of the sources and methods by which consumers pay for health care for themselves and their families, and by which employers procure health insurance for their employees and dependents of their employees and, as a consequence, expansion in the overall number of consumers of health care services. The Affordable Care Act was designed, in substantial part, to make available, or subsidize the premium costs of, health care insurance for some of the millions of uninsured (or underinsured) consumers, in particular those who fall below certain income levels. The Affordable Care Act proposed to accomplish that objective through various provisions, including the following: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents; (ii) the provision of means tested subsidies for premium costs to certain individuals and families based upon their income relative to federal poverty levels; (iii) the requirement that individual consumers obtain, and certain employers provide, a minimum level of health care insurance, and the provision of a penalty in the form of taxes on consumers and employers that do not comply with these mandates; (iv) the expansion of private commercial insurance coverage generally through reforms such as prohibition on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps; and (v) the expansion of existing public programs for individuals and families, including the Medicaid program. The Affordable Care Act has produced some of the results expected from its passage – an increase in utilization of health care services by those who were avoiding or rationing their health care. Although bad debt expenses and/or charity care may have been reduced as a result of some provisions of the Affordable Care Act, increased utilization has also resulted in increased

variable and fixed costs of providing such health care services, which costs may or may not be offset by increased revenues.

The Affordable Care Act contains a number of coverage expansion measures, including prohibitions against insurers denying coverage or imposing coverage exclusions on children with pre-existing conditions, provisions permitting young adults to obtain coverage under their parents' plans, and restrictions on insurance policy coverage limits. An array of coverage expansion, health insurance regulation and tax increase measures are also in effect, including broad insurance coverage mandates for individuals and certain employer mandates.

In June 2012, in response to litigation brought by a group of state attorneys general, the U.S. Supreme Court *(National Federation of Independent Business v. Sebelius)* upheld most provisions of the Affordable Care Act while also substantially limiting the law's expansion of Medicaid, allowing states to choose between participating in the expansion while receiving additional federal payments or foregoing the expansion and retaining existing payments. Instead of fully expanding the Arkansas Medicaid program as envisioned by the Affordable Care Act, the State of Arkansas sought and obtained a waiver from the federal government to instead institute a hybrid approach commonly referred to as the "private option." Under the current version of the private option, individuals in Arkansas earning less than 138% of the federal poverty level income amount are eligible to receive a government subsidy to purchase private insurance through an insurance exchange. The adoption of the State's private option program by the Arkansas General Assembly, effective June 1, 2014, resulted in insurance coverage to an estimated 285,000 previously uninsured persons and a corresponding decrease in the costs of uncompensated care to Arkansas hospitals. The Arkansas private option program had had a significant positive impact on the Corporation's financial performance since its inception. Any repeal or revision of the Affordable Care Act could potentially invalidate the Arkansas private option program, which, in turn, could have a material negative impact on patient revenues of Corporation and its ability to satisfy its payment obligations with respect to the Series 2021 Bonds.

Under State law, the private option program requires annual reauthorization and appropriation by a vote of at least 75% of the senators and representatives in each chamber of the Arkansas General Assembly. Approval in 2018 was accomplished with 27 votes (27 required) in the Senate and 79 votes (75 required) in the House. Reauthorization was obtained in 2016, 2017 and 2018 only after a number of amendments to the program such as (i) requiring the payment of small premiums by persons earning between 100% and 138% of the federal poverty level income amount, (ii) the requirement for able-bodied recipients to work, be engaged in work or education training, or volunteer with a charitable organization (the "Work Requirement"), (iii) reducing the retroactive eligibility standard for Medicare coverage from 90 days before enrollment to 30 days prior to enrollment, and (iv) rebranding of the program as "Arkansas Works." The amendments were approved through a waiver process with the Centers for Medicare and Medicaid Services ("CMS").

The Work Requirement, the first of its kind in the nation, became effective in June of 2018, and requires non-exempt beneficiaries to report 80 hours each month of work, work training, education or community service. The reporting process, which required the submission of hours through an online portal, proved to be controversial. In August 2018, Arkansas Works had 265,223 total enrollees. By December 2018, approximately 18,000 beneficiaries had been removed from the program. In March of 2019, the Work Requirement was struck down by a federal judge in the United States District Court for the District of Columbia *(Gresham v. Azar)*. In February 2020, a federal appeals court panel from the United States Court of Appeals for the District of Columbia Circuit unanimously upheld the lower court's ruling striking down the Work Requirement. The Trump administration petitioned the United States Supreme Court to hear an appeal of the decision and that petition was granted in December 2020. Oral arguments, originally set for March 2021, were cancelled at the request of the acting U.S. Solicitor General. The Biden administration has reversed the position of the Trump administration regarding waiver approvals for work requirements in conjunction with the Medicaid Program. On March 17, 2021,

CMS revoked the waiver previously issued to Arkansas. No further action has been taken by the Supreme Court with regard to the appeal.

Because the earlier decision did not grant a stay, the Work Requirement was not in effect after March of 2019 and individuals who lost eligibility for Arkansas Works coverage are currently eligible to reapply. Reauthorization and appropriation of the program for 2019 was impacted as a result of the initial decision by the federal judge; although the bill to fund the Division of Medical Services, which implements the state Medicaid program, passed the Senate, it failed in the House of Representatives, achieving only 58 votes (75 required). Brought before the chamber again, the bill received the 75 votes needed to pass to fund the program for 2019. Since the Medicaid Expansion in 2013, it has proven difficult to achieve the 75 necessary votes necessary for the Division of Medical Services' appropriation. Reauthorization was extended for another year without controversy in April 2020. In 2021, the reauthorization and appropriation bill passed on its fifth try in the House, eventually receiving 78 votes to pass, though it passed on the first vote in the Senate.

Given the annual appropriation requirement for the Arkansas private option (which is also subject to a lengthy review and approval process by CMS with respect to any changes to the program), the State budget challenges stemming from the COVID-19 pandemic, and the current political environment, the long-term status of Arkansas' private option program cannot be assured. In order for the program to continue into the State's next fiscal year, it will be necessary for the Arkansas House of Representatives and Senate to approve reauthorization by the 75% supermajorities of senators and representatives described above in the regular session of the Arkansas General Assembly which reconvenes in January 2023. As noted above, CMS has rescinded the waivers that permitted the work requirements discussed above in connection with Medicaid expansion in several states, including Arkansas. Arkansas has filed an administrative appeal of its formal rescission. Although a rescission of such waivers is subject to legal challenge by the states that enacted work requirements in reliance thereon, the results of any such challenge are impossible to predict.

Given these developments, legislation known as the Arkansas Health and Opportunity for Me Act ("ARHOME") was enacted by the Arkansas General Assembly in March 2021 and signed by the Governor. ARHOME retains the private insurance model for purchasing health insurance plans for participants that exists in the current Arkansas Works program, but makes the private option available only to those applicants who meet certain work requirements similar to those previously included in the Arkansas Works program. Otherwise qualifying applicants who do not satisfy such work requirement incentives will nevertheless be covered under ARHOME on a fee-for-service basis, under which providers are generally reimbursed for services at a lesser rate than by private insurers. Approval from CMS is required for these provisions, which Arkansas requested in July 2021. There can be no assurance that CMS approval will be granted for ARHOME, and if and in what form any future continuation of the Medicaid expansion program in Arkansas will be enacted, and, if enacted, the impact on Medicaid revenues received by the Corporation.

Given the annual appropriation requirement for the Arkansas private option program (which is also subject to a lengthy review and approval process by CMS with respect to any changes to the program), potential State budget challenges, and the current political environment, the long-term status of Arkansas' private option program cannot be assured.

Any repeal or revision of the Arkansas private option program that would reduce the number of Arkansans with insurance coverage could have a material negative impact on patient revenues of the Corporation and its ability to satisfy its payment obligations with respect to its indebtedness, including the Series 2021 Bonds.

Any repeal or amendment of the Affordable Care Act (or change in the implementation thereof) or of the Arkansas private option expansion could have a material negative impact on revenues of the Corporation and its ability to satisfy its payment obligations under the Loan Agreement with respect to the Series 2021 Bonds.

In 2014, the federal and state health insurance exchanges intended to facilitate the purchase of health insurance became operational. The federal exchange and some state exchanges initially experienced widespread technical difficulties and lower than expected enrollment figures. Issues with respect to the exchange have been largely resolved. Health insurance providers participating in the health insurance exchanges are subject to regulation of benefit packages and review of premiums. Purchasers of insurance on these exchanges meeting certain income limitations are eligible for tax credits. The U.S. Supreme Court has upheld United States Treasury Regulations permitting health insurance exchange purchasers to receive tax credit subsidies, regardless of whether the purchase is made through a federal or a state-operated health exchange.

In 2015, the employer mandate, after being delayed twice, went into effect for certain employers, and in 2016, the employer mandate for smaller employers became effective. In November 2015, the Bipartisan Budget Act of 2015 repealed a provision of the Affordable Care Act which required employers offering one or more health benefit plans and having more than 200 full-time employees to automatically enroll new full-time employees in a health plan.

The Affordable Care Act contains provisions aimed at reducing Medicare and Medicaid reimbursements to providers and reducing projected growth of the Medicare program, including reducing Medicare Advantage payments, reducing reimbursement under the disproportionate share hospital ("DSH") program, and tying provider payments more closely to efficiency and quality outcomes. Another major component of the Affordable Care Act is its enhanced health care program integrity provisions. The Affordable Care Act contains more than thirty-two sections relating to health care fraud and abuse and federal health care program integrity, as well as significant amendments to existing criminal, civil and administrative anti-fraud statutes, Specially, the Affordable Care Act amended the False Claims Act ("FCA") (described below under the caption "REGULATION OF THE HEALTH CARE INDUSTRY –Fraud and Abuse Laws and Regulations –*Billing and Reimbursement Practices*") regarding the timing of the obligation to reimburse overpayments. Further, the Affordable Care Act authorizes the Secretary of Health and Human Services ("HHS") to exclude a provider's participation in the Medicare, Medicaid and the Children's Health Insurance Program programs, as well as to suspend payments to a provider, pending an investigation of a credible allegation of fraud against the provider. The potential for increased legal exposure due to the Affordable Care Act's enhanced compliance and regulatory requirements, disclosure and transparency obligations, quality of care expectations and extraordinary enforcement provisions could increase the Corporation's operating expenses.

With expanded health insurance coverage under the Affordable Care Act, the Corporation has benefitted from reduced charity care write-offs and bad debt expenses. A portion of those gains, however, have been offset by the increase in high deductible insurance plans under which insured patients are more likely to fail to make payment. The Corporation has also benefitted from the expansion of the Medicaid program and increased Medicaid reimbursement for services provided by employed physicians. Conversely, the Affordable Care Act has resulted in lower Medicare reimbursements and reduced Medicare and Medicaid DSH funding. The new reimbursement methodologies have resulted in increased pressures for greater operational efficiency. Also, since commercial and managed care insurers have experienced increased regulation and fees, the Corporation's negotiations with those insurers have become more difficult.

Many states have also enacted or are considering health care reform measures. Both as a part of recent reform efforts and throughout the preceding decades, numerous legislative proposals have been introduced or proposed in the Arkansas General Assembly aimed at effecting major changes in health care policy and systems. The purpose of much of the statutory and regulatory activity has been to control health care costs, particularly costs paid under the Medicaid program. A significant portion of the Corporation's revenue is derived from the Medicaid program. It is not known what additional proposals may be proposed or adopted or, if adopted, what effect such proposals would have on the Corporation's operations or revenue.

Legislative Efforts to Repeal, Replace or Amend the Affordable Care Act

The content and implementation of the Affordable Care Act has been, and remains, highly controversial. Accordingly, the Affordable Care Act has continually faced multi-front challenges, including repeated repeal efforts, since its enactment. Management cannot predict the impact any major modification or repeal of the Affordable Care Act, or any replacement health care reform legislation, might have on the Corporation's business or financial condition, although such effects could be material. In particular, any legal, legislative or executive action that reduces federal health care program spending, increases the number of individuals without health insurance, reduces the number of people seeking health care, or otherwise significantly alters the health care delivery system or insurance markets could have a material adverse effect on the Corporation's business or financial condition.

Several attempts to repeal and/or replace the Affordable Care Act have been made since its passage. While past attempts have not been successful in gaining the approval of both chambers of Congress to repeal the Affordable Care Act in its entirety, certain portions of the Affordable Care Act have been repealed or their implementation delayed. Most notably, as a result of the passage of the Tax Cuts and Jobs Act of 2017, the Affordable Care Act requirement that individuals obtain health insurance or pay a penalty has been eliminated.

In addition to the potential legislative changes discussed above, Affordable Care Act implementation and the Affordable Care Act insurance exchange markets can be significantly impacted by executive branch actions.

As a result of a ruling in a lawsuit *(House of Representatives v. Azar (nee Price, nee Burwell*)) challenging the legality of cost-sharing subsidies paid by the federal government to insurance companies that offer coverage under the Affordable Care Act insurance exchanges, President Trump announced in October 2017 that the payment of such subsidies would terminate immediately. Such action impacted the insurance exchange market by reducing the number of plans available on the Affordable Care Act health insurance exchanges and significantly increasing insurance premiums. In response to such termination, health insurers offering qualified plans enacted rate increases for 2018 and 2019. In Arkansas, the four insurers offering qualified plans enacted 2018 rate increases ranging from 14.2% to 24.78%. Rate increases for 2019 showed more stability, with increases averaging from 1% to 4.4%. Approved rate increases for 2020 ranged from 0.51% to 2.89%, and approved rate changes for 2021 ranged from a decrease of -1.77% to an increase of 5.87%. A Kaiser Family Foundation study concluded that 2018 premium increases were a reaction to the termination of cost-sharing subsidy payments, and the 2019, 2020 and 2021 rate changes suggest that the market is becoming much more stable and sustainable. Management cannot predict the likelihood or effect of any such executive actions on the Corporation's business or financial condition, though such effects could be material.

More recent executive action presents further questions, the effects of which are impossible to predict. The Office of Management and Budget issued a proposal on May 6, 2019 to change how inflation is used to calculate the official definition of poverty used by the Census Bureau. A final notice of rulemaking has not been published. A lower estimate of inflation would likely mean the poverty level would rise at a slower rate, potentially resulting in the loss of healthcare coverage. The effect of this executive action, as well as any other executive action issued in the future impacting the Affordable Care Act, on the business and financial condition of the Corporation cannot be predicted.

It is not known which additional actions may be proposed or adopted or, if adopted, what effect such actions would have on the Corporation's operations or revenue. However, the increased focus and interest on federal and state health care reform may increase the likelihood of further significant changes affecting the health care industry in the near future. There can be no assurance that recently enacted, currently proposed or future health care legislation, regulation or other changes in the administration or interpretation of governmental health care programs will not have an adverse effect on the Corporation. Reductions in funding levels of the Medicare or Medicaid programs, changes in payment methods under the Medicare and Medicaid programs, reductions in State funding, or other legislative or regulatory

changes could materially reduce the Corporation's patient service revenue. See the caption "SOURCES OF PATIENT SERVICE REVENUE" in Appendix A hereto.

Third-Party Reimbursement

Apart from reimbursement by the federal government under Medicare and the federal and state governments under Medicaid, a substantial portion of the Corporation's revenue is provided by private third-party payors (such as health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other commercial insurers). Generally, reimbursement received from large national HMOs and PPOs and commercial insurance companies that have specific contracts with the Corporation is lower than reimbursement received from smaller networks and commercial insurance companies which do not have contracts with the Corporation. Future contract negotiations between such third-party payors and the Corporation, and other efforts of these third-party payors and of employers to limit health-care costs, could adversely affect the level of utilization of the Corporation's services, or reimbursement to the Corporation, or both. In addition, it is possible that competitive pricing of plan premiums could cause an HMO or PPO or insurance carrier to operate at a loss and expose the Corporation to delays in payment or nonpayment of claims for services to plan participants or insured patients.

Changes in sources of revenue and case mix intensity may also adversely affect the Corporation's operating revenue. For example, if patients formerly covered by commercial insurance programs that pay full hospital and physician charges shift to high deductible health plans, health savings accounts ("HSAs"), HMOs, PPOs or other third-party payors such as contracted insurance that pay lower negotiated rates, the adjustments to determine net patient service revenue would increase, which (absent an offsetting decrease in operating expenses) would result in a decrease in operating income. In addition, if the average severity of illness or condition of patients covered by a capitated plan or contracted insurance with per diem charges or charges based on diagnosis were to increase after execution of the related plan contract, operating expenses could increase without an offsetting increase in operating revenue. Approximately 35.4% of the patient service revenue of the Corporation for Fiscal Year 2021 was derived from patients in managed care plans (other than Medicare and Medicaid managed care plans), including contracted insurance. Traditional health insurance programs are increasingly reimbursing outpatient services using case rates and bundled payments for related services. Those payment methodologies put a provider at risk for cases requiring more services than are assumed by the applicable case rate or bundled payment.

Blue Cross and Blue Shield of Arkansas ("BCBSA") reimburses hospitals under a Participating Hospital Agreement, pursuant to which hospitals are reimbursed on a DRG price reimbursement system. Such Participating Hospital Agreement establishes DRGs for all impatient care and pays the lower of actual charges or the DRG plus a percentage of the actual charges in excess of the DRG based on financial incentives. BCBSA has the right to cancel its Participating Hospital Agreement with a hospital by giving advance notice and could therefore use its power to cancel in an effort to reduce its payments in order to improve its financial position. As the impact of any such reduction in payment would be dependent upon the extent of such reduction, it is not possible to estimate the effect such a reduction in payment would have on the revenues of the Corporation.

It is expected that the provisions of the Affordable Care Act (e.g. coverage requirements, prohibitions on pre-existing conditions exclusions, excise taxes, health insurance exchanges), whether or not amended, will continue to cause major changes for third-party payors, but considerable uncertainty remains as to future changes and their implementation and impact. The implementation of such provisions could adversely affect the levels of reimbursement received by the Corporation for services provided as well as potentially increasing exposure to further self-pay deductibles or coinsurance and the cost of providing services.

Growth of Alternative Delivery Systems

In recent years, for various reasons, including changes in methods of payments for health care services, hospitals generally have experienced reductions or only small increases in the average length of stay for patients and a decline (or a relative decline compared to service area population growth) in hospital admissions. Medicaid, Medicare and other purchasers of health care services continue to review their benefit plans in order to create incentives for cost containment. Increases in deductibles and co-payments and increased offerings of HSAs for employer-provided insurance result in increased delays and difficulties in collecting hospital reimbursement. Traditional health insurance programs, which pay for services on a fee-for-service basis, are giving way to health insurance programs being offered with economic incentives for employees and employers. Certain private insurance companies' contract with some hospitals on an "exclusive" or a "preferred" provider basis, and some insurers have introduced PPOs. Under an exclusive provider plan, which includes most HMOs, private payors limit coverage to those services provided by selected hospitals. With this contracting authority, private payors direct patients away from nonselected hospitals by denying coverage for services provided by them.

Increased sensitivity to the cost of health care has led to substantial growth of HMOs, PPOs and other alternative delivery systems. The growth of alternative delivery systems can have negative impacts on health care providers in several ways. A provider generally will not be able to serve the patients of alternative delivery systems with which it does not contract, and a provider is generally required to substantially reduce its charges to obtain a contract to serve alternative delivery system patients. Also, the alternative delivery systems market is becoming increasingly competitive, and many of the alternative delivery systems may not survive. A health care provider that has a contract with an alternative delivery system in poor financial condition may be responsible for providing care even though the alternative delivery system is unable to pay the provider for the services. Health care cost sensitivity has also caused more employers to provide all or part of their employee health insurance benefits through self-insurance mechanisms, and self-insured employers are increasingly using aggressive tactics and third-party administrators to shop for discounts. State timely payment regulations may not apply to the self-insured market, and self-insured employers are not always as financially stable as larger, state-regulated health plans.

Most HMOs, PPOs and contracted insurers currently pay health care providers on a discounted fee-for-service basis, or on a case rate or a fixed rate per day of care, all of which may result in payment at less than actual cost. Also, the volume of patients directed to a provider under an HMO or PPO contract or under a contracted insurance arrangement may vary significantly from projections. Some HMOs are now offering or mandating a "capitation" payment method under which providers are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" to or otherwise directed to receive care from a particular provider. In a capitated payment system, the provider assumes a financial risk for the cost and scope of care given to such HMO enrollees for the term of the contract. The Corporation has not entered into any contracts which provide for capitated services. The growth of PPOs, HMOs and alternative delivery systems may require the Corporation to substantially reduce its charges to service members of such plans, and any such reduction in charges could materially adversely affect the Corporation's operating revenue.

The Affordable Care Act establishes a Medicare Shared Savings Program that seeks to promote accountability and coordination of care through the creation of Accountable Care Organizations ("ACOs"). The program allows hospitals, physicians and others to form ACOs and work together to invest in infrastructure and redesign integrated delivery processes to achieve high quality and efficient delivery of services. ACOs that achieve quality performance standards are eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. The final rules regarding ACOs are complex and qualification requirements are formidable. Participants in ACOs in some events have to marshal a large upfront financial investment to form unique and untested

ACO structures, which may or may not succeed in gaining qualification. For those that do qualify, it is unknown whether the savings will be sufficient to recoup the initial investment. In addition, although the regulation provides for waivers of certain federal laws, there may remain regulatory risks for participating hospitals, as well as financial and operational risks. In particular, since the federal ACO regulation would not preempt state law, providers participating as a federal ACO must be organized and operated in compliance with existing state statutes and regulations. It remains unclear whether investments made by providers who pursue federal ACO status will be warranted by increased payment. Nevertheless, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change. The potential impacts of these initiatives and the regulation for ACOs are unknown, but they are expected to introduce greater risk and complexity to health care finance and operations. The Corporation participates in an ACO, Baxter Physician Partners, with Baxter Regional Medical Center located in Mountain Home, Arkansas.

Integrated Delivery Systems

Health facilities and health care systems may own, control or have affiliations with relatively large physician groups and independent practice associations. Frequently, the sponsoring health facility or health system will be the capital and funding source for such alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits.

These types of alliances are generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care, to increase physician availability to the community and/or to enhance the managed care capability of the affiliated hospitals and physicians. However, these goals may not be achieved, and an unsuccessful alliance may be costly and counterproductive to all of the above stated goals. See Appendix A hereto which includes information on the Corporation's employment and recruitment of physicians.

These types of alliances are likely to become increasingly important to the success of hospitals as a result of changes to the health care delivery and reimbursement systems that are intended to restrain the rate of increases of health care costs, encourage coordinated care, promote collective provider accountability and improve clinical outcomes. The Affordable Care Act authorizes several alternative payment programs for Medicare that promote, reward or necessitate integration among hospitals, physicians and other providers.

Whether these programs will achieve their objectives and be expanded or mandated as conditions of Medicare participation cannot be predicted. However, Congress and the Centers for Medicare and Medicaid Services ("CMS") have clearly emphasized continuing the trend away from the fee-for-service reimbursement model, which began in the 1980s with the introduction of the prospective payment system for inpatient care, and toward an episode based payment model that rewards use of evidence-based protocols, quality and satisfaction in patient outcomes, efficiency in using resources, and the ability to measure and report clinical performance. This shift is likely to favor integrated delivery systems, which may be better able than stand-alone providers to realize efficiencies, coordinate services across the continuum of patient care, track performance and monitor and control patient outcomes. Changes to the reimbursement methods and payment requirements of Medicare, which is the dominant purchaser of medical services, are likely to prompt equivalent changes in the commercial sector, because commercial payors frequently follow Medicare's lead in adopting payment policies.

While payment trends may stimulate the growth of integrated delivery systems, these systems carry with them the potential for legal or regulatory risks. Many of the risks discussed in "REGULATION OF THE HEALTH CARE INDUSTRY" below may be heightened in an integrated delivery system. Current laws, in many respects, were not designed to accommodate coordinated action among hospitals, physicians and other health care providers to set standards, reduce costs and share savings, among other things. In October 2011, CMS, the Federal Trade Commission, and the Department of Justice jointly issued guidance regarding waivers and safe harbors to enable providers to participate in the Medicare Shared Savings Program. Although CMS and the agencies that enforce these laws are

expected to continue to institute new regulatory exceptions, safe harbors or waivers that will enable providers to participate in payment reform programs, there can be no assurance that such regulations will be forthcoming or that any regulations or guidance issued will sufficiently clarify the scope of permissible activity. State law prohibitions or state law requirements may also introduce complexity, risk and additional costs in organizing and operating integrated delivery systems. Tax-exempt hospitals and health systems also face the risk in affiliating with for-profit entities that the Internal Revenue Service will determine that compensation practices or business arrangements result in private benefit or private use or generate unrelated business income for the hospitals and health systems.

In addition, integrated delivery systems present business challenges and risks. Inability to attract or retain participating physicians may negatively affect managed care, contracting and utilization. The technological and administrative infrastructure necessary both to develop and operate integrated delivery systems and to implement new payment arrangements in response to changes in Medicare and other payor reimbursement is costly. Hospitals may not achieve savings sufficient to offset the substantial costs of creating and maintaining this infrastructure.

Health care providers, responding to health care reform and other industry pressures, are increasingly moving toward integrated delivery systems, managing the health of populations of individuals, patient-centered medical homes, bundled payments, and capitated insurance plans. Some health care organizations that traditionally operated hospitals may, directly or in partnership, take on actual insurance risk.

Risks Associated with the Provision of Uncompensated Care

Although the Corporation has and will continue to maximize payment or reimbursement for the care it provides, the Corporation recognizes its obligation to provide uncompensated care to the medically indigent. Obligations to provide uncompensated care can be derived from anti-dumping, emergency care, continuity of care and other laws that might apply to the Corporation. See "REGULATION OF THE HEALTH CARE INDUSTRY—Fraud and Abuse Laws and Regulations" below. See also "—Internal Revenue Service Policy Regarding Maintenance of 501(c)(3) Tax Exemption" below under this caption as to additional requirements and limitations for nonprofit entities under the Affordable Care Act and the federal tax code. Also, many nonprofit entities have been and are subject to litigation attempting to establish obligations to provide uncompensated care based on the tax-exempt status of the entity under federal or state law. Increased unemployment or other adverse economic conditions could increase the proportion of patients who are unable to pay all or any of the cost of their care.

Competitive Environment

The Corporation could face increased competition in the future from other hospitals, from skilled nursing facilities and from other forms of health care delivery that offer health care services to the population which the Corporation currently serves. This includes the construction of new or the renovation of existing hospitals and skilled nursing facilities, health maintenance organization facilities, ambulatory surgery centers, freestanding emergency facilities, private laboratory and radiological services, home care, intermediate nursing home care, preventive care and drug and alcohol abuse programs.

In addition, competition could result from forms of health care delivery that are able to offer lower priced services to the population served by the Corporation. These services could be substituted for some of the revenue-generating services currently offered by the Corporation. The services that could serve as substitutes for hospital services include skilled and specialized nursing facilities, diagnostics, home care, preventive care, and drug and alcohol abuse programs. Competition may also come from specialty hospitals or organizations, particularly those facilities providing specialized services in areas with high visibility and strong margins, such as cardiac services and surgical services, and having specialty physicians as investors.

The State does not currently have a certificate of need program; consequently, entry of additional providers of health care in the Corporation's service area is not limited by any State requirement of need determination.

Various health care providers in the State have engaged in mergers or joint ventures with other providers resulting in consolidation of competing facilities. The Affordable Care Act (particularly the ACO model) could create incentives for vertical integration, incorporating a range of health care settings. The Corporation's ability to maintain a rate structure and preserve or increase its market share (especially with respect to private pay and commercially insured patients) may be inhibited by the existence of other players in the market having a greater ability to provide services at reduced rates or to negotiate for increased shares of the market.

The Corporation recently entered into a collaborative venture with CoxHealth, Springfield, Missouri. The health systems will jointly open a new physician practice facility in Harrison, Arkansas in order to expand healthcare access for residents of North Central Arkansas. The facility will be located in an existing building owned by North Arkansas Medical Services. CoxHealth will manage the renovation of the building. When completed, the building will house a variety of physician practices from both NARMC and CoxHealth, thereby offering patients convenient access to complimentary services offered by both health systems. As part of its ongoing planning process, the Corporation has considered and will continue to consider potential affiliations or alignments with other healthcare providers.

For a discussion of the hospital competitors in the primary and secondary service areas of the Medical Center, see the caption "COMPETITION" in Appendix A attached to this Official Statement.

Potential Negative Rankings Based on Clinical Outcomes, Quality, Patient Satisfaction and Other Performance Measures

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 and rank the quality, safety and cost of health care services provided by hospitals and physicians. HIS has established the "Hospital Compare" website (http://www.hospitalcompare.hhs.gov/), which is expected to be expanded and improved as Affordable Care Act provisions place more emphasis on the collection and utilization of health care data. Published rankings such as "score cards," tiered hospital networks with higher copayments and deductibles for nonemergent use of lower-ranked providers, "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of health care providers and the members of their medical staffs and to influence the behavior of consumers and providers such as the Corporation. Measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology are becoming increasingly common. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition.

The Affordable Care Act includes "value-based purchasing" provisions, which provide that Medicare inpatient payments to hospitals will be determined, in part, based on a program under which value-based incentive payments are made in a fiscal year to hospitals based on the quality of care provided during that fiscal year. The program was funded through the reduction of hospital inpatient care payments by 1%, beginning in federal fiscal year 2013, progressing to 2% in federal fiscal year 2017. This reduction may be offset by incentive payments for hospitals that meet or exceed certain quality standards. The Corporation experienced or will experience adjustments to hospital inpatient care payments of $15.54 (increase), $4.12 (increase), $17.91 (decrease), $11.78 (increase) and $10.13 (decrease) per Medicare admission in fiscal years 2017, 2018, 2019, 2020 and 2021, respectively. These provisions are expected to increase the importance of hospital performance data, which will be publicly available on the Hospital Compare website. See "REGULATION OF THE HEALTH CARE INDUSTRY — Medicare Reimbursement — Part A Reimbursement of Inpatient Services" below.

Environmental Factors Affecting the Health Care Industry

Health care facilities and operations are subject to a wide variety of federal, state and local environmental and occupational and safety laws and regulations. Among the types of regulatory requirements faced by health care providers are: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos, polychlorinated biphenyls and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials; and requirements for training employees in the proper handling and management of hazardous materials and wastes. In their role as owners and operators of properties or facilities, health care providers may be responsible for investigating and remedying hazardous substances located on or migrating from their property. Typical health care operations include, in various combinations, the handling, use, storage, transportation, disposal and discharge of infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants or contaminants. For this reason, health care operations are particularly susceptible to the practical, financial and legal risks associated with such environmental and safety laws and regulations, and noncompliance may result in damage to individuals, property or the environment; may interrupt operations or increase their cost, or both; may trigger investigations, administrative proceedings, penalties or other government agency actions; and may result in legal liability, including damages, injunctions or fines, some or all of which may not be covered by insurance. There can be no assurance that the Corporation will not be materially adversely affected by such environmental and safety risks.

Information Systems

The ability to adequately price and bill health care services and to accurately report financial results depends on the integrity of the data stored within information systems, as well as the operability of such systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. Technology malfunctions, malware or failure to understand and use information systems properly could result in the dissemination of or reliance on inaccurate information and affect patient safety, as well as in disputes with patients, physicians and other health care professionals. There can be no assurance that efforts to upgrade and expand information systems capabilities, protect and enhance these systems, and develop new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Such efforts could be costly and are subject to cost overruns and delays in application, which could negatively affect the financial condition of the Corporation.

Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike federal laws, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could damage a health care provider's reputation and materially adversely affect business operations.

Cybersecurity

Healthcare providers and insurers are highly dependent upon integrated electronic medical record and other information systems to deliver high quality, coordinated and cost-effective care. These systems

necessarily hold large quantities of highly sensitive protected health information. As a result, the electronic systems and networks of healthcare providers and insurers are considered likely targets for cyberattacks and other potential breaches of their systems. In addition to regulatory fines and penalties, healthcare entities subject to breaches may be liable for the costs of remediating the breaches, damages to individuals (or classes) whose information has been breached, reputational damage and business loss, and damage to the information technology infrastructure. A number of health care providers have recently been the victims of hacker attacks with ransomware, in which hackers attempt to extort money in exchange for returning the provider's systems to normal. The Corporation has taken and continues to take measures to protect its information technology system against such cyberattacks, but there can be no assurance that the Corporation will not experience a significant breach. If such breach occurs, the financial consequences of such a breach could have a materially adverse impact on the Corporation. See the caption "REGULATION OF THE HEALTH CARE INDUSTRY—Electronic Transmission of Health Information; Privacy and Security Regulations" below.

Other Factors Generally Affecting the Corporation

In the future, the following factors, among others, may affect the operations, facilities and financial performance of the Corporation to an extent that cannot be determined at this time:

- Medical and scientific advances, pressures for efficiency generated by recent health care reform measures, the increasing role of HMOs, PPOs and other managed health care organizations, preventive medicine, improved occupational health and safety and improved outpatient care could result in decreased usage of inpatient hospital facilities. Also, as medical technology becomes more sophisticated and costly, the Corporation could encounter problems with availability, financing or operation of technology, which could adversely affect utilization.
- Competition from other health care providers now or hereafter located in the service area of the Corporation could adversely affect the Corporation's operations. Such competition includes physicians directly providing competitive outpatient services.
- The Corporation could be adversely affected by general economic trends (including increases in unemployment or inflation) and by changes in the demographics in its service area. Difficulties in increasing charges and other fees, while at the same time maintaining scope and quality of health services, may affect the ability of the Corporation to maintain sufficient operating margins.
- The healthcare industry and the Corporation have, from time to time, suffered from a scarcity of nursing and other qualified healthcare personnel. A shortage of qualified professional personnel, including physicians and nurses, could limit operations and/or significantly increase payroll costs. This scarcity may further be intensified as utilization of health care services increases as a consequence of the Affordable Care Act's expansion of the number of insured consumers. The Corporation cannot control the prevailing wage rates in its service area, and any increase in such rates will directly affect its costs of operations.
- No assurance can be given that the Corporation will be successful in maintaining the desired complement of physicians. Changes in the number or composition or admitting practices of the medical staff could affect the Corporation's reputation or services and thus its operations and revenues.
- Health care providers are major employers with a complex mix of professional, technical, clerical, housekeeping, maintenance and other types of workers. Large employers bear a variety of risks flowing from employer-employee relationships as well as employee-patient interactions (for example, discrimination claims, tort actions and work-related injuries); some of these risks are not covered by insurance. Nonprofit

health care providers and their employees are under the jurisdiction of the National Labor Relations Board, which has adopted rules permitting collective bargaining units among a hospital's employees. Also, the National Labor Relations Board has ruled that interns and residents can form unions. There are presently no employees of the Corporation represented by a union. Any future unionization of employees could cause an increase in costs of salaries and benefits. Moreover, work stoppages, slowdowns or lockouts could reduce, interrupt or otherwise adversely affect operations of the Corporation.

- The Corporation could be adversely affected by changes in law or rulings imposing indigent care requirements as a condition of maintaining state or federal tax-exempt status, or by other efforts of taxing authorities to impose taxes related to the property or operations of nonprofit organizations. See "—Internal Revenue Service Policy Regarding Maintenance of 501(c)(3) Tax Exemption" below under this caption.
- Substantial liabilities under federal and state antitrust laws and other trade regulations may arise in connection with a wide variety of activities, including joint ventures; merger, acquisition, and affiliation activities; payor contracting; certain pricing and salary setting activities; and relationships with physicians, including medical staff credentialing. The application of antitrust laws to health care is evolving, and enforcement activity appears to be increasing. Antitrust violations may be subject to criminal and/or civil enforcement actions by government agencies as well as by private litigants. Integration incentives under the Affordable Care Act may come into conflict with this increased antitrust enforcement pressure.
- The State does not presently have a program for the regulation or review of the rates charged for health care services furnished to private-paying patients. If such a program were established, or if wage or price controls were otherwise imposed with respect to the health care industry, such developments could have an adverse effect on the Corporation's revenue. Also, the absence of any Arkansas certificate of need program could facilitate the entry of competing health care providers into the Corporation's service area.
- Natural disasters or acts of terrorism (including bioterrorism) could result in the Corporation providing significant unreimbursed services, as well as causing property damage, employee injury and service interruptions.
- As large employers, hospitals may incur significant expenses to fund benefit plans for employees and former employees and to fund required workers' compensation benefits. Funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed or designated for other purposes. See "Note 11 – Pension Plan" to the System's financial statements in Appendix C hereto and the caption "PROFESSIONAL STAFF AND EMPLOYEES" in Appendix A hereto for certain information regarding the Corporation's defined contribution retirement plans and health insurance benefits.

Malpractice and General Liability Claims

In recent years, the number of malpractice and general liability suits and the dollar amounts of damage awards have increased nationwide, resulting in substantial increases in insurance premiums, which may have an adverse financial impact on the Corporation. Litigation may also arise against the Corporation from its corporate and business activities, such as its status as an employer. While the Corporation maintains malpractice and general liability insurance coverage which management and its independent consultants consider adequate, management is unable to predict the availability or cost of such insurance in the future. In addition, it is possible that certain types of liability awards may not be

covered by insurance as in effect at the relevant times. See the captions "LITIGATION" herein and "MISCELLANEOUS - Litigation" in Appendix A hereto.

Additional Bonds

The Indenture and the Loan Agreement permit the Corporation to incur obligations relating to Additional Bonds secured by and payable from the Pledged Revenues of the Corporation on a parity basis with the pledge and lien securing the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds. The issuance of Additional Bonds secured on a parity basis with the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds which does not result in a comparable increase in the Pledged Revenues of the Corporation would result in a dilution of the security for the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds. See the subcaption "THE SERIES 2021 BONDS – Additional Bonds" herein for a description of the limitations on the issuance of such Additional Bonds.

Damage or Destruction

Although the Corporation will be required to obtain certain kinds of insurance set forth in the Loan Agreement, there can be no assurance that the Corporation will not suffer uninsured losses in the event of damage to or destruction of the Corporation's facilities due to fire or other calamity or in the event of other unforeseen calamities. In order to alleviate the risks of such an occurrence, the Corporation maintains business interruption insurance with a total limit in excess of $315 million for all locations and commercial property insurance coverage in the amount of approximately $315 million.

Property Tax Exemption

Under present Arkansas law and rulings, buildings and the property appurtenant thereto that are owned by a nonprofit corporation are exempt from property taxes levied by political subdivisions of the State, beginning on the date that the nonprofit corporation acquires ownership of such property and buildings, so long as the property and buildings are used for the exempt purposes of the nonprofit entity and not used or held for profit (although such property is subject to special assessments for local improvements to the property). Management expects that the ownership and operation of its health care facilities will not result in a loss of the exemption from property taxes for such facilities. Nevertheless, relevant laws, regulations and rulings are subject to change, and no assurance can be given that any future change in exempt status would not have a material adverse effect on the Corporation.

Risk of Redemption

The Series 2021 Bonds are subject to redemption or acceleration prior to maturity in certain circumstances. See the subcaptions "– Optional Redemption" and "– Extraordinary Redemption" under the caption "THE SERIES 2021 BONDS" herein. Bondholders may not realize their anticipated yield on investment to maturity because the Series 2021 Bonds may be redeemed or accelerated prior to maturity at par or at a redemption price that results in the realization of less than the anticipated yield to maturity.

Nonprofit Health Care Environment

The significant tax benefits received by nonprofit, tax-exempt hospitals have increasingly caused the business practices of such hospitals to be subject to scrutiny by public officials and the press, and to political and legal challenges of the ongoing qualification of such organizations for tax-exempt status. Multiple governmental authorities, including state attorneys general, the Internal Revenue Service (the "IRS"), Congress and state legislatures have held hearings and carried out audits regarding the conduct of tax-exempt organizations, including tax-exempt hospitals. Citizen organizations, such as labor unions and patient advocates, have also focused public attention on the activities of tax-exempt hospitals and health systems and raised questions about their practices. The IRS imposes certain reporting requirements on hospitals and health systems, including through Schedule H, Schedule J and Schedule K of the Form 990. Proposals to increase the regulatory requirements for nonprofit hospitals' retention of tax-exempt status, such as by establishing a minimum level of charity care, have also been introduced repeatedly in Congress. These challenges and examinations, and any resulting legislation, regulations, judgments or

penalties, could materially change the operating environment for nonprofit providers and have a material adverse effect on the Corporation. Significant changes in the obligations of nonprofit, tax exempt hospitals and challenges to or loss of the tax-exempt status of nonprofit hospitals generally, or the Corporation in particular, could have a material adverse effect on the Corporation. See "—Internal Revenue Service Policy Regarding Maintenance of 501(c)(3) Tax Exemption" under this caption below.

Internal Revenue Service Policy Regarding Maintenance of 501(c)(3) Tax Exemption

The Corporation is an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), exempt from the payment of federal income taxes under Section 501(a) of the Code, and the Corporation has received a letter from the Internal Revenue Service confirming such status.

The tax-exempt status of interest on the Series 2021 Bonds depends upon maintenance by the Corporation and any other entity receiving or benefitting from proceeds of the Series 2021 Bonds of its status as an organization described in Section 501(c)(3) of the Code. In order to maintain that status, the Corporation is required to comply with current and future IRS regulations and rulings governing tax-exempt health care facilities. The Corporation has covenanted under the Loan Agreement and the Tax Regulatory Agreement not to perform any acts or enter into any agreements which would adversely affect such 501(c)(3) status.

In order to maintain its tax-exempt status under federal law, the Corporation must not be operated to any substantial degree for the benefit of private individuals and may not allow its earnings to inure to the benefit of any individuals having a personal or private interest in their organizations or operations. These proscriptions, in practice, regulate business dealings between health care providers and physicians. Tax-exempt health care providers generally are required to demonstrate that their business dealings with physicians benefit the community served by the provider independently from any direct benefit received by the provider itself. The Corporation is not presently being challenged or investigated by the IRS with respect to these matters.

The IRS has reaffirmed, in the context of federal Medicare and Medicaid anti-kickback laws, the principle that violation of criminal statutes is inconsistent with continued recognition of an organization's tax-exempt status. Thus, the tax-exempt status of a nonprofit health care provider could be subject to revocation if the entity were determined to have violated federal or state anti-kickback laws by providing illegal remuneration to physicians in exchange for the referral of Medicaid or Medicare patients or to have otherwise violated state anti-kickback laws or federal laws restricting referrals. See the caption "REGULATION OF THE HEALTH CARE INDUSTRY—Fraud and Abuse Laws and Regulations" below.

The Affordable Care Act has imposed certain additional requirements for 501(c)(3) nonprofit hospitals (such as the Corporation). Such nonprofit entities must conduct periodic community health needs assessments and must include an implementation report with their annual Form 990 information returns. They must also adopt formal financial assistance and emergency treatment policies; may not charge more for care to those who qualify for financial assistance and may not pursue certain collection actions without making a determination as to financial assistance eligibility; and must include audited financial statements with their Form 990 annual information returns. Failure of a nonprofit hospital to complete the required community health needs assessment may result in imposition of a $50,000 excise tax or revocation of its tax-exempt status. Form 990 information is to be reviewed by the Department of the Treasury at least once every three years, and the Department of the Treasury is also required to provide related reports to Congress. The Corporation's community health needs assessment was conducted and implementation strategy was adopted in 2019. Work is currently underway on the next community health needs assessment, which is expected to be completed in March 2022.

On December 29, 2014, the Secretary of the Treasury issued final regulations under Section 501(r) of the Code that provide detailed and comprehensive guidance relating to requirements for community health needs assessments, financial assistance policies, emergency medical care policies,

limitations on charges and billing and collection practices, and also provide guidance on consequences of failure to satisfy Section 501(r) requirements. Among the required financial assistance policies is a limitation on the amount charged for emergency or other medically necessary care provided to individuals eligible for assistance under the hospital's financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care and to make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in extraordinary collection actions. These final regulations are complex and are administratively burdensome to implement. Generally, the regulations apply to tax years beginning after December 29, 2015, and provide that a hospital organization may rely on a reasonable, good faith interpretation of the Section 501(r) requirements for tax years beginning on or before December 29, 2015, which may include compliance with certain prior proposed regulations under Section 501(r).

Taxing authorities in certain state and local jurisdictions have sought to impose or increase property taxes, sales and use taxes, and other taxes related to the property and operations of nonprofit organizations, including health care providers, particularly where such authorities are dissatisfied with the amount of service provided to indigent patients. At the federal level, however, the IRS has ruled that the tax-exempt status of nonprofit hospitals is based on a variety of factors but is not dependent upon their acceptance of patients who cannot pay. It is possible that future administrative or judicial proceedings or legislation could have the effect of requiring nonprofit institutions to increase their services to indigent patients to retain their tax-exempt status. In the recent past, legislation was introduced in Congress that would make a hospital's tax-exempt status hinge on the extent of its care to indigents, but the bills have not been enacted into law.

The IRS has audit guidelines which implement a policy to scrutinize more closely the activities of health care providers to ensure that they satisfy the requirements for tax-exempt status. Given these audit guidelines and other related pronouncements by the IRS, it may be more difficult for such entities to maintain their tax-exempt status. Health care providers may be forced to forgo otherwise favorable opportunities for certain joint ventures, recruitment and other arrangements to maintain their tax-exempt status or to avoid other sanctions.

Licensure and Accreditation

The Medical Center is licensed by the State of Arkansas. Management of the Corporation currently anticipates no difficulty in renewing or maintaining currently held licenses, certifications or accreditations. Nevertheless, actions in any of the areas could result in the loss of the ability of the Corporation to operate all or a portion of its facilities and could affect its ability to receive third party reimbursement from various programs.

Risks Related to Lease Agreement

The Medical Center is owned by the Issuer and leased to the Corporation pursuant to the terms of an Assignment and Lease Agreement dated as of March 1, 1997, as amended by an Amendment to Assignment and Lease Agreement dated as of November 1, 2010 (as amended, the "Lease Agreement"). The Lease Agreement has a stated term ending December 31, 2041. See the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT" herein.

The Lease Agreement is subject to early termination upon the occurrence of any of the events described under the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT – Events of Termination" herein. In such event, although the obligations of the Corporation under the Loan Agreement, the Note and the Bond Guaranty Agreement shall continue, it is unlikely that the Corporation will possess sufficient assets to fulfill said obligations, and because the sole security for the payments by the Corporation pursuant to the Loan Agreement, the Note and the Bond Guaranty Agreement is the Pledged Revenues, it is unlikely that any attempt to enforce the Corporation's obligations would result in payment in full of the principal of and interest on the Bonds.

Pursuant to the Indenture, the Issuer has covenanted that, whether or not the Lease Agreement or any successor lease is then in effect, it will use its best efforts to operate the facilities constituting the Medical Center, or to cause such facilities to be operated, as a "hospital" or other "health care facilities" within the meaning of the Act. The Issuer has also covenanted that it will use its best efforts to ensure that Pledged Revenues are deposited with the Trustee in sufficient amounts at all times to pay the principal of, premium, if any, and interest on the Bonds when due.

In the event of early termination of the Lease Agreement, there can be no assurance that the Issuer could operate the Medical Center in such a manner, or would be successful in locating a successor lessee that could operate the Medical Center in such a manner, as would produce sufficient Pledged Revenues to pay the principal of, premium, if any, and interest on the Bonds when due. However, see the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT – Title to Property" herein.

Secondary Market

Subject to prevailing market conditions and applicable securities laws, the Underwriter presently intends, but is not obligated, to make a market in the Series 2021 Bonds. Consequently, investors may not be able to resell the Series 2021 Bonds purchased should they wish to do so for emergency purposes or otherwise.

Forward-Looking Statements

This Official Statement (including the information included in Appendix A hereto) contains statements relating to future results that are "forward-looking statements" as defined in the Private Securities Litigation Reform Act of 1995. When used in this Official Statement, the words "estimate," "intend," "expect" and similar expressions identify forward-looking statements. Any forward-looking statement is subject to uncertainty and risks that could cause actual results to differ, possibly materially, from those contemplated in such forward-looking statements. Inevitably, some assumptions used to develop forward-looking statements will not be realized or unanticipated events and circumstances may occur. Therefore, investors should be aware that there are likely to be differences between forward-looking statements and actual results; those differences could be material.

REGULATION OF THE HEALTH CARE INDUSTRY

General Health Care Industry Factors

The Corporation and the health care industry in general are subject to regulation by a number of governmental and private agencies, including those which administer the Medicare and Medicaid programs discussed below, and are affected by federal and state policies concerning the manner in which health care is provided, administered and financed. The health care industry is accordingly sensitive to frequent and substantial legislative and regulatory changes, including persistent federal and state efforts to control the growth of governmental spending on health care programs. In addition, Congress and other governmental agencies have focused on the provision of care to indigent and uninsured patients, prevention of "dumping" such patients on public hospitals in order to avoid providing non-reimbursed care, the unlawful payment of remuneration in exchange for referral of patients, physician self-referral, inaccurate billing, security and privacy of health-related information, and other issues. In recent years, federal and state governments have exerted sharply increased efforts and resources on enforcing laws and regulations against fraud, waste and abuse within government health care programs, and governmental enforcement is increasingly supplemented by lawsuits brought by private citizens. Health care providers that fail to comply with Medicare, Medicaid, and commercial payor rules and guidelines are increasingly likely to receive onerous administrative, civil, and even criminal penalties and may also be subject to exclusion from participation in Medicare, Medicaid and other federal programs.

During the fiscal year ended March 31, 2021, Medicare patients (including members of Medicare HMOs) accounted for approximately 51.1% of the Corporation's patient service revenue, while

Medicaid patients accounted for approximately 12.2% of its patient service revenue. See the caption "SOURCES OF PATIENT SERVICE REVENUE" in Appendix A hereto and "— Medicaid Reimbursement" under this caption. The provisions of the Affordable Care Act, unless repealed or amended, are expected to reduce Medicare payments to providers, including the Corporation. Future reductions in funding levels of these programs and other changes designed to limit increases in costs paid by those programs could have a material negative effect on the revenue of the Corporation.

In the years leading up to the Affordable Care Act, federal budget legislation included substantial funding cuts in Medicare and Medicaid payments, and diverse and complex mechanisms to limit the amount of money paid to health care providers under both the Medicare and Medicaid programs were enacted. While the Affordable Care Act generally expands Medicaid coverage and funding, it also contains provisions aimed at reducing Medicare and Medicaid reimbursements to providers.

The Budget Control Act of 2011 (the "Budget Control Act"), which was enacted in August 2011, limits the federal government's discretionary spending caps at levels necessary to reduce expenditures between fiscal years 2015 and 2021 by $917 billion. The discretionary spending caps do not apply to Medicare, Social Security, Medicaid and other entitlement programs. The Budget Control Act also created a Joint Select Committee on Deficit Reduction (the "Committee"), which was tasked with making recommendations to further reduce the federal deficit by $1.5 trillion. As a result, and in exchange for raising the debt ceiling, the Budget Control Act established mandatory spending cuts, known as sequestration (or across the board) cuts intended to achieve $1.2 trillion in savings through fiscal year 2021, and an automatic 2% reduction in Medicare program payments for all health care providers, which took effect in April 2013, was set in place. The Consolidated and Further Continuing Appropriations Act of 2013, was subsequently enacted, providing funds for operation of the federal government on September 30, 2013, and off-setting some the sequestration mandated reductions for federal fiscal year 2014. In December 2013, Congress and the President signed the Bipartisan Budget Act of 2013 that increased sequestration caps for federal fiscal years 2014 and 2015 by $45 billion and $18 billion, respectively, but extended the caps into 2023. On August 2, 2019, President Trump signed into law, a bill suspending the debt ceiling until July 31, 2021. Since that time, the U.S. Treasury has been using temporary extraordinary measures to extend the time in which the federal government can continue to pay on its obligations. Congressional discussions are underway on various ways to obtain approval of a further suspension of the debt ceiling or an increase in the debt limit. Failure to timely obtain such approval could result in substantial disruption of financial markets and increased borrowing costs.

Continued statutory and regulatory efforts to control health care costs, particularly costs paid under the Medicare and Medicaid programs (either generally or for particular classes of health care providers), can be expected. The recent increase in focus and interest on federal and state health care reform may increase the likelihood of additional significant cost control measures being enacted in the near future. It is unlikely that the Corporation could attract sufficient numbers of private pay patients to become self-sufficient without reimbursement from governmental programs. See the caption "RISK FACTORS —Legislative and Regulatory Changes; Health Care Reform" herein.

Over the past several years, numerous and varied legislative and regulatory actions to reform the health care system have been proposed at both federal and state levels. Such proposals have included establishment of a single-payor system, encouragement of voluntary efforts to expand health care coverage, stimulation of competition among health care providers, adoption or expansion of "patients' bills of rights" and similar programs, changes in licensure requirements, and other changes in methods of delivering, regulating and financing health care services. The Affordable Care Act focuses on health insurance mandates; insurance exchanges and other measures to expand healthcare coverage and control health insurance premiums; modifications to methods and rates of payment to health care providers and other measures to control health care costs; use of electronic records and empirical research data to move toward "evidence-based medicine" protocols; new methods and increased enforcement resources to combat waste, fraud and abuse; and alternative approaches to medical malpractice disputes. For acute-

care hospital providers such as the Corporation, the Affordable Care Act presently seems to present a trade-off, with lower Medicare and Medicaid reimbursement rates and more stringent federal regulation being balanced against increased insurance coverage and reduced emergency services burdens. In recent years, the Corporation has benefited from reduced charity care write-offs and bad debt expenses. A portion of those gains however have been off-set by the increased use of high-deductible insurance plans under which insured patients are more likely to fail to make payment. Additional federal or state reform legislation or regulatory measures could be enacted in the future, and such legislative and regulatory action could adversely affect the operations and financial condition of health care providers by reducing government reimbursement or other income, imposing additional uncompensated operating costs, or restricting the provision of new or expanded health care services. **No assurance can be given that the operations and financial condition of the Corporation will not be materially adversely affected by ongoing or future legislative and regulatory changes.**

Regulatory and Contractual Actions That Could Affect the Corporation

The Corporation is subject to regulation, certification, licensing, accreditation and policy changes by various federal and state government agencies (including agencies which administer the Medicare and Medicaid programs), by certain nongovernmental agencies and other professional review organizations. No assurance can be given as to the effect on future operations of the Corporation of existing laws, regulations and standards for such certification, licensing or accreditation, or of any future changes in such laws, regulations and standards. Adverse actions relating to certification, licensure or accreditation could result in the loss of the ability of the Corporation to operate all or a portion of its facilities and could affect its ability to receive third-party reimbursement from various programs.

Medicare Reimbursement

The Corporation is certified as a provider of Medicare services and has historically received significant revenue from the Medicare program. See the caption "SOURCES OF PATIENT SERVICE REVENUE" in Appendix A hereto. Changes in the Medicare program are therefore likely to have a material effect on the Corporation. Medicare is a federal health benefits program administered by CMS within HHS to provide health insurance primarily to beneficiaries who are 65 years of age or older.

The Medicare program was originally authorized in 1965 and has been frequently amended. Medicare originally operated under a fee-for-service system whereby health care providers were paid under Medicare as they rendered services to Medicare beneficiaries. Starting in the 1980s, managed care was introduced into the Medicare program, affording Medicare beneficiaries the option to enroll in a managed care organization that has entered into a payment agreement with CMS. Managed care within the Medicare system has since expanded its role and is now known as Medicare Advantage, which permits a variety of health plans operating under different payment arrangements and utilizing cost-saving mechanisms that have been widely available in the private sector to contract to cover the health care needs of Medicare recipients. Payments to health care providers under Medicare Advantage can be expected to vary widely from plan to plan, utilizing arrangements such as discounted fee-for-service and capitated models.

Medicare benefits are payable under Part A which covers inpatient hospital services, skilled nursing care, and hospice services, certain home health services and certain other services; and Part B, which covers hospital outpatient services, physician and ambulatory services, durable medical equipment, certain home health services and certain other items and services. Medicare Part B is a voluntary program, and only those eligible beneficiaries who pay the Part B premiums receive benefits. Part C governing the Medicare Advantage program provides for payment to Medicare Advantage plans from the Part A and Part B trust funds. Part C requires that Medicare Advantage plans cover at least those items and services currently covered under Parts A and B, other than hospice care. Additional benefits may be offered as part of a basic package or pursuant to an extra charge. Part D provides Medicare prescription drug coverage.

Part A Reimbursement of Inpatient Services. Since the early 1980s, legislative action and the promulgation of related regulations have resulted in significant changes in the Medicare program. Medicare originally provided reimbursement for the reasonable direct and indirect costs of inpatient hospital services furnished to beneficiaries. Congress subsequently adopted a prospective payment system to cover the routine and ancillary operating costs of most Medicare inpatient hospital services. Under Medicare's prospective payment system ("PPS"), hospital discharges are classified into categories of specific diagnosis-related groups of services ("DRGs"), which are based roughly on estimated intensity and hospital resources necessary to furnish care for each principal diagnosis and are indexed for wages in the hospital's metropolitan area. Hospitals generally receive a fixed amount based upon the assigned DRG, on a per discharge basis for each Medicare patient (other than those enrolled in a Medicare Advantage plan), regardless of how long the patient remains in the hospital or the volume of ancillary services provided to the patient. Additional payments (referred to as "outlier payments") may be made to hospitals for cases involving extremely long periods of stay or unusually high costs in comparison with other discharges in the same DRG. Under PPS, hospitals may retain payments in excess of costs but must absorb costs in excess of payments.

DRG rates are subject to adjustment by CMS, including reductions mandated by the Affordable Care Act and Budget Control Act and are subject to federal budget considerations. Adjustments are made annually based on a "market basket" of estimated cost increases. In recent years, market basket adjustments for inpatient hospital care have averaged approximately 2% to 4% annually. The Affordable Care Act contains provisions aimed at reducing Medicare (and Medicaid) payments to providers, including reductions in the annual market basket adjustments. The Affordable Care Act also provides for overall reductions in DRG-based payments to be phased in through 2019, in amounts ranging from 0.10% to 0.75% each year through federal fiscal year 2021.

The DRG reductions are intended to offset incentive payments to hospitals under the Hospital Value-Based Purchasing ("HVBP") program created pursuant to the Affordable Care Act, which links a portion of Medicare inpatient PPS payments to performance on certain quality measures. The HVBP program is intended to shift from payments based on volume to incentive payments to hospitals based on specified performance measures. These measures include both clinical process of care measures and patient experience of care (survey) measures. Hospitals are scored on these measures on both achievement (relative to other hospitals) and improvement (relative to the hospitals' own performance during a baseline period). Data and scores are made available to the public on the Hospital Compare website. The measures are expected to change over time, in order to continue to raise the bar as quality improves for hospitals generally. As part of the HVBP program, the experienced or will experience adjustments to hospital inpatient care payments of $15.54 (increase), $4.12 (increase), $17.91 (decrease), $11.78 (increase) and $10.13 (decrease) per Medicare admission in fiscal years 2017, 2018, 2019, 2020 and 2021, respectively. The Corporation cannot predict the potential long-term effects of the HVBP program.

Increasingly, the Medicare and Medicaid programs seek to penalize providers that do not successfully participate in quality initiatives; CMS has created categories of serious errors in the provision of health care services that will result in denial of reimbursement to providers. See "RISK FACTORS—Legislative and Regulatory Changes; Health Care Reform" herein. The Affordable Care Act specifically provides for Medicare payment reductions for hospitals showing excess 30-day readmission rates with respect to certain medical conditions, for hospitals with high rates of certain hospital acquired conditions, and for hospitals failing to "meaningfully use" information technology.

The American Taxpayer Relief Act of 2015 requires CMS to recoup funds from hospitals based on changes in documentation and coding that have increased PPS payments but that do not represent real increases in the intensity of services provided to patients. In the final regulations for fiscal year 2014, CMS stated that it intends to phase in this recoupment over time, starting with a 0.8% reduction in the Medicare standardized amount for 2014. Additional recoupment adjustments were in effect for federal fiscal years 2015 through 2017.

In addition to payments for hospital operating and capital costs, the Medicare program provides additional reimbursement to hospitals for the direct costs of graduate medical education ("GME"), as well as indirect medical education ("IME") costs attributable to a teaching hospital's approved graduate medical education programs.

Hospitals receive additional Medicare reimbursement for a portion of the bad debts associated with providing covered services to Medicare patients, and for rendering services to a disproportionately high share of low-income patients. Under PPS, hospitals that serve a disproportionate share of low-income patients receive, in addition to payments related to operating and capital costs discussed above, an additional Medicare DSH (disproportionate share hospital) adjustment. A hospital may qualify for a Medicare DSH payment based upon a statutory formula relating to a hospital's number of Medicaid and certain Medicare days to total days. The Arkansas provider fee program is described under the caption "Medicaid Reimbursement" below which apportions DSH payments.

Certain physician services are reimbursed under Medicare on the basis of a national fee schedule called the "resource-based relative-value scale" ("RB-RVS"). The RB-RVS fee schedule establishes payment amounts for all physician services, including services of provider-based physicians, and is subject to annual updates. The Sustainable Growth Rate ("SGR"), which has been a limit on the growth of Medicare payments for physician services, was linked to changes in the U.S. Gross Domestic Product over a ten-year period. In April 2015, Congress adopted legislation eliminating the SGR limitation. The legislation provided for Medicare payment increase to physicians over a five-year period while a transition is made to a system based on quality of care.

Uncertainty surrounds the future determination of reimbursement levels related to DRG classifications, DSH adjustments, HVBP incentives and GME and IME costs (as well as reimbursement for outpatient services, as discussed below). In addition, the Medicare program is subject to judicial interpretations, administrative rulings, governmental funding restrictions and requirements for utilization review (such as second opinions for surgery and preadmission criteria). Such matters, as well as more general governmental budgetary concerns, may reduce payments made to the Corporation under the Medicare program, and future Medicare payment rates may not be sufficient to cover increases in the cost of providing services to Medicare patients.

Part B Reimbursement of Outpatient Services. Part B of Medicare generally covers certain hospital outpatient services, physician services, medical supplies and durable equipment. Certain outpatient procedures which are provided within 72 hours of an inpatient admission are considered to be part of the inpatient services and are not separately reimbursed. A prospective payment system now applies to covered hospital outpatient services ("Ambulatory Payment Categories"); CMS establishes relative payment rates for Ambulatory Payment Categories based on hospital claims and cost report data and sets certain specified limits on coinsurance payable for such services. Laboratory, therapy and certain radiology services are paid under a fee schedule. The Bipartisan Budget Act of 2015 created a mandate that new off-campus hospital outpatient departments established on or after November 2, 2015, will not be eligible for reimbursement under the outpatient prospective payment system after January 1, 2017. The effect of the prospective payment system on the Corporation depends upon the ability of management to control costs of covered services. There can be no assurance that reimbursement for outpatient services will be sufficient to cover costs for such services.

Medicaid Reimbursement

Medicaid is a combined federal and state program for certain low-income and needy individuals that is jointly funded by the federal government and the states. Pursuant to broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets the payment rate for services; and administers its own Medicaid program. In Arkansas, the Medicaid program is administered by the Arkansas Department of Human Services. The Corporation is certified as a provider of Medicaid services and has a participation agreement with the State. The Corporation has historically received revenue from the Medicaid program, and changes in the Medicaid

program are therefore likely to affect the Corporation. The Corporation's Fiscal Year 2021 revenue from Medicaid was approximately 12.2% of its patient service revenue. See the caption "SOURCES OF PATIENT SERVICE REVENUE" in Appendix A hereto. Fiscal considerations in setting both federal and State budgets will directly affect the funds available to providers for payment of services rendered to Medicaid patients. Since State payments to Medicaid providers are subject to State legislative appropriation, delays in appropriations and State budget pressures which may occur from time to time create a risk that payments for services to Medicaid patients will be withheld or delayed.

Inpatient hospital services under Medicaid are reimbursed under a cost reimbursement methodology subject to certain cost limitations. Medicaid outpatient hospital services are generally reimbursed in accordance with fee schedules produced by the State Department of Human Services. These payments are supplemented under the provider assessment program, which assesses participating hospitals a tax based on net revenue. The federal government matches the assessment amount at a rate of approximately 3 to 1, and these amounts are allocated to private hospitals in Arkansas based on each hospital's share of total Medicaid patients. Based on the Medicaid reimbursement methodologies, there can be no assurance that Medicaid revenue will cover expenses for Medicaid patients.

The Affordable Care Act contains provisions aimed at reducing Medicaid and Medicare reimbursements to providers. See "—Medicare Reimbursement—Part A Reimbursement of Inpatient Services" above under this caption for a discussion of market basket and other reimbursement reductions imposed by the Affordable Care Act.

While Arkansas has recently implemented a program to manage the care of Medicaid beneficiaries with specialized needs for developmental disabilities and behavioral health service, at the present time Medicaid managed care organizations do not have a significant presence in the Corporation's service area relating to the provision of acute care. If such Medicaid managed care organizations were to become more active in the Corporation's service area in the future, there can be no assurance that the Corporation would be selected as a provider by Medicaid managed care organizations or, if selected, that the revenue received under such managed care contracts would be adequate to pay the costs of treating the Medicaid beneficiaries covered by such contracts.

The amount of Medicaid reimbursement received by providers in the future will depend on, among other things, fiscal considerations of both the federal and state governments in establishing their budgets for funding the Medicaid program. Because a portion of Medicaid's program costs are paid by the State, the absolute level of Medicaid revenue paid to the Corporation, as well as the timeliness of their receipt, may be partly dependent upon the financial condition of and budgetary factors facing the State, which may be adversely affected by factors beyond the State's control. State budgets are not only affected by State economic conditions but also by a combination of Arkansas constitutional provisions that limit taxes and revenues. Consequently, the State's ability to appropriate additional funds for the Medicaid program, or to increase taxes to provide additional revenue for health care, is limited by the State Constitution and may be further restricted by initiated ballot proposals or by other changes in law or policy. Future changes in State law or policy could adversely affect State Medicaid funding. To the extent that future changes in State law, policy, or financial conditions cause the State to reduce its funding of the non-federal portion of Medicaid reimbursement, the revenue of Medicaid providers such as the Corporation could be adversely affected.

While the Affordable Care Act has expanded Medicaid eligibility and funding in the State, considerable uncertainty remains as to its impact. Medicaid funding may be affected further by future health care reform legislation and general governmental budgetary concerns. The Secretary of HHS has advocated converting Medicaid to a "block grant" funded program, meaning states would receive a fixed dollar amount from the federal government rather than the current funding approach based upon level of state expenditure. The effect of block grant funding on the State's Medicaid Program and the Corporation is not known at this time; however, it is likely to have an adverse effect on the Corporation. Such factors could lead to future reductions in Medicaid payments, and Medicaid payment rates could be

insufficient to cover increases in costs of providing services to Medicaid patients. It is impossible to predict the effect such changes might have on the Corporation.

Medicare Advantage Plans. Part C of the Social Security Act gives most Medicare beneficiaries the option to obtain Medicare coverage either under the traditional Medicare program (Parts A and B as described above), or under a Medicare Advantage plan. A Medicare Advantage plan may be offered by a coordinated care plan (such as an HMO or PPO), a provider sponsored organization (a network operated by health care providers rather than an insurance company), a private fee-for-service plan, or a combination of a medical savings account ("MSA") and contributions to a Medicare Advantage plan. Each Medicare Advantage plan, except an MSA plan, is required to provide at least the benefits offered under Medicare Parts A and B (other than hospice care) and any additional benefits approved by the Secretary of HHS. A Medicare Advantage plan will receive a capitated monthly payment from HHS for each Medicare beneficiary who has elected coverage under the plan. In general, health care providers such as the Corporation must contract with Medicare Advantage plans to treat Medicare Advantage enrollees at agreed upon rates, with the exception of Private Fee for Service plans which do not require a contract with the provider.

Medicare and Medicaid Annual Cost Reporting; Audits

The annual cost reports of the Corporation, which are required under the Medicare and Medicaid programs, are subject to audit which ultimately may result in retroactive adjustments to the amounts determined to be due to or from the Corporation under these programs. Medicare and Medicaid regulations provide for withholding payment in certain circumstances if audits determine that an overpayment of Medicare or Medicaid funds has been made. These audits often require several years to reach the final determination of amounts earned under each program based on cost. Providers also have rights of appeal. As of November 15, 2021, the Corporation has settled its Medicare costs reports through Fiscal Year 2018 and has settled its Medicaid cost reports for Fiscal Years 2017, 2019 and 2020.

The Corporation is not aware of any situation whereby a material Medicare or Medicaid payment is presently being withheld, and does not anticipate that substantial withholdings or audit adjustments not covered by existing reserves will be made in the future. However, if such withholdings or audit adjustments were to be assessed, such an occurrence could have a material adverse effect on the Corporation's financial position.

In addition to the cost report audits described above, Medicaid has implemented an audit program relating to overpayment of Medicaid claims in specified years. The Corporation may be required to repay certain claims, but does not expect such repayments to be material in amount. Under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal or state statutes, which could subject the Corporation to civil or criminal sanctions. See the discussion of the False Claims Act in "Fraud and Abuse Laws and Regulations—*Billing and Reimbursement Practices*" under this caption. The Affordable Care Act requires identified overpayments to be repaid within 60 days of discovery; failure to meet this deadline may result in False Claims Act liability.

Recovery Audit Contractors

Over the last several years, CMS has implemented and expanded a program for the use of recovery audit contractors ("RACs") to search for improper Medicare payments, and the Affordable Care Act has extended the use of RACs to the Medicaid program, Medicare Advantage and Medicare Part D. RACs are compensated in part on the basis of their collections, and the program has reportedly resulted in significant recoveries of Medicare overpayments. The Corporation cannot anticipate the amount or volume of its past Medicare claims that will be reviewed by the RACs or what the results of any such audits may be. The amount of volume of RAC activity is not expected to materially impact the Corporation's financial statements.

Fraud and Abuse Laws and Regulations

The Affordable Care Act provides new methods and increased resources to combat waste, fraud and abuse, and these provisions are expected to be a significant source of funding for implementation of health care reform. Significantly, the Affordable Care Act authorizes the exclusion of a provider from participation in Medicare, Medicaid and other governmental programs, as well as the suspension of payments to a provider, pending an investigation of a credible allegation of fraud against a provider. Thus, providers may experience adverse financial consequences based on a mere allegation of violation of a federal fraud and abuse law, even if such allegation is unproven or is never proved. The Affordable Care Act also allows CMS to reduce provider payments by set-offs for various types of federal liabilities providers (or their affiliates) may have. The Affordable Care Act provides for additional program integrity measures aimed at fraud prevention and detection (e.g. data integration, sharing and matching; also enhanced provider screening and enrollment requirements).

The Affordable Care Act also creates incentives for providers to create more integrated and coordinated care platforms, and there may be some potential for tension between these incentives and certain types of fraud and abuse regulation.

Anti-Kickback Laws. The federal Medicare/Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act (the "Anti-Kickback Law") make it a criminal felony offense (subject to certain exceptions) to knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business for which reimbursement is provided under the Medicare or Medicaid programs or other "federal health care programs," or in return for the purchasing, leasing, ordering or arranging for, or recommending the purchasing, leasing, or ordering of, any good, facility, service or item for which payment is made in whole or in part under a federal health care program. For purposes of the Anti-Kickback Law, a "federal health care program" includes the Medicare and Medicaid programs, as well as any other health plan or program funded directly, in whole or in part, by the United States government. The Affordable Care Act contains provisions relaxing the intent requirements for criminal liability under the Anti-Kickback Law, so that actual knowledge of statutory requirements or specific intent to violate them is not required for a criminal prosecution. The Affordable Care Act also provides that Anti-Kickback Law violations may constitute a basis for False Claims Act liability; see "*Billing and Reimbursement Practices*" below under this caption.

In addition to criminal penalties, violations of the Anti-Kickback Law can lead to civil monetary penalties and suspension or exclusion from participation in Medicare, Medicaid and other federal health care programs. A person who violates the Anti-Kickback Law is subject to damages of up to three times the total amount of remuneration offered, paid, solicited or received. The government may exclude from a federal health care program any individual who has a direct or indirect ownership or control interest in a sanctioned entity and has acted in deliberate ignorance, or is an officer or managing employee of the sanctioned entity, irrespective of whether the individual participated in the wrongdoing. Exclusion from the Medicare or Medicaid programs would have a material adverse impact on the operations and financial condition of the Corporation.

The scope of prohibited payments in the Anti-Kickback Law is broad and has been broadly interpreted by courts in many jurisdictions. Read literally, the statute places at risk many otherwise legitimate business arrangements, potentially subjecting such arrangements to lengthy, expensive investigations and prosecutions initiated by federal and state governmental officials. In particular, the Office of the Inspector General of HHS has expressed concern that the acquisition of physician practices by entities in a position to receive referrals of business reimbursable by Medicare from such practices could violate the Anti-Kickback Law. In addition, the Anti-Kickback Law covers certain economic arrangements involving hospitals, physicians and other health care providers, including joint ventures, space and equipment rentals, management and personal services contracts and physician employment contracts. HHS has adopted regulations establishing certain payment practices and arrangements as "safe harbors" which are deemed not to violate the Anti-Kickback Law. The safe harbors are, however,

narrow, and do not cover a wide range of economic relationships which many hospitals, physicians and other health care providers have historically considered to be legitimate business arrangements not prohibited by the Anti-Kickback Law. Because the safe harbor regulations do not purport to describe comprehensively all lawful or unlawful economic arrangements or other relationships between health care providers and referral sources, it is uncertain whether hospitals and other health care providers that have these arrangements or relationships may need to alter them in order to ensure compliance with the Anti-Kickback Law.

Billing and Reimbursement Practices. Health care providers, including hospitals and physicians' clinics, are also subject to criminal, civil and exclusionary penalties for violating billing and reimbursement standards under state and federal law. In recent years, state and federal enforcement authorities have investigated and prosecuted providers for submitting false claims to Medicare or Medicaid for services not rendered or for misrepresenting the level or necessity of services actually rendered in order to obtain a higher level of reimbursement. The United States Department of Justice has instituted a number of national investigations concerning allegations under the federal False Claims Act relating to alleged improper billing practices by hospitals. Significant fines and penalties are being imposed in these areas, and, since enforcement authorities are in a position to exert considerable settlement pressure against providers, substantial settlement amounts are being paid. In additions, the False Claims Act authorizes "qui tam" actions in which a private person (known as a "relator") sues on behalf of the government. If the lawsuit is successful, the relator is eligible to receive a percentage of the recovered amount. The Affordable Care Act also allows CMS to reduce provider payments by set offs for various types of federal liabilities providers (or their affiliates) may have. This "cross provider" recovery provision (which may extend to all entities sharing a federal tax identification number) constitutes an important change from prior rules.

These enforcement activities are aimed at a wide variety of health care related activities, many of which have not generally been perceived as "fraud." In many areas, regulatory authorities have not provided clear guidance. The False Claims Act and similar laws may be violated merely by reason of inaccurate or incomplete reports, and ordinary course errors and omissions may result in liability. Because the Corporation has structured its accounting and financial systems around complex billing code mechanisms imposed by the Medicare and Medicaid programs, the Corporation may not be able to comply expeditiously with future Medicare and Medicaid modifications, which could result in an adverse effect on operations.

CMS is reviewing health care providers that are receiving large proportions of their Medicare revenues from outlier payments. The Corporation does not receive a meaningful amount of such outlier payments, and management does not believe that any such review would result in a material adjustment.

Restrictions on Referrals. Federal law (the "Stark Law") prohibits physicians from referring Medicare or Medicaid patients for certain designated health services where the physician has an ownership or other financial interest in the provider of the referral services. Any services furnished pursuant to a referral prohibited under the Stark Law are not eligible for payment by the Medicare or Medicaid programs, and the provider is prohibited from billing any third-party for such services. Violations can result in denial of payment, imposition of substantial civil money penalties and exclusion from the Medicare and Medicaid programs.

There are a number of exceptions for certain arrangements, such as employment arrangements, personal service and physician recruitment activities meeting specified criteria, which are not considered violative of these federal referral prohibitions. Regulations which the Secretary of HHS has stated are indicative of HHS' position provide further clarification regarding the application of these federal laws; however, numerous ambiguities and questions of interpretation exist concerning application of referral restrictions to specific business arrangements. The Affordable Care Act contains additional restrictions on some Stark Law exceptions, and also provides new self-disclosure protocols for Stark Law violations as described below.

As mandated by the Affordable Care Act, CMS has established a voluntary self-referral disclosure protocol (the "SRDP") under which hospitals and other entities may voluntarily self-report Stark violations and seek a reduction in potential refund obligations. However, because the SRDP is relatively new and published settlement amounts do not indicate a correlation to the total potential overpayment disclosed, it is difficult to determine at this time whether the SRDP will provide significant monetary relief to hospitals that discover and self-report inadvertent Stark law violations. The Corporation may make self-disclosures under the SRDP as appropriate from time to time. Management believes that the Corporation is currently in material compliance with the Stark Law. However, in light of the technical nature of the Stark law, the scarcity of case law interpreting the Stark Law and the breadth and complexity of the Stark Law, there can be no assurances that the Corporation will not be found to have violated the Stark Law, and if so, whether any repayment obligation or sanction imposed would have a material adverse effect on the operations of the Corporation or the financial condition of the Corporation.

Anti-Dumping. In 1986, in response to concerns regarding inappropriate hospital transfers of emergency patients based on the patient's inability to pay for the services provided, Congress enacted the Emergency Medical Treatment and Active Labor Act. This so-called "anti-dumping" law restricts the hospital's right to inquire as to the patient's ability to pay until a medical screening exam has been performed and if necessary, the patient's condition has been stabilized. It requires adherence to certain procedures before an emergency patient or patient in labor may be transferred to another facility. Failure to comply with this law can result in exclusion from the Medicare and/or Medicaid programs as well as civil and criminal penalties. Failure of the Corporation to meet these legal responsibilities could adversely affect the financial condition of the Corporation. See also "RISK FACTORS — Internal Revenue Service Policy Regarding Maintenance of 501(c)(3) Tax Exemption" herein.

Other Federal Legislation. Extensive procedural and substantive changes to fraud and abuse and reimbursement related provisions of federal law have been enacted, including within the Affordable Care Act. In part, the changes provided funding and other incentives to encourage more vigorous enforcement of existing law. In addition, criminal and civil penalty provisions have been added, existing requirements and penalties have been extended to additional federal programs, and changes have been made to mandatory and permissive exclusion provisions. Criminal violations relating to "health care fraud" and "federal health care offense" have been defined. Civil monetary penalties have been added for actions such as patterns of incorrect coding or billing for unnecessary services, offering inducements to beneficiaries to obtain services from a particular provider, and for contracting with, or employing, an individual who is excluded from participation in a federal health care program. These legislative changes have and will continue to produce a very substantial number of proposed and final rules, advisory opinions and other notifications, all of which could have a material adverse effect on the financial condition or results of operations of the Corporation.

Compliance. Management believes that its business relationships, billing and claims practices and other operations and activities materially comply with the terms of all applicable state and federal fraud and abuse laws and regulations. However, in light of the broad scope of these provisions, the narrowness of safe harbor regulations, and the scarcity of case law or other concrete guidance in interpreting them, there can be no assurance that the Corporation will not be challenged under fraud and abuse provisions in the future. Such a challenge could materially adversely affect the financial condition of the Corporation. The increasing pace of development of new laws and regulations increases the risk of failure to comply with applicable legal requirements as interpreted by federal and state agencies. The Corporation maintains an ongoing compliance program.

Electronic Transmission of Health Information; Privacy and Security Regulations

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), added two prohibited practices the commission of which may lead to civil monetary penalties: (i) the practice or pattern of presenting a claim for an item or service on a reimbursement code that the person knows or

should know will result in greater payment than appropriate (i.e., upcoding); and (ii) the practice of submitting claims for payment for medically unnecessary services. Violation of such prohibited practices due to civil neglect could amount to civil monetary penalties ranging from $50,000 to $1.5 million for all identical violations in a calendar year and/or imprisonment. Management of the Corporation is not aware of any violations of the prohibited practices provisions of HIPAA.

HIPAA also includes administrative simplification provisions intended to facilitate the processing of health care payments by encouraging the electronic exchange of information and the use of standardized formats for health care information. Congress recognized, however, that standardization of information formats and greater use of electronic technology presents additional privacy and security risks due to the increased likelihood that databases of personally identifiable health care information will be created and the ease with which vast amounts of such data can be transmitted. Therefore, HIPAA requires the establishment of distinct privacy and security protections for individually identifiable health information ("Protected Health Information" or "PHI").

HHS promulgated privacy regulations under HIPAA (the "Privacy Rule") that protect the privacy of PHI maintained by health care providers (including hospitals), health plans, and health care clearinghouses (collectively, "Covered Entities") and provide individuals with certain rights regarding their PHI (including, for example, access to PHI, amending PHI, and receiving an accounting of disclosures of PHI). Security regulations have also been promulgated under HIPAA (the "Security Rule"). The Security Rule requires Covered Entities to have certain administrative, technical and physical safeguards in place to ensure the confidentiality, integrity and availability of all electronic PHI they create, receive, maintain or transmit. Additionally, HHS promulgated regulations to standardize the electronic transfer of information pursuant to certain enumerated transactions (the "Transactions and Code Sets Rule").

In September of 2015, the HHS Office of the Inspector General released two reports that reviewed the Office of Civil Rights' ("OCR") enforcement of HIPAA. The first report (the Privacy Report) suggests that OCR strengthen its oversight of covered entities' compliance with the Privacy Rule. The second report (the "Breach Enforcement Report") suggests that OCR strengthen its follow-up of reported HIPAA breaches. In response to the reports, there has been a dramatic increase in the number of HIPAA enforcement actions and settlements, and OCR is empowered to conduct random audits of covered entities and business associates. OCR has stated that the audits will primarily consist of a review of policies and procedures, but if serious compliance issues are identified OCR may initiate a separate compliance review to further investigate which may result in settlements and fines. Despite the implementation of network security measures by the Corporation, its information technology systems may be vulnerable to breaches, ransom malware, hacker attacks, computer viruses, physical or electronic break-ins and other similar events or issues. Such events or issues could lead to the inadvertent disclosure of protected health information or other confidential information, could have an adverse effect on the ability of the Corporation to provide health care services, or could result in government civil, criminal or monetary penalties.

The 2009 Health Information Technology for Economic and Clinical Health ("HITECH") Act significantly changed the landscape of federal privacy and security laws regarding PHI. The HITECH Act (i) extended the reach of HIPAA, certain provisions of the Privacy Rule, and the Security Rule; (ii) imposed a breach notification requirement on HIPAA covered entities and their business associates; (iii) limited certain uses and disclosures of PHI; (iv) increased individuals' rights with respect to PHI; and (v) increased enforcement of, and penalties for, violations of the privacy and security of PHI.

The HITECH Act also created a federal breach notification requirement that mirrors protections that many states have passed in recent years. This requirement provides that the Corporation must notify patients of any unauthorized access, acquisition or disclosure of their unsecured PHI that poses significant risk of financial, reputational or other harm to a patient. In addition, a new breach notification requirement was established requiring reporting to the Secretary of HHS and, in some cases, local media

outlets, of certain unauthorized access, acquisition of disclosure of unsecured PHI that poses significant risk of financial, reputational or other harm to a patient.

In January of 2013, HHS issued an omnibus final rule interpreting and implementing various provisions of the HITECH Act, including a final breach notification rule. In addition, the facilities of the Corporation are also subject to any state law that is related to the reporting of data breaches and more restrictive than the regulations and/or requirements issued under HIPAA and the HITECH Act.

Any violation of HIPAA, the HITECH Act or other regulations promulgated thereunder is subject to HIPAA civil and criminal penalties, including monetary penalties and/or imprisonment. Management of the Corporation believes it is in substantial compliance with HIPAA, the HITECH Act, and the rules promulgated thereunder, but there can be no assurance that the Corporation will not experience a HIPAA privacy or security breach. The Corporation conducts annual security risk assessments and develops corrective action plans to address remediation of any identified risks, threats or vulnerabilities to electronic protected health information or gaps in applicable requirements.

SUMMARY OF PORTIONS OF THE LOAN AGREEMENT

The following is a summary of certain portions of the Loan Agreement. The summary does not purport to be complete and reference is made to the full text of the Loan Agreement for a complete description of its terms.

Repayment of Loan

The Corporation unconditionally agrees that it will make payments to the Trustee for the account of the Issuer, in lawful money of the United States of America, in such amounts and at such times, if not sooner required under the terms of the Loan Agreement, as shall be necessary to enable the Trustee to make full and prompt payment when due of the principal of, premium, if any, and interest on all Bonds issued and outstanding under the Indenture, whether at their dates of maturity, upon call for redemption prior to stated maturity, or upon acceleration of stated maturity, and to make all required transfers of money to the Trustee required under the Loan Agreement.

Additional Payments

The Corporation agrees to make additional payments ("Additional Payments") to the Issuer and the Trustee, as required to provide for administrative expenses, reimbursement of expenses and outlays, and any "rebate" owed to the United States.

Payments to Trustee for Deposit in Bond Fund

On or before the twenty-fifth day of each month, the Corporation shall transfer to the Trustee for deposit in the Bond Fund moneys in an amount equal to 1/6 of the next interest payment and 1/12 of the next principal payment due on the Bonds. So long as such payments are made as due, the Corporation shall maintain control of the Pledged Revenues.

Application of Pledged Revenues

If the Corporation fails to make required deposits to the Bond Fund as provided in the preceding paragraph, all Pledged Revenues shall, within three days after collection by the Corporation, be deposited by the Trustee in the Revenue Fund. Money in the Revenue Fund shall be transferred therefrom at the times and in the amounts to the various funds and accounts as provided in the Indenture.

Insurance; Damage or Destruction

The Corporation shall procure insurance on the Medical Center against the risks and in the amounts as is customarily maintained by persons operating similar hospital facilities.

The Corporation covenants and agrees to notify the Trustee and the Issuer immediately in the case of the damage to or destruction of the Medical Center or any material portion thereof as a result of fire or other casualty.

In the Lease Agreement, the Issuer and the Corporation have agreed, and each hereby confirms, that in the event of an insured loss with respect to the Medical Center, or any portion thereof, the proceeds payable by the insurer shall, to the extent thereof, be utilized to restore and replace said loss. However, in no event shall the Issuer or the Corporation be required to contribute any moneys of their own toward said replacement or restoration. However, the Lease Agreement also provides that should Issuer and Corporation mutually agree that insurance proceeds are insufficient to reasonably restore any insured loss and that, by reason thereof, the Medical Center may no longer be suitable for operation as a hospital, then upon the agreement of the Issuer and the Corporation, the insurance proceeds shall be delivered to the Issuer and the Lease Agreement shall terminate. Any insurance proceeds so delivered to the Issuer shall be applied to the prepayment of the Notes.

Condemnation

The Trustee shall cooperate fully with the Corporation and the Issuer in the handling and conduct of any prospective or pending condemnation proceedings with respect to the Medical Center facilities or any part thereof. To the extent that any condemnation or threat thereof results in the termination of the Lease Agreement, any available condemnation award or payment received in a sale transaction consummated under the threat of condemnation shall be applied to the prepayment of the Notes.

Remodeling, Improvements and Additions

The Issuer and the Corporation shall each have the privilege of remodeling the Medical Center or making additions, modifications, or improvements thereon or thereto to the extent and in the manner described in the Lease Agreement, and which will not adversely affect the ability of the Issuer or the Corporation to comply with the provisions of the Loan Agreement and the Indenture.

Rates and Charges

The Corporation agrees to use its best efforts to operate the Medical Center on a revenue-producing basis and to charge such fees and rates for its facilities and services and to exercise such skill and diligence as to provide income from the operation of the Medical Center, together with the other available funds, sufficient to pay promptly all payments due on the Notes and on its other indebtedness, all expenses of the operation, maintenance and repair of the Medical Center, and all other payments required to be made by it under the Loan Agreement to the extent permitted by law. The Corporation further agrees that it will, from time to time, as often as necessary and to the extent permitted by law and prevailing market conditions, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Loan Agreement.

If, in any Fiscal Year, the Historical Debt Service Coverage Ratio of the Corporation is less than 1.20:1 (as determined by an independent certified public accountant and communicated in writing to the Trustee), the Trustee shall require the Corporation, at its expense, to retain a Hospital Consultant to make recommendations with respect to the rates, fees and charges of the Corporation's methods of operation and other factors affecting its financial condition in order to increase such Historical Debt Service Coverage Ratio to the highest practicable level and, in all events, to at least 1.20:1.

The foregoing provisions notwithstanding, if, in any Fiscal Year, the Historical Debt Service Coverage Ratio of the Corporation is less than 1.20:1 (as determined by an independent certified public accountant and communicated in writing to the Trustee), the Trustee shall not be obligated to require the Corporation to retain a Hospital Consultant to make such recommendations if: (a) there is filed with the Trustee and the Issuer a written report addressed to them by a Hospital Consultant (which Hospital Consultant and report, including without limitation the scope, form, substance, and other aspects of such report, are acceptable to the Trustee and the Issuer), which contains an opinion of such Hospital Consultant that applicable laws or regulations are the sole reason which has prevented the Corporation

from generating Net Income Available for Debt Service during such Fiscal Year in an amount sufficient to cause the Historical Debt Service Coverage Ratio to equal or exceed 1.20:1, not as a result of any factor or circumstance within the control of the Corporation, and, if requested by the Trustee or the Issuer, such report is accompanied by a concurring opinion of independent counsel (which counsel and opinion, including without limitation the scope, form, substance, and other aspects thereof, are acceptable to the Trustee and the Issuer) as to any conclusions of law supporting the opinion of such Hospital Consultant; (b) the report of such Hospital Consultant indicates that the rates charged by the Corporation are such that, in the opinion of the Hospital Consultant, the Corporation has generated the maximum amount of Pledged Revenues reasonably practicable, given such laws or regulations; and (c) the Historical Debt Service Coverage Ratio of the Corporation for such Fiscal Year was at least 1.00:1. The Corporation shall not be required to cause the Hospital Consultant's report referred to in the preceding sentence to be prepared more frequently than once every two Fiscal Years if, at the end of the first of such two Fiscal Years, the Corporation provides to the Trustee and the Issuer an opinion of independent counsel (which counsel and opinion, including without limitation the scope, form, substance, and other aspects thereof, are acceptable to the Trustee and the Issuer) to the effect that the applicable laws and regulations underlying the Hospital Consultant's report delivered in respect of the previous Fiscal Year have not changed in any material way.

Permitted Indebtedness of Corporation

The Corporation covenants that it will not incur any indebtedness (whether or not incurred through the issuance of Additional Notes) other than:

(a) Additional Notes, if prior to incurrence thereof there is delivered to the Trustee a written report of the Accountants (which report, including without limitation the scope, form, substance and other aspects thereof, is acceptable to the Trustee) stating that the Historical Debt Service Coverage Ratio of the Corporation for the two most recently completed Fiscal Years preceding the incurrence of such Additional Notes for which financial statements reported upon by independent certified public accountants are available was not less than 1.30:1;

(b) Additional Notes for completion of Medical Center facilities if there is delivered to the Trustee: (1) an Officer's Certificate of the Corporation stating that at the time the original Note or Notes for the Medical Center facilities to be completed were executed, the Corporation had reason to believe that the proceeds of such Note or Notes, together with other moneys then expected to be available, would provide sufficient moneys for the construction and equipping of such Medical Center facilities, (2) a statement of an expert acceptable to the Trustee setting forth the amount then estimated to be needed to complete the Medical Center facilities, and (3) an Officer's Certificate of the Corporation stating that the proceeds of such Additional Notes to be applied to the completion of the Medical Center facilities, together with a reasonable estimate of investment income to be earned on such proceeds and available to pay such costs, the amount of moneys, if any, committed to such completion from available cash or marketable securities and reasonably estimated earnings thereon, enumerated bank loans (including letters or lines of credit) and federal or state grants reasonably expected to be available, will be in an amount not less than the amount set forth in the statement of the expert referred to in clause (2) above;

(c) Additional Notes for the purpose of refunding (whether in advance or otherwise) any Outstanding Notes if prior to the incurrence thereof there is delivered to the Trustee either (1) an Officer's Certificate of the Corporation stating that, taking into account the issuance of the proposed Notes and the application of the proceeds thereof and any other funds available to be applied to such refunding, the Maximum Annual Debt Service Requirement of the Corporation will not be increased, or (2) the Accountant's report described in subsection (a) above; and

(d) Subordinated indebtedness without limit.

Consolidation or Merger

The Corporation will not consolidate with or merge into another corporation or permit any other corporation to consolidate with or merge into it unless the surviving, purchasing, resulting or transferee corporation, as the case may be, if other than the Corporation:

(a) assumes in writing all of the obligations of the Corporation under the Loan Agreement;

(b) has a net worth and a net worth to debt ratio at least equal to that of the Corporation as of the date of such consolidation or merger;

(c) the previous two Fiscal Years' net earnings of the Corporation combined with the other corporation's net earnings for a like period results in a combined average of net earnings for the previous two Fiscal Years' of not less than that of the Corporation;

(d) is an exempt organization under Section 501(c)(3) of the Code;

(e) is duly qualified to do business in the State; and

(f) is acceptable to the Issuer.

Events of Default

The happening of one or more of the following events shall constitute an "event of default" under the Loan Agreement:

(a) if default shall be made in the due and punctual payment of the principal of, or interest or premium, if any, on any Note when and as the same shall become due and payable;

(b) if default shall be made in the due and punctual transfer of money to the Trustee pursuant to Article VI of the Loan Agreement when due and payable;

(c) if the Corporation shall have defaulted in the performance or observance of any other of the covenants, agreements or conditions contained in the Loan Agreement or in the Notes, and such default shall have continued for a period of 30 days after written notice thereof, specifying such default and requiring the same to be remedied, shall have been given to the Corporation by the Issuer or the Trustee, or to the Corporation and the Trustee by the Owners of not less than 25% in aggregate principal amount of the Bonds Outstanding;

(d) if the Corporation shall (i) admit in writing its inability to pay its debts generally as they come due, (ii) file a petition in bankruptcy or take advantage of any insolvency act, (iii) make an assignment for the benefit of its creditors, (iv) consent to the appointment of a receiver of itself or of the whole or any substantial part of its property, or (v) on a petition in bankruptcy filed against the Corporation, be adjudicated a bankrupt; or

(e) if the Corporation shall file a petition or answer seeking reorganization or arrangement under the federal bankruptcy laws or any other applicable law or statute of the United States of America or any state thereof, or if a court of competent jurisdiction shall enter an order, judgment or decree appointing, without the consent of the Corporation, a receiver of the Corporation, of the whole or any substantial part of its property, or approving a petition filed against the Corporation seeking reorganization of the Corporation under the federal bankruptcy laws or any other applicable law or statute of the United States of America or any state thereof, and such order, judgment or decree shall not be vacated or set aside or stayed within 60 days from the date of the entry thereof, or if, under the provisions of any other law for the relief or aid of debtors, any court of competent jurisdiction shall assume custody or control of the Corporation or of the whole or any substantial part of its property, and such custody or control shall not be terminated or stayed within 60 days from the date of assumption of such custody or control.

Acceleration

In each and every case of an event of default, and during the continuance of such event of default unless cured by the Corporation within 30 days after written notice thereof, and, unless the principal of all the Notes shall have already become due and payable, the Issuer or the Trustee by notice in writing to the Corporation, may, and upon the written request of the Owners of not less than 25% in principal amount of the Bonds then Outstanding shall, declare the principal of all the outstanding Notes, and the interest accrued thereon, to be due and payable immediately, and upon any such declaration the same shall become and shall be immediately due and payable, anything in the Loan Agreement or in the Notes contained to the contrary notwithstanding.

Remedies

The Issuer or the Trustee, in case of an event of default, may, and upon the written request of the Owners of not less than a majority in principal amount of the Bonds then Outstanding, and upon being indemnified to their satisfaction, shall, exercise any or all of the following remedies to the extent then permitted by law:

(a) The Issuer or the Trustee, themselves or by their respective agents or attorneys, may take possession of all the Pledged Revenues as received and forthwith exercise all rights, powers and franchises of the Corporation in respect thereof, collect the earnings and income therefrom, pay all insurance premiums, taxes and assessments levied on the Medical Center properties, and all disbursements and liabilities of the Trustee under the Indenture, and apply the Pledged Revenues in the manner required by the Loan Agreement.

(b) The Issuer or the Trustee may proceed to protect and enforce its rights and the rights of the owners of the Bonds by a suit or suits in equity or at law, either in mandamus or for the specific performance of any covenant or agreement contained in the Loan Agreement or in aid of the execution of any power granted in the Loan Agreement, or for the foreclosure of the Loan Agreement, or for the enforcement of any other appropriate legal or equitable remedy, as the Issuer or the Trustee, being advised by counsel, may deem most effectual to protect and enforce any of the rights or interests under the Bonds and/or the Loan Agreement. All rights of action under the Loan Agreement or under any of the Notes may be enforced by the Issuer or the Trustee without the possession of any of the Notes or the production thereof on any trial or other proceeding relative thereto and any such suit or proceeding instituted by the Issuer or the Trustee shall be brought in their names as Issuer or Trustee, and any recovery of judgment shall be for the ratable benefit of the owners of the Bonds.

(c) The Issuer or the Trustee may exercise any and all remedies available to them under the Uniform Commercial Code and, with or without entry, sell the Pledged Revenues, and upon such sale may make and deliver to the purchaser a good and sufficient bill of sale or assignment for the same. The Issuer and the Trustee are irrevocably appointed the true and lawful attorneys of the Corporation, in its name and stead, to execute and deliver all necessary bills of sale, assignments and transfers, the Corporation ratifying and confirming all that its said attorneys shall lawfully do by virtue of the Loan Agreement.

(d) The Issuer or the Trustee, upon the bringing of a suit to foreclose the Loan Agreement, as a matter of right, without notice and without giving bond to the Corporation or anyone claiming under it, may have a receiver appointed of all the Pledged Revenues pending such proceedings, with such powers as the court making such appointment shall confer, including such powers as may be necessary or usual in such cases for the protection and control of the Pledged Revenues, and the Corporation does irrevocably consent to such appointment.

(e) The Trustee is appointed by the Issuer as its true and lawful attorney in fact with authority to make or file, on behalf of the Issuer and on behalf of all Owners of the Bonds, as a class, any proof of debt, amendment to proof of debt, petition or other documents; to receive payment of all sums becoming distributable on account thereof; to execute any other papers and documents and to do and

perform any and all acts and things for and in behalf of the Issuer and of all Owners of the Bonds as a class, as may be necessary or advisable in the opinion of the Trustee, in order to have the respective claims of the Issuer and of the Owners of the Bonds against the Corporation allowed in any equity receivership, insolvency, liquidation, bankruptcy or other proceedings, to which the Corporation shall be a party. The powers granted to the Trustee shall not prevent the Issuer from exercising such powers in its own right. The Trustee shall have full power of substitution and delegation in respect of any such powers.

Supplemental Loan Agreements Not Requiring Consent of Owners of the Bonds

The Corporation, when authorized by resolution of its Board of Directors, and the Issuer, from time to time and at any time, subject to the conditions and restrictions of the Loan Agreement and the Indenture, may enter into loan agreements supplemental thereto, which loan agreements thereafter shall form a part thereof, for any one or more of all of the following purposes:

(a) To add to the covenants and agreements of the Corporation under the Loan Agreement, or to surrender any right or power herein reserved to or conferred upon the Corporation;

(b) To make such provisions for the purpose of curing any ambiguity, or of curing, correcting or supplementing any defective or inconsistent provisions contained in the Loan Agreement, or in regard to matters or questions arising under the Loan Agreement, as the Corporation may deem necessary or desirable and not inconsistent with the Loan Agreement and which shall not adversely affect the interests of the Owners of the Bonds;

(c) To subject, describe or redescribe any property subjected or to be subjected to the lien of the Loan Agreement;

(d) To provide for the issuance of Additional Notes or other obligations to the extent permitted by the Loan Agreement;

(e) To make such additions, deletions, or modifications as may be necessary to assure compliance with Section 145 of the Code relating to qualified 501(c)(3) obligations, Section 148(f) of the Code relating to required rebate of excess investment earnings to the United States, or otherwise as may be necessary to assure exemption from federal income taxation of interest on the Bonds; and

(f) To modify, amend or supplement the Loan Agreement or any loan agreement supplemental thereto in such manner as to permit the qualification thereof under the Trust Indenture Act of 1939 or any similar federal statute hereafter in effect, and, for the purpose of such qualification, to add to the Loan Agreement or any loan agreement supplemental thereto such other terms, conditions and provisions as may be required by said Trust Indenture Act of 1939 or similar federal statute.

Supplemental Loan Agreements Requiring Consent of Owners of the Bonds

With the consent of the Owners of not less than fifty-one percent (51%) in aggregate principal amount of the Outstanding Bonds, the Corporation, when authorized by a resolution of its Board of Directors, and the Issuer, may from time to time and at any time enter into a supplemental loan agreement for the purpose of adding any provisions to or changing in any manner or eliminating any of the provisions of the Loan Agreement or of any supplemental loan agreement; provided, however, that no such supplemental loan agreement shall (a) extend the fixed maturity of the Notes, reduce the rate of interest thereon, extend the time of payment of interest, reduce the amount of the principal thereof, or reduce any premium payable on the redemption thereof, without the consent of the Owner of each Note or Bond so affected, or (b) reduce the aforesaid percentage of Owners of Bonds required to approve any such supplemental loan agreement or (c) permit the creation of any lien on the Pledged Revenues prior to or on a parity with the lien of the Loan Agreement, or deprive the Owners of the Bonds of the lien created by the Loan Agreement upon said Pledged Revenues, without the consent of the Owners of all the Outstanding Bonds. Upon receipt by the Trustee of a certified resolution authorizing the execution of any such supplemental loan agreement and upon the filing with the Trustee of evidence of the consent of the Owners, as aforesaid, the Issuer shall join with the Corporation in the execution of such supplemental

loan agreement unless such supplemental loan agreement shall affect the Issuer's own rights, duties or immunities under the Loan Agreement or otherwise, in which case the Issuer may in its discretion, but shall not be obligated to, enter into such supplemental loan agreement.

It shall not be necessary for the consent of the Owners of the Bonds to approve the particular form of any proposed supplemental loan agreement, but it shall be sufficient if such consent shall approve the substance thereof.

Discharge and Satisfaction

The covenants, liens and pledges created or imposed pursuant to the Loan Agreement may be fully discharged and satisfied with respect to the Notes in any one or more of the following ways:

(a) By paying all of the Bonds, principal and interest, when the same become due and payable;

(b) By depositing with the Trustee in the manner provided by the Indenture and for that purpose, at or before the date of maturity or redemption, money in the necessary amount to pay or redeem all of the Bonds;

(c) By depositing with the Trustee, and for such purpose, at or before the date of maturity or redemption, Defeasance Obligations in an amount sufficient, including any income or increment to accrue thereon, but without the necessity of any reinvestment, to pay or redeem such Bonds in accordance with their terms; and

(d) By the payment of all other sums payable hereunder and under the Indenture by the Corporation.

Upon such discharge and satisfaction, the Loan Agreement shall cease, determine and become null and void, and thereupon the Issuer shall, upon the Written Request of the Corporation, and upon receipt by the Issuer of an Officers' Certificate from the Corporation and the Trustee, and an opinion of counsel, each stating that in the opinion of the signers all conditions precedent to the satisfaction and discharge of the Loan Agreement have been complied with, forthwith execute proper instruments acknowledging satisfaction of and discharging the Loan Agreement. The satisfaction and discharge of the Loan Agreement shall be without prejudice to the rights of the Trustee to charge and be reimbursed by the Corporation for any expenditures which it may thereafter incur in connection therewith.

Corporation's Liability Terminated

Upon the deposit with the Trustee, in trust, at or before maturity, of money or Defeasance Obligations in the amount required to discharge the Notes, provided that if the Bonds are to be redeemed prior to the maturity thereof notice of such redemption shall have been given as provided in the Indenture, or such provisions satisfactory to the Trustee shall have been made for the giving of such notice, all liability of the Corporation in respect of the Notes shall cease, determine and be completely discharged; and provided, further, that notwithstanding such deposit, the Corporation shall nevertheless be obligated to pay such amounts as shall be necessary to provide for the payment in full of the principal of, redemption premium, if any, and interest on the Bonds so defeased if, for any reason, the amount so deposited shall be insufficient for the intended purposes.

SUMMARY OF PORTIONS OF THE INDENTURE

The Indenture is a contract between the Issuer and the Trustee for the benefit of Holders of any Bonds issued pursuant to the Indenture. Under the Indenture, the Issuer has assigned to the Trustee all of the Issuer's right, title and interest in the Notes and the Loan Agreement (except for certain rights to payment of expenses and indemnification). Set forth below is a summary of certain provisions of the Indenture which does not purport to be comprehensive. Reference is made to the full text of the Indenture for a complete description of its terms.

Creation of Funds and Application of Fund Proceeds

The following funds and accounts, to be held by the Trustee, are hereby created by the Issuer and the money deposited therein shall be held and applied as described generally below.

(a) Revenue Fund

(b) Bond Fund, and therein the -

(i) Interest Account (and subaccounts therein), and the

(ii) Principal Account (and subaccounts therein)

(c) Costs of Issuance Account

(d) Debt Service Reserve Fund (and subaccounts therein)

(e) Operating Fund

(f) Rebate Fund (and subaccounts therein)

Revenue Fund

So long as the Corporation makes the required monthly payments to the Trustee for deposit in the Bond Fund in an amount equal to 1/6 of the interest on and 1/12 of the principal of the Bonds next due, the Corporation shall maintain control of the Pledged Revenues. See the caption "SUMMARY OF PORTIONS OF THE LOAN AGREEMENT – Payments to Trustee for Deposit in Bond Fund" herein. In the event said required payments are not made when due, all Pledged Revenues shall be paid directly to the Trustee and shall be deposited by the Trustee in the Revenue Fund and shall be applied as follows:

Bond Fund

There shall be deposited into the applicable subaccounts within the Interest Account in the Bond Fund as and when received:

(a) Such portion of Bond proceeds as may be specified in the Indenture or by Written Request of the Issuer or the Corporation;

(b) That portion of all monthly Note payments under the Loan Agreement representing interest, which shall generally be equal to 1/6 of the interest on the Bonds next due; and

(c) All other moneys received by the Trustee under and pursuant to any of the provisions of the Indenture, the Loan Agreement or the Bond Guaranty Agreement directing such moneys to be paid into the Bond Fund – Interest Account.

There shall be deposited into the applicable subaccounts within the Principal Account in the Bond Fund as and when received:

(a) That portion of all monthly Note payments under the Loan Agreement representing principal, which shall generally be equal to 1/12 of the principal of the Bonds next due;

(b) All moneys received as Sinking Fund Installments; and

(c) All other moneys received by the Trustee under and pursuant to any of the provisions of the Indenture, the Loan Agreement or the Bond Guaranty Agreement directing such moneys to be paid into the Bond Fund – Principal Account.

Debt Service Reserve Fund

There shall be deposited into the Debt Service Reserve Fund, as and when received, such portion of the proceeds of a series of Bonds or funds from other sources as may be specified in the Indenture, in

any supplemental indenture, or in any Written Request as shall be required to cause the amounts on deposit therein to equal the Debt Service Reserve Fund Requirement. Additional deposits shall be made to the Debt Service Reserve Fund from the Revenue Fund in order to maintain a minimum balance therein of not less than the Debt Service Reserve Fund Requirement.

Moneys in the Debt Service Reserve Fund shall be used solely:

(a) for the payment of the principal, redemption premium, if any, and interest on the Bonds Outstanding, to the extent moneys in the Bond Fund are insufficient for such purposes;

(b) to pay the Trustee's and Paying Agent's fees and charges, to the extent that other funds are not available for these purposes; and

(c) for transfers into the Bond Fund – Principal Account whenever the balance in the Debt Service Reserve Fund shall exceed the Debt Service Reserve Fund Requirement.

Costs of Issuance Account

There shall be deposited into the Costs of Issuance Account, as and when received, such portion of the proceeds of a series of Bonds as may be specified in the Indenture or by Written Request of the Issuer or the Corporation. An amount not in excess of two percent (2%) of the lesser of (i) the aggregate face amount or (ii) the issue price of the Bonds shall be used to pay for or provide for the payment of Issuance Costs. Moneys in the Costs of Issuance Account shall be disbursed by the Trustee upon the Written Request of the Issuer or the Corporation for any Issuance Costs incurred in connection with the issuance and sale of any Bonds. At such time as the Corporation or the Issuer shall furnish to the Trustee a certificate stating that all such Issuance Costs have been paid, the Trustee shall transfer any money remaining in the Costs of Issuance Account to the applicable subaccount of the Bond Fund – Interest Account.

Operating Fund

The Operating Fund shall be used in the event that the Corporation shall be required to deposit Pledged Revenues with the Trustee pursuant to the Loan Agreement, and otherwise at the option of the Corporation. The Operating Fund shall be held in a separate checking account and may be disbursed by the Corporation for the purpose of paying Current Expenses, or for any other lawful purpose, on the signatures of such officers of the Corporation as may have been so authorized by the Board of Directors of the Corporation, such authorization to be evidenced to the satisfaction of the Trustee.

Rebate Fund

The Trustee shall establish and maintain a fund separate from any other fund established and maintained under the Indenture which shall be designated as the Rebate Fund. Within the Rebate Fund, the Trustee shall maintain such accounts as shall be necessary in order to comply with the terms and requirements of the Tax Regulatory Agreement. Subject to the provisions in the Indenture requiring transfer to the United States of America, all money at any time deposited in the Rebate Fund shall be held by the Trustee in trust, to the extent required to satisfy the Rebate Amount (as defined in the Tax Regulatory Agreement), for payment to the United States of America, and neither the Issuer, the Corporation, nor the Owner of any Bonds shall have any rights in or claim to such money.

Investment of Money

All money held by the Trustee in any fund or account created pursuant to the Indenture, including any special fund, shall be invested and reinvested by the Trustee, pursuant to written directions of the Corporation, in Permitted Investments which shall mature, or be subject to redemption at the option of the owner thereof, not later than the respective dates when the money held for the credit of such fund, account or special fund will be required for the purposes intended.

Account or Fund Credited; Transfer of Income

Permitted Investments shall be deemed at all times to be a part of the fund, account or special fund for which such investment was made, and losses sustained by reason of such investments shall be charged against such fund, account or special fund and the net earnings and income received by reason of such investments shall be credited to such fund, account or special fund.

Improvement Bonds

Additional Bonds (herein referred to as the "Improvement Bonds") may be issued by the Issuer under and secured by the Indenture, at one time or from time to time, subject to the conditions hereinafter provided, for the purpose of providing funds, with any other available funds, for paying the cost of any Improvements to the Medical Center, together with incidental expenses and payments in connection therewith.

Improvement Bonds shall be issued in such amount, shall be dated, shall mature, shall bear interest at the rate or rates (not exceeding the maximum rate then permitted by law), shall be redeemable at such times and prices, subject to the provisions of Article III of the Indenture, and shall have such other provisions as may be provided by the supplemental indenture authorizing the issuance of the Improvement Bonds.

Except as to any differences in the date, in the maturities, in the rate or rates of interest and in the provisions for redemption, the Improvement Bonds shall be on a parity with and shall be entitled to the same benefit and security of the Indenture as the Series 2006 Bonds, the Series 2011 Bonds, the Series 2021 Bonds and any Additional Bonds issued under the provisions of the Indenture.

Improvement Bonds shall be executed substantially in the form and manner set forth in the Indenture with such changes and revisions as may be necessary or appropriate to conform to the supplemental indenture authorizing the issuance of the Improvement Bonds. The Trustee shall authenticate and deliver the Improvement Bonds upon receipt of at least the following:

(a) a copy, certified by the County Clerk of the Issuer, of the ordinance adopted by the Issuer authorizing the issuance, execution and delivery of the Improvement Bonds and the execution, delivery and performance of the supplemental indenture and an amendment to the Loan Agreement describing in general terms the Improvements to be provided and estimating the cost of such Improvements and any required payments to the Construction Fund, the Bond Fund, the Debt Service Reserve Fund, the Costs of Issuance Account, or other funds or accounts required by the Indenture, or a supplemental indenture, and all incidental costs in connection with the issuance and delivery of the Improvement Bonds;

(b) a certificate of the County Judge of the Issuer stating in substance that (i) the Issuer is not, and upon the issuance of the Improvement Bonds will not be, in default under the Indenture or under any supplemental indenture and (ii) all conditions precedent provided in the Indenture and any supplemental indenture relating to the issuance of the Improvement Bonds have been complied with;

(c) an opinion of counsel for the Corporation in the form provided in the Indenture;

(d) a statement, signed by the Consulting Architect, giving the Consulting Architect's estimate of the date on which the Improvements for which the Improvement Bonds are to be issued will be placed in use and operation and his estimate of the total amount required for paying the Cost of such Improvements;

(e) a report of the Accountants acceptable to the Trustee, stating that the requirements of the Loan Agreement with respect to which Additional Notes may be incurred by the Corporation have been met;

(f) executed counterparts of the amendment to the Loan Agreement and the supplemental indenture; and

(g) a Written Request to the Trustee, signed by the County Judge of the Issuer, to authenticate and deliver the Improvement Bonds to the purchaser or purchasers therein identified.

Refunding Bonds

Additional Bonds (herein referred to as "Refunding Bonds") may be issued under and secured by the Indenture, at any time or times, subject to the conditions hereinafter provided, for the purpose of providing funds for refunding all or part of the Bonds then Outstanding of any series, including the payment of any redemption premium thereon and interest which will accrue on the Bonds to the earliest redemption date, and any expenses in connection with such refunding. Such Refunding Bonds may also be issued to provide for the defeasance of all of a series of Bonds outstanding in accordance with Article XII of the Indenture and to pay expenses in connection therewith.

Refunding Bonds shall be designated in such manner, shall mature, shall bear interest at such rate or rates (not exceeding the maximum rate then permitted by law), shall be redeemable at such times and prices, subject to the provisions of Article III of the Indenture, and shall have such other provisions, all as may be provided by the supplemental indenture authorizing the issuance of such Refunding Bonds. Except as to any differences in the date, in the maturities, in the rate or rates of interest and in the provisions for redemption, the Refunding Bonds shall be on a parity with and shall be entitled to the same benefits and security of the Indenture as the Series 2006 Bonds, the Series 2011 Bonds, the Series 2021 Bonds and any other Additional Bonds issued under the Indenture.

Subordinate Bonds

Upon the approval of the Corporation, additional bonds payable from Pledged Revenues may be issued, which additional bonds are junior and subordinate to the Bonds, whether or not secured by the Indenture, without regard to the requirements for the issuance of Improvement Bonds or Refunding Bonds.

Defaults; Events of Default

If any of the following events occur, it is hereby defined as and declared to be and to constitute an "event of default":

(a) Default in the due and punctual payment of any interest on any Bond; or

(b) Default in the due and punctual payment of the principal of any Bond, whether at the stated maturity thereof or when called for redemption; or

(c) There shall occur an event of default under the Tax Regulatory Agreement (as defined therein);

(d) Default in the performance or observance of any other of the covenants, agreements or conditions on the part of the Issuer contained in the Indenture or in the Bonds and failure to remedy the same after notice thereof; or

(e) An "event of default" (as therein defined) shall have occurred under the Loan Agreement; or

(f) An "event of default" (as therein defined) shall have occurred under the Bond Guaranty Agreement.

Acceleration Remedies; Rights of Bond Owners

Upon the occurrence of an event of default, the Trustee may, and upon the written direction of the Owners of not less than 25% in aggregate principal amount of Bonds then Outstanding, shall, by notice in writing delivered to the Issuer declare the principal of and interest accrued on all Bonds then Outstanding

immediately due and payable and such principal and accrued interest shall thereupon be and become immediately due and payable.

Upon the occurrence of an event of default, the Trustee may pursue any available remedy at law or in equity to enforce the payment of the principal and interest on the Bonds then Outstanding, including enforcement of any rights of the Issuer under the Loan Agreement.

Rights and Remedies of Owners of the Bonds; Indemnity of Trustee

No Owner of any Bond shall have any right to institute any suit, action or proceeding at law or in equity for the enforcement of the Indenture or for the execution of any trust thereof or for the appointment of a receiver or any other remedy thereunder, unless (a) a default has occurred of which the Trustee has been notified, or of which it is deemed to have notice, (b) such default shall have become an event of default and the Owners of not less than twenty-five percent (25%) in aggregate principal amount of Bonds then Outstanding shall have made written notice to the Trustee and shall have offered it reasonable opportunity either to proceed to exercise the powers granted by the Indenture or to institute such action, suit or proceeding in their own name or names, (c) they have offered to the Trustee indemnity, and (d) the Trustee shall thereafter fail or refuse to exercise the powers granted by the Indenture, or to institute such action, suit or proceeding in its own name; and such notification, request and offer of indemnity are declared in every case at the option of the Trustee to be conditions precedent to the execution of the powers and trusts of the Indenture, and to any action or cause of action for the enforcement of the Indenture, or for the appointment of a receiver or for any other remedy under the Indenture; it being understood and intended that no one or more Owner or Owners of the Bonds shall have any right in any manner whatsoever to affect, disturb or prejudice the lien of the Indenture by its, his or their action or to enforce any right except in the manner provided in the Indenture, and that all proceedings at law or in equity shall be instituted, had and maintained in the manner provided in the Indenture, and for the equal and ratable benefit of the Owners of all Bonds then Outstanding.

Notice of Certain Defaults to the Issuer and the Corporation; Opportunity of the Issuer and the Corporation to Cure Such Defaults

No default (other than by reason of nonpayment) under the Indenture or the Bonds shall constitute an event of default until actual notice of such default by first class mail (postage prepaid) shall be given to the Issuer and the Corporation by the Trustee or by the Owners of not less than twenty-five percent (25%) in aggregate principal amount of all Bonds Outstanding, and the Issuer shall have had thirty (30) days after receipt of such notice to correct said default or cause said default to be corrected, and shall not have corrected said default or caused said default to be corrected within the applicable period; provided, however, if said default be such that it cannot be corrected within the applicable period, it shall not constitute an event of default if corrective action is instituted by the Issuer or the Corporation within the applicable period and diligently pursued until the default is corrected.

With regard to any alleged default concerning which notice is given to the Issuer and the Corporation, the Issuer grants to the Trustee full authority for the account of the Issuer to perform any covenant or obligation alleged in said notice to constitute a default, in the name and stead of the Issuer with full power to do any and all things and acts to the same extent that the Issuer could do and perform any such things and acts and with power of substitution.

Supplemental Indentures Not Requiring Consent of Owners of Bonds

The Issuer and the Trustee may, without the consent of, or notice to, any of the Owners enter into an indenture or indentures supplemental to the Indenture as shall not be inconsistent with the terms and provisions of the Indenture for any one or more of the following purposes:

(a) To make such provisions for the purpose of curing any ambiguity, or of curing, correcting or supplementing any defective or inconsistent provisions contained in the Indenture, or in regard to matters or questions arising under the Indenture, as the Issuer may deem necessary

or desirable and not inconsistent with the Indenture and which shall not adversely affect the interests of the Owners of the Bonds;

(b) To subject to the Indenture additional revenues, properties or collateral;

(c) To provide for the issuance of Additional Bonds to the extent permitted by the Indenture;

(d) To modify, amend or supplement the Indenture or any indenture supplemental thereto in such manner as to permit the qualification thereof under the Trust Indenture Act of 1939 or any similar federal statute then in effect or to permit the qualification of the Bonds for sale under the securities laws of any of the states of the United States of America, and, if they so determine, to add to the Indenture or any indenture supplemental thereto such other terms, conditions and provisions as may be permitted by said Trust Indenture Act of 1939 or similar federal statute;

(e) To evidence the appointment of a separate or Co-Trustee or the succession of a new Trustee or Paying Agent under the Indenture; or

(f) To make such additions, deletions or modifications as may be necessary to assure compliance with Section 145 of the Code relating to qualified 501(c)(3) obligations, Section 148(f) of the Code relating to required rebate to the United States, or otherwise as may be necessary to assure the exclusion from gross income for federal income tax purposes of interest on the Bonds.

Supplemental Indentures Requiring Consent of Owners of the Bonds

Exclusive of supplemental indentures for the purposes described above, the Owners of not less than two-thirds in aggregate principal amount of the Bonds then Outstanding shall have the right, from time to time, anything contained in the Indenture to the contrary notwithstanding, to consent to and approve the execution by the Issuer and the Trustee of such other supplemental indenture or indentures as shall be deemed necessary and desirable by the Trustee for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the Indenture or in any supplemental indenture; provided, however, that the above shall not permit, or be construed as permitting, without the consent of the Owners of all Outstanding Bonds, (a) an extension of the maturity or mandatory sinking fund redemption date of the principal of or the interest on any Bond, or (b) a reduction in the principal amount of any Bond or the rate of interest, or sinking fund redemption requirements, thereon, or (c) a privilege or priority of any Bond or Bonds over any other Bond or Bonds, or (d) a reduction in the aggregate principal amount of the Bonds required for consent to such supplemental indenture, or (e) the creation of any lien other than a lien ratably securing all of the Bonds at any time Outstanding, or (f) any modification of the trusts, powers, rights, obligations, duties, remedies, immunities and privileges of the Trustee without the written consent of the Trustee.

Bonds Deemed to be Paid; Defeasance

If the Issuer shall pay or cause to be paid, or there shall be otherwise paid or provision for payment made, to or for the Owners of the Bonds the principal of, premium, if any, and interest due or to become due thereon at the times and in the manner stipulated therein, and shall pay or cause to be paid to the Trustee all sums of moneys due or to become due according to the provisions of the Indenture, then the estate and rights granted by the Indenture shall cease, terminate and be void, whereupon the Trustee shall cancel and discharge the lien of the Indenture, and execute and deliver to the Issuer such instruments in writing as shall be requisite to cancel and discharge the lien thereof, and release, assign and deliver unto the Issuer any and all of the estate, right, title and interest in and to any and all rights assigned or pledged to the Trustee or otherwise subject to the lien of the Indenture, except moneys or securities held by the Trustee for the payment of the principal of and interest on the Bonds, and except moneys or securities in the Rebate Fund.

Any Bond shall be deemed to be paid within the meaning of the Indenture when payment of the principal of and premium, if any, on such Bond, plus interest thereon to the due date or redemption date thereof (whether such due date be by reason of maturity or upon redemption as provided in the Indenture, or otherwise), either (a) shall have been made or caused to have been made in accordance with the terms thereof, or (b) shall have been provided for by irrevocably depositing with the Trustee, in trust and irrevocably setting aside exclusively for such payment, (i) moneys sufficient to make such payment, or (ii) noncallable Government Obligations maturing as to principal and interest in such amount, and at such times as will insure the availability of sufficient moneys to make such payment, and all necessary and proper fees, compensation and expenses of the Trustee, if any, pertaining to the Bonds with respect to which such deposit is made shall have been paid or the payment thereof provided for to the satisfaction of the Trustee. At such times as a Bond shall be deemed to be paid under the Indenture, it shall no longer be secured by or entitled to the benefits of the Indenture, except for the purposes of any such payment from the escrowed Government Obligation.

SUMMARY OF PORTIONS OF THE BOND GUARANTY AGREEMENT

The following is a summary of certain provisions of the Bond Guaranty Agreement. The summary does not purport to be complete and reference is made to the full text of the Bond Guaranty Agreement for a complete description of its terms.

Guaranty

The Corporation guarantees to the Trustee for the benefit of the owners from time to time of the Series 2021 Bonds, (a) the full and prompt payment of the principal of and premium, if any, on any Series 2021 Bond when and as the same shall become due and payable, whether at the stated maturity thereof, by acceleration, call for redemption or otherwise, and (b) the full and prompt payment of any interest on any Bond when and as the same shall become due and payable.

In the event of a default in the payment of principal of or premium, if any, on any Series 2021 Bond when and as the same shall become due, whether at the stated maturity thereof, by acceleration, call for redemption or otherwise, or in the event of a default in the payment of any interest on any Series 2021 Bond when and as the same shall become due, the Trustee may, and if requested so to do by the owners of not less than a majority in aggregate principal amount of the Series 2021 Bonds then outstanding and upon indemnification as provided below, shall be obligated to proceed under the Bond Guaranty Agreement, and the Trustee, in its sole discretion, shall have the right to proceed first and directly against the Corporation under the Bond Guaranty Agreement without proceeding against any other person or exhausting any other remedies which it may have and without resorting to any other security held by the Issuer or the Trustee.

Before taking any action under the Bond Guaranty Agreement, the Trustee may require that satisfactory indemnity be furnished by the owners of the Series 2021 Bonds requesting such action for the reimbursement of all expenses and to protect against all liability, except liability which is adjudicated to have resulted from the Trustee's gross negligence or willful misconduct by reason of any action so taken.

Security for Bond Guaranty Agreement Obligations

Notwithstanding any other provision contained elsewhere in the Bond Guaranty Agreement or in the Indenture to the contrary, the obligations of the Corporation under the Bond Guaranty Agreement are secured solely by Pledged Revenues within the Corporation's possession and control.

Specific Note Prepayment Obligations

In the event the Lease Agreement is to be terminated by either the Issuer or the Corporation prior to its expiration in accordance with the provisions thereof, the Corporation shall immediately prepay the remaining balance of the Series 2021 Note to the extent of available Pledged Revenues within its control in excess of one month's operating expenses for the Medical Center (based upon the average monthly

operating expenses of the Medical Center for the preceding fiscal year). Such prepayment shall be applied to the redemption of the Series 2021 Bonds prior to maturity, at the direction of the Issuer, in accordance with the terms of the Indenture.

In the event the Lease Agreement is to be terminated because of damage to or destruction of the Medical Center as a result of fire or other casualty, the Corporation shall immediately prepay the remaining balance of the Series 2021 Note to the extent of available Pledged Revenues within its control in excess of one month's operating expenses for the Medical Center (based upon the average monthly operating expenses of the Medical Center for the preceding fiscal year). Such prepayment shall be applied to the redemption of the Series 2021 Bonds prior to maturity, at the direction of the Issuer, in accordance with the terms of the Indenture.

In the event the Lease Agreement is to be terminated because of condemnation of all or a portion of the Medical Center, the Corporation shall immediately prepay the remaining balance of the Series 2021 Note to the extent of available Pledged Revenues within its control in excess of one month's operating expenses for the Medical Center (based upon the average monthly operating expenses of the Medical Center for the preceding fiscal year). Such prepayment shall be applied to the redemption of the Series 2021 Bonds prior to maturity, at the direction of the Issuer, in accordance with the terms of the Indenture.

In the event any action by the Issuer or the Corporation causes any interest on the Series 2021 Bonds to become taxable to the owners thereof pursuant to the Code, and in the judgment of the Trustee such effect cannot be remedied within a reasonable period of time, the Corporation shall immediately prepay the remaining balance of the Series 2021 Note to the extent of available Pledged Revenues within its control in excess of one month's operating expenses for the Medical Center (based upon the average monthly operating expenses of the Medical Center for the preceding fiscal year). Such prepayment shall be applied to the redemption of the Series 2021 Bonds prior to maturity, at the direction of the Issuer, in accordance with the terms of the Indenture.

SUMMARY OF PORTIONS OF THE LEASE AGREEMENT

The Medical Center has been leased to the Corporation by the Issuer pursuant to the terms of an Assignment and Lease Agreement dated as of March 1, 1997, as amended by an Amendment to Assignment and Lease Agreement dated as of November 1, 2010 (as amended, the "Lease Agreement"). Set forth below is a summary of certain provisions of the Lease Agreement which does not purport to be comprehensive. Reference is made to the full text of the Lease Agreement for a complete description of its terms.

Terms and Consideration

The Lease Agreement has a term with a stated maturity of December 31, 2041. For and in consideration of the use of the Medical Center premises, the Corporation has agreed to pay $25.00 to the Issuer on or before March 1 of each year during the term of the Lease Agreement.

Use of Leased Premises

The Corporation agrees to use the leased premises for the purpose of carrying on therein and thereon the business of running a hospital for the care of persons who require medical and surgical attention, or for any other purpose incidental or related to the provision of health care to the citizens of the Issuer.

Maintenance of Leased Premises

The Corporation agrees to maintain the leased premises, including the grounds, furnishings and equipment, in suitable condition. Subject to obtaining any necessary regulatory approvals, the Corporation agrees to maintain and provide all equipment, furnishings, supplies and other personal property required for the proper operation, maintenance and repair of the leased premises in an economical and efficient manner, consistent with generally acceptable medical facilities comparable to

the Medical Center. The Corporation agrees that the equipment and supplies furnished by it shall conform to the standards approved by the appropriate state licensing authorities, and the Corporation will strive to so maintain and replace such equipment and supplies that the same shall at all times be approved by such licensing authorities.

Operating Costs

The Corporation agrees to hold the Issuer harmless against any and all deficits arising out of the operation of the Medical Center and it assumes and agrees to pay all operating expenses. Nothing in the Lease Agreement shall be construed to authorize the Corporation to obligate the Issuer to any third party nor to authorize the Corporation to pledge the full faith and credit of the Issuer.

Insurance Coverage

The Corporation agrees to secure and maintain at all times during the term of the Lease Agreement adequate fire and extended coverage insurance upon the leased premises and the contents thereof in one or more reputable insurance companies authorized to transact business in the State of Arkansas. The amount of coverages shall at no time be less than ninety percent (90%) of the aggregate obtainable according to normal underwriting practice in effect from time to time during the term of the Lease Agreement. In the event of an insured loss of the leased premises and/or any of the personalty therein supplied by the Issuer, the proceeds payable therefor by the insurers shall, to the extent thereof, be used to restore and replace said loss or losses, but in no event shall the Corporation be required to contribute any sums toward said replacement or restoration. The policy or policies issued from time to time to protect the building and property of the Issuer shall contain loss payable clauses to the Issuer and the Corporation, and the Issuer binds itself that the proceeds thereof shall be applied to the restoration of any losses; provided, should the Issuer and the Corporation mutually agree that the proceeds of said policies shall be insufficient to reasonably restore any insured loss and that, by reason thereof, said building or buildings and equipment may no longer be suitable to the operation of a hospital, then upon the agreement of the Issuer and the Corporation, the proceeds of said insurance shall be delivered to the Issuer and the Lease Agreement shall terminate. See, however, the captions "SECURITY FOR THE BONDS" and "THE SERIES 2021 BONDS – Extraordinary Redemption" herein.

Title to Property

All additional structures constructed on the leased premises and all capitalized equipment, furniture, appliances and apparatuses purchased by the Corporation for use on the leased premises shall become the property of the Issuer upon the expiration or sooner termination of the Lease Agreement. Further, any other land, structures, equipment, furniture, appliances, apparatuses, cash, cash equivalents, accounts receivable, inventory or other personal property of any and every kind used by the Corporation in the operation of the Medical Center at the expiration or sooner termination of the Lease Agreement shall become the property of the Issuer. In any event, and notwithstanding anything which may be construed to the contrary, the Corporation is obligated to return to the Issuer at the termination of the Lease Agreement a fully equipped and operating hospital.

Management

The Corporation shall have full and complete charge of the administration, management and operation of the Medical Center and shall have the exclusive right to determine and make all fiscal, technical and professional policies relating thereto. Should any gains be derived through the operation of the Medical Center, the same shall inure to and be the property of the Corporation.

While the amount of charity care provided by the Medical Center shall be left to the discretion of the Corporation, the Corporation will maintain at least historical dollar levels of charity care subject to the determination of the Corporation, in its sole judgment, that such levels are practicable in light of funds which may be available.

The Corporation shall have the full and exclusive charge of the employment and dismissal of personnel, including, but not limited to, administrator, managers and nurses, and shall fix the duties and prescribe the working conditions of each.

The Corporation agrees that the Medical Center, to the extent of its available facilities and personnel, shall be open at all times to patients without discrimination because of race, creed, color, sex, national origin or disability.

The Corporation shall have the full power and exclusive authority to determine the type of health care services to be provided by the Medical Center.

The Corporation shall have the full power and exclusive authority to prescribe the qualifications for membership on and the composition of the medical staff of the Medical Center, it being contemplated, however, that the Corporation shall require high standards and will operate the Medical Center in a manner and upon such basis as to create and maintain an efficient and qualified hospital organization.

Events of Termination

(a) Upon sixty (60) days' written notice by the Corporation to the Issuer, the Lease Agreement may be terminated prior to its expiration date, at the sole option of the Corporation for any of the following reasons:

(i) In the event the Corporation shall find it is unable to operate the Medical Center through lack of sufficient income from its operation or because of lack of cooperation on the part of physicians and surgeons in the use of the Medical Center, or for any other reason attributable to income, however caused;

(ii) The destruction of the Medical Center or contents thereof by fire, explosion, action of the elements or any other cause;

(iii) Damage to the Medical Center, or contents thereof, which, in the opinion of the Corporation, would render the continued operation of the Medical Center impractical;

(iv) A strike, or other cessation of work by the personnel of the Medical Center, or a boycott thereof, resulting in loss of sufficient income or personnel, in the Corporation's opinion, to enable it to operate in accordance with desirable standards; or

(v) The occurrence of any other contingency or the happening of any other event or series of events or contingencies resulting in the Corporation being deprived of sufficient income to enable it to operate successfully in the opinion of the Corporation.

(b) Upon written notice as provided below, by the Issuer to the Corporation, the Lease Agreement may be terminated by the Issuer prior to its expiration date for any of the following reasons:

(i) Mismanagement or misconduct of operations of the Medical Center by the Corporation;

(ii) The Corporation's failure to comply with its obligations under the terms of the Lease Agreement;

(iii) The Corporation's failure to provide the Issuer the opportunity to veto nomination of prospective members of the Corporation's Board of Directors; or

(iv) Insolvency of the Corporation.

Should any of the four (4) conditions above occur, the Issuer shall give the Corporation notice in writing to correct any such condition or conditions, and should the Corporation fail to do so within sixty (60) days from the date of said notice, the Lease Agreement shall be terminated.

Indemnification

The Corporation agrees to indemnify and hold the Issuer harmless from and against any and all claims and/or suits arising out of the Corporation's operation of the Medical Center. The Corporation further agrees to pay for any and all costs, including, but not limited to all legal fees incurred by the Issuer in hiring legal counsel to represent the Issuer to defend any legal claim, challenges or lawsuit arising out of the operation of the Medical Center and/or the enactment or operation of the Lease Agreement.

SUMMARY OF PORTIONS OF THE CONTINUING DISCLOSURE AGREEMENT

The Corporation has entered into an undertaking in the form of the Continuing Disclosure Agreement as required by the Indenture for the benefit of the Beneficial Owners of the Series 2021 Bonds to cause certain operating information and financial statements to be sent to the Municipal Securities Rulemaking Board (the "MSRB") annually and to cause notice to be sent to the MSRB of certain specified events, pursuant to the requirements of Section (b)(5)(i) of Rule 15c2-12 of the Securities Exchange Act of 1934, as amended (the "Rule").

The Corporation is a party to prior undertakings pursuant to the Rule requiring that it file certain operating information and financial statements and notice of the occurrence of certain listed events with the MSRB through its Electronic Municipal Market Access system ("EMMA"). During the past five years, the Corporation has identified certain instances in which filings were not made as required by such agreements. A listing of such instances, which may not be inclusive, is set forth below.

The Corporation's Audited Financial Statements for Fiscal Years 2018 and 2019 were not posted on a timely basis (4 days and 68 days late, respectively). The Corporation's Annual Financial Information (defined below) for Fiscal Year 2018 was not posted on a timely basis (8 days late). Further, in the past the Corporation did not file notices of late filings as required by the Rule.

The Corporation makes no representation as to the materiality of the continuing disclosure delinquencies and omissions described above.

The Corporation has undertaken steps to ensure future compliance with its continuing disclosure undertakings.

The Continuing Disclosure Agreement contains the following covenants and provisions:

(a) The Corporation covenants that it will disseminate, or will cause the Dissemination Agent to disseminate, the Annual Financial Information and the Audited Financial Statements (in the form and by the dates set forth in Exhibit I to the Continuing Disclosure Agreement) by delivering such Annual Financial Information and the Audited Financial Statements to the MSRB within 180 days of the completion of the Corporation's Fiscal Year. The Corporation is required to deliver or cause delivery of such information in Prescribed Form and by such time so that such entity receives the information by the dates specified.

(b) If any part of the Annual Financial Information can no longer be generated because the operations to which it is related have been materially changed or discontinued, the Corporation will disseminate or cause dissemination of a statement to such effect as part of its Annual Financial Information for the year in which such event first occurs.

(c) If any amendment is made to the Continuing Disclosure Agreement, the Annual Financial Information for the year in which such amendment is made (or in any notice or supplement provided to the MSRB) shall contain a narrative description of the reasons for such amendment and its impact on the type of information being provided.

(d) The Corporation covenants that it will disseminate or cause dissemination in a timely manner, not in excess of ten (10) Business Days after the occurrence of the event, of Listed Events Disclosure to the MSRB in Prescribed Form. Notwithstanding the foregoing, notice of optional or

unscheduled redemption of any Series 2021 Bonds need not be given under the Continuing Disclosure Agreement any earlier than the notice (if any) of such redemption is given to the owners of the Series 2021 Bonds pursuant to the Indenture. The Corporation is required to deliver or cause delivery of such Listed Events Disclosure in the same manner as provided for Annual Financial Information and Audited Financial Statements.

(e) Not later than five (5) Business Days prior to the date specified in paragraph (a) above for providing the Annual Financial Information Disclosure to the MSRB, the Corporation shall provide such Annual Financial Information Disclosure to the Dissemination Agent. If by such date the Dissemination Agent has not received a copy of the Annual Financial Information Disclosure, the Dissemination Agent shall contract the Disclosure Representative to determine if the Corporation is in compliance with the requirements of paragraph (a) above. If the Dissemination Agent is unable to verify that the Annual Financial Information Disclosure has been provided to the MSRB by the date required in paragraph (a), the Dissemination Agent shall file a notice of the failure to file with the MSRB.

(f) The Continuing Disclosure Agreement has been executed in order to assist the Participating Underwriter in complying with the Rule; however, the Continuing Disclosure Agreement shall inure solely to the benefit of the Corporation, the Dissemination Agent, if any, the Issuer, the Trustee and the Beneficial Owners of the Series 2021 Bonds, and shall create no rights in any other person or entity. In the event of a failure of the Corporation to comply with any provision of the Continuing Disclosure Agreement, the Beneficial Owner of any Series 2021 Bond may seek specific performance by court order to cause the Corporation to comply with its obligations under the Continuing Disclosure Agreement. A default under the Continuing Disclosure Agreement shall not be deemed an Event of Default under the Indenture, the Loan Agreement or any other agreement, and the sole remedy under the Continuing Disclosure Agreement in the event of any failure of the Corporation or the Dissemination Agent to comply with the Continuing Disclosure Agreement shall be an action to compel performance.

(g) The Undertaking of the Corporation pursuant to the Continuing Disclosure Agreement shall be terminated when the Corporation shall no longer have any legal liability for any obligation on or relating to the repayment of the Series 2021 Bonds. The Corporation shall give notice to the MSRB, or shall cause the Dissemination Agent to give such notice, in a timely manner and in Prescribed Form in such event.

(h) The Corporation and the Dissemination Agent may amend the Continuing Disclosure Agreement, and any provision of the Continuing Disclosure Agreement may be waived, if (i) the amendment or waiver is made in connection with a change in circumstances that arises from a change in legal requirements, change in law, or change in the identity, nature or status of the Corporation or type of business conducted; (ii) the Continuing Disclosure Agreement, as amended, or the provision, as waived, would have complied with the requirements of the Rule at the time of the primary offering, after taking into account any amendments or interpretations of the Rule, as well as any change in circumstances; (iii) the amendment or waiver does not materially impair the interests of the Beneficial Owners of the Series 2021 Bonds, as determined either by parties unaffiliated with the Issuer or the Corporation (such as the Trustee) or by an approving vote of the Beneficial Owners of the Series 2021 Bonds holding a majority of the aggregate principal amount of the Series 2021 Bonds (excluding Series 2021 Bonds held by or on behalf of the Corporation or its affiliates) pursuant to the terms of the Indenture at the time of the amendment; or (iv) the amendment or waiver is otherwise permitted by the Rule.

(i) The following terms used under this caption shall have the meanings set forth below:

"Annual Financial Information" means financial information and operating data (exclusive of Audited Financial Statements) of the type appearing or incorporated by reference under the captions "HISTORICAL UTILIZATION," "PROFESSIONAL STAFF AND EMPLOYEES – Discharges by Physician Specialty and Discharges by Physician Age Group" and "SOURCES OF PATIENT SERVICE REVENUES" in Appendix A of the final Official Statement.

"Annual Financial Information Disclosure" means the dissemination of disclosure concerning Annual Financial Information and the dissemination of the Audited Financial Statements as set forth in subsection (a) above.

"Audited Financial Statements" means the audited consolidated financial statements of the Corporation prepared pursuant to generally accepted accounting standards and as described in Exhibit I to the Continuing Disclosure Agreement.

"Beneficial Owner" shall mean any person which (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Series 2021 Bonds (including persons holding Series 2021 Bonds through nominees, depositories or other intermediaries), or (b) is treated as the owner of any Series 2021 Bonds for federal income tax purposes.

"Business Day" means any day other than a Saturday or Sunday or a day on which banks in the State of Arkansas or in the state in which the Dissemination Agent is located are open for business.

"Commission" means the U.S. Securities and Exchange Commission.

"Disclosure Representative" means the Chief Financial Officer of the Corporation or his or her designee, or such other person as the Corporation shall designate in writing to the Dissemination Agent from time to time.

"Dissemination Agent" shall mean Regions Bank, Little Rock, Arkansas, acting in its capacity as a dissemination agent under the Continuing Disclosure Agreement, or any successor dissemination agent designated in writing by the Corporation and which has filed with the Trustee a written acceptance of such designation.

"EMMA" means the Electronic Municipal Market Access facility for municipal securities disclosure of the MSRB.

"Exchange Act" means the Securities Exchange Act of 1934, as amended.

"Financial Obligation" shall mean a: (A) debt obligation; (B) derivative instrument entered into in connection with, or pledged as security or a source of payment for, an existing or planned debt obligation; or (C) guarantee of obligations described in (A) or (B).

"Fiscal Year" means any period of twelve (12) consecutive months adopted by the Corporation as its fiscal year for financial reporting purposes.

"Listed Event" means the occurrence of any of the following events with respect to the Series 2021 Bonds:

(i) Principal and interest payment delinquencies;

(ii) Nonpayment-related defaults, if material;

(iii) Unscheduled draws on debt service reserves reflecting financial difficulties;

(iv) Unscheduled draws on credit enhancements reflecting financial difficulties;

(v) Substitution of credit or liquidity providers, or their failure to perform;

(vi) Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the security, or other material events affecting the tax status of the security;

(vii) Modifications to rights of security holders, if material;

(viii) Bond calls, if material, and tender offers;

(ix) Defeasances;

(x) Release, substitution or sale of property securing repayment of the securities, if material;

(xi) Rating changes;

(xii) Bankruptcy, insolvency, receivership or similar event of the Corporation;

(xiii) The consummation of a merger, consolidation or acquisition involving the Corporation or the sale of all or substantially all of the assets of the Corporation, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material;

(xiv) Appointment of a successor or additional trustee or the change of name of a trustee, if material;

(xv) Incurrence of a Financial Obligation of the obligated person, if material, or agreement to covenants, events of default, remedies, priority rights, or other similar terms of a Financial Obligation of the obligated person, any of which affect security holders, if material; and

(xvi) Default, event of acceleration, termination event, modification of terms, or other similar events under the terms of a Financial Obligation of the obligated person, any of which reflect financial difficulties.

"Listed Events Disclosure" means dissemination of a notice of a Listed Event as set forth in subsection (d) above.

"MSRB" shall mean the Municipal Securities Rulemaking Board established in accordance with the provisions of Section 15B(b)(1) of the 1934 Act.

"Participating Underwriter" means each broker, dealer or municipal securities dealer acting as an underwriter in any primary offering of the Series 2021 Bonds.

"Prescribed Form" means, with regard to the filing of Annual Financial Information, Audited Financial Statements and notices of Listed Events with the MSRB at www.emma.msrb.org (or such other address or addresses as the MSRB may from time to time specify), such electronic format, accompanied by such identifying information, as shall have been prescribed by the MSRB and which shall be in effect on the date of filing of such information.

"Rule" shall mean Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission ("SEC") under the Exchange Act, as the same may be amended from time to time.

"State" means the State of Arkansas.

"Undertaking" means the obligations of the Corporation pursuant to subsections (a) and (d) above.

TAX MATTERS

General Matters

In the opinion of Kutak Rock LLP, Bond Counsel, under existing laws, regulations, rulings and judicial decisions, interest on the Series 2021 Bonds is excludable from gross income for federal income tax purposes and is not a specific preference item for purposes of the federal alternative minimum tax. The opinion described in the preceding sentence assumes the accuracy of certain representations and compliance by the Issuer and the Corporation with certain covenants designed to satisfy the requirements of the Code that must be satisfied subsequent to the issuance of the Series 2021 Bonds. Failure to comply with certain of such requirements may cause interest on the Series 2021 Bonds to be included in gross

income for federal income tax purposes retroactive to the date of issuance of the Series 2021 Bonds. The Issuer and the Corporation have covenanted to comply with such requirements.

Tax Treatment of Original Issue Discount. The Series 2021 Bonds maturing on May 1 of each of 2028, 2029 and 2030 are being sold at an original issue discount (collectively, the "OID Bonds," and individually, the "OID Bonds"). The difference between the initial public offering prices, as set forth on the inside cover page hereof, of such OID Bonds and their stated amounts to be paid at maturity constitutes original issue discount treated as interest that is excluded from gross income for federal income tax purposes, subject to the caveats and provisions described above.

In the case of an owner of an OID Bond, the amount of original issue discount which is treated as having accrued with respect to such OID Bond is added to the cost basis of the owner in determining, for federal income tax purposes, gain or loss upon disposition of such OID Bond (including its sale, redemption or payment at maturity). Amounts received upon disposition of such OID Bond which are attributable to accrued original issue discount will be treated as tax-exempt interest, rather than as taxable gain, for federal income tax purposes.

Original issue discount is treated as compounding semiannually, at a rate determined by reference to the yield to maturity of each individual OID Bond bearing original issue discount, on days which are determined by reference to the maturity of such OID Bond. The amount treated as original issue discount on such OID Bond for a particular semiannual accrual period is equal to (i) the product of (a) the yield to maturity for such OID Bond (determined by compounding at the close of each accrual period) and (b) the amount which would have been the tax basis of such OID Bond at the beginning of the particular accrual period if held by the original purchaser, (ii) less the amount of any payments on such OID Bond during the accrual period. The tax basis is determined by adding to the initial public offering price on such OID Bond the sum of the amounts which would have been treated as original issue discount for such purposes during all prior periods. If such OID Bond is sold between semiannual compounding dates, original issue discount which would have accrued for that semiannual compounding period for federal income tax purposes is to be apportioned in equal amounts among the days in such compounding period.

Owners of OID Bonds should consult their own tax advisors with respect to the determination for federal income tax purposes of original issue discount accrued with respect to OID Bonds as of any date, with respect to the accrual of original issue discount for such OID Bonds purchased in the secondary markets and with respect to the state and local tax consequences of owning OID Bonds.

Tax Treatment of Original Issue Premium. The Series 2021 Bonds maturing on May 1, 2022, 2023, 2024, 2025, 2026, 2027 and 2033 are being sold at an original issue premium (collectively, the "Premium Bonds," and individually, a "Premium Bond"). Under the Code, the difference between the principal amount of a Premium Bond and the cost basis of such Premium Bond to an owner thereof is "bond premium." Under the Code, bond premium is amortized over the term of a Premium Bond (i.e., the maturity date of a Premium Bond or its earlier call date) for federal income tax purposes. An owner of a Premium Bond is required to decrease his or her basis in such Premium Bond by the amount of the amortizable bond premium attributable to each taxable year (or portion thereof) he or she owns such Premium Bond. The amount of the amortizable bond premium attributable to each taxable year is determined on an actuarial basis at a constant interest rate determined with respect to the yield on a Premium Bond compounded on each interest payment date. The amortizable bond premium attributable to a taxable year is not deductible for federal income tax purposes.

Owners of Premium Bonds (including purchasers of Premium Bonds in the secondary market) should consult their own tax advisors with respect to the precise determination for federal income tax purposes of the treatment of bond premium upon sale, redemption or other disposition of Premium Bonds and with respect to the state and local consequences of owning and disposing of Premium Bonds.

***Bank Qualification*.** The Issuer has represented that it does not reasonably anticipate issuing greater than $10,000,000 of tax-exempt obligations in calendar year 2021 (excluding certain private activity and refunding bonds) and that it has designated the Series 2021 Bonds as "qualified tax-exempt obligations" within the meaning of Section 265(b)(3) of the Code. Accordingly, Bond Counsel is of the opinion that in the case of certain banks, thrift institutions or other financial institutions owning the Series 2021 Bonds, a deduction is allowed for 80% of that portion of such institutions' interest expense allocable to interest on the Series 2021 Bonds. Bond Counsel has expressed no opinion with respect to any deduction for federal income tax purposes of interest incurred or continued by a holder of the Series 2021 Bonds or a related person to purchase or carry the Series 2021 Bonds.

The accrual or receipt of interest on the Series 2021 Bonds may otherwise affect the federal income tax liability of the owners of the Series 2021 Bonds. The extent of these other tax consequences will depend upon such owner's particular tax status and other items of income or deduction. Bond Counsel has expressed no opinion regarding any such consequences. Purchasers of the Series 2021 Bonds, particularly purchasers that are corporations (including S corporations and foreign corporations operating branches in the United States), property or casualty insurance companies, banks, thrifts or other financial institutions, certain recipients of Social Security or Railroad Retirement benefits, taxpayers entitled to claim the earned income credit, taxpayers entitled to claim the refundable credit in Section 36B of the Code for coverage under a qualified health plan, and taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry tax-exempt obligations, should consult their tax advisors as to the tax consequences of purchasing or owning the Series 2021 Bonds.

Bond Counsel has expressed no opinion regarding other federal tax consequences arising with respect to the Series 2021 Bonds.

Recognition of Income Generally. Section 451 of the Code was amended by Pub. L. No. 115-97, enacted December 22, 2017 (sometimes referred to as the Tax Cuts and Jobs Act), to provide that taxpayers using an accrual method of accounting for federal income tax purposes generally will be required to include certain amounts in income, including original issue discount and market discount, no later than the time such amounts are reflected on certain financial statements of such taxpayer. The application of this rule may require the accrual of income earlier than would have been the case prior to the amendment of Section 451 of the Code. Investors should consult their own tax advisors regarding the application of this rule and its impact on the timing of the recognition of income related to the Series 2021 Bonds under the Code.

Backup Withholding. As a result of the enactment of the Tax Increase Prevention and Reconciliation Act of 2005, interest on tax-exempt obligations such as the Series 2021 Bonds is subject to information reporting in a manner similar to interest paid on taxable obligations. Backup withholding may be imposed on payments made to any owner of the Series 2021 Bonds who fails to provide certain required information, including an accurate taxpayer identification number, to any person required to collect such information pursuant to Section 6049 of the Code. The reporting requirement does not in and of itself affect or alter the excludability of interest on the Series 2021 Bonds from gross income for federal income purposes or any other federal tax consequence of purchasing, holding or selling tax-exempt obligations.

Changes in Federal and State Tax Law

From time to time, there are legislative proposals in the Congress and in the states that, if enacted, could alter or amend the federal tax matters referred to under this heading "TAX MATTERS" 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. See the caption "RISK FACTORS" herein.

State Taxes

Bond Counsel is of the opinion that, under existing law, the interest on the Series 2021 Bonds is exempt from all state, county and municipal taxes in the State of Arkansas.

UNDERWRITING

Under a bond purchase agreement entered into by and among the Issuer, the Corporation and Stephens Inc. (the "Underwriter"), the Series 2021 Bonds are being purchased at a price equal to $9,766,094.40 (representing the stated principal amount of the Series 2021 Bonds plus a net original issue premium of $167,759.40 and less an underwriting discount of $111,665.00). The bond purchase agreement provides that the Underwriter will purchase all of the Series 2021 Bonds if any are purchased. The obligation of the Underwriter to accept delivery of the Series 2021 Bonds is subject to various conditions contained in the bond purchase agreement, including the absence of pending or threatened litigation questioning the validity of the Series 2021 Bonds or any proceedings in connection with the issuance thereof and the absence of material adverse changes in the financial or business condition of the Corporation.

The Underwriter intends to offer the Series 2021 Bonds to the public initially at the offering prices or yields set forth on the inside cover page of this Official Statement, which offering prices (or bond yields establishing such offering prices) may subsequently change without any requirement of prior notice. The Underwriter reserves the right to join with dealers and other underwriters in offering the Series 2021 Bonds to the public. The Underwriter may offer and sell Series 2021 Bonds to certain dealers (including dealers depositing Series 2021 Bonds into investment trusts) at prices lower than the public offering price.

The Corporation has agreed to indemnify the Underwriter and the Issuer against certain civil liabilities in connection with the offering and sale of the Series 2021 Bonds, including certain liabilities under federal securities laws.

The Underwriter and its affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage services. The Underwriter and its affiliates have, from time to time, performed and may in the future perform, various financial advisory, commercial banking, investment banking and swap counterparty services for the Issuer and the Corporation, for which they received or will receive customary fees and expenses. In the ordinary course of their various business activities, the Underwriter and its affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities, which may include credit default swaps) and financial instruments (including bank loans) for their own accounts and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of the Issuer or the Corporation.

LEGAL MATTERS

Legal matters incident to the authorization and issuance of the Series 2021 Bonds are subject to the unqualified approving opinion of Kutak Rock LLP, Little Rock, Arkansas, Bond Counsel, whose approving opinion will be delivered with the Series 2021 Bonds, and the form of which is attached as Appendix D to this Official Statement. Certain matters will be passed upon for the Corporation by Ellis, Ellis, Hammons & Johnson, P.C., Springfield, Missouri.

LITIGATION

There is not now pending nor to the knowledge of the Issuer or the Corporation, threatened, any litigation restraining or enjoining the issuance or delivery of the Series 2021 Bonds or questioning or affecting the validity of the Series 2021 Bonds or the proceedings or authority under which they are to be issued. Neither the creation, organization or existence, nor the title of the present members and officers of the Issuer or the Corporation to their respective offices is being contested. There is no litigation pending or, to the knowledge of the Issuer or the Corporation, threatened which in any manner questions the right of the Issuer or the Corporation to enter into the Loan Agreement or the Lease Agreement or to secure the Series 2021 Bonds in the manner provided in the Indenture.

The Corporation has no litigation or proceedings pending, or, to its knowledge, threatened against it which may not be adequately covered by the Corporation's reserves and insurance policies, or which, in the opinion of the Corporation and its defense counsel, could have a material adverse effect on the Corporation's business or financial position. See the caption "MISCELLANEOUS - Litigation" in Appendix A hereto.

INDEPENDENT AUDITORS

Set forth in Appendix C to this Official Statement are the consolidated financial statements of North Arkansas Medical System (the "System") as of and for the fiscal years ended March 31, 2021 and 2020, which consolidated financial statements have been audited by BKD, LLP, independent certified public accountants, as stated in their Independent Auditor's Report appearing in Appendix C. The notes set forth in Appendix C are an integral part of such consolidated financial statements, and the statements and notes should be read in their entirety. The System did not request BKD, LLP to perform any updating procedures subsequent to the date of its audit request on the March 31, 2021, consolidated financial statements.

MISCELLANEOUS

The Corporation has furnished the information in this Official Statement and in the appendices hereto relating to the Corporation, its operations and the Medical Center. The Underwriter has furnished the information in this Official Statement with respect to the public offering prices of the Series 2021 Bonds and the information under the caption "UNDERWRITING."

The summaries in this Official Statement of certain provisions of the Indenture, Loan Agreement, Bond Guaranty Agreement, Lease Agreement, the Series 2021 Bonds, Continuing Disclosure Agreement and other documents do not purport to be complete, and reference is made to such documents for a complete statement of their provisions.

The attached appendices are integral parts of this Official Statement and must be read together with all of the foregoing statements.

ACCURACY AND COMPLETENESS OF OFFICIAL STATEMENT

Any statements made in this Official Statement involving matters of opinion or of estimates, whether or not so expressly stated, are set forth as such and not as representations of fact, and no representation is made that any of the estimates will be realized.

The information contained in this Official Statement has been taken from sources considered to be reliable, but is not guaranteed. To the best knowledge of the Issuer and the Corporation, this Official Statement does not include any untrue statement of a material fact, nor does it omit the statement of any material fact required to be stated herein, or necessary to make the statements herein, in light of the circumstances under which they were made, not misleading.

The Issuer and the Corporation have authorized and approved the execution and delivery of this Official Statement and its use by the Underwriter in connection with the offering and sale of the Series 2021 Bonds.

BOONE COUNTY, ARKANSAS

By: /s/ Robert Hathaway
County Judge

APPROVED BY:

NORTH ARKANSAS REGIONAL MEDICAL CENTER

By: /s/ Matt Miller
Chair

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APPENDIX A

NORTH ARKANSAS REGIONAL MEDICAL CENTER

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GENERAL

History and Background

North Arkansas Regional Medical Center (the "Corporation") is a nonprofit corporation organized and existing under the laws of the State of Arkansas for the purpose of leasing and operating a general hospital in the City of Harrison, Arkansas. The address of the Corporation is 620 North Main, Harrison, Arkansas 72601, and its telephone number is (870) 414-4000.

The Corporation has received a determination letter from the Internal Revenue Service dated December 30, 1996, recognizing the Corporation as an organization of the type described in Section 501(c)(3) of the Code and thus exempt from Federal income taxation under Section 501(a) of the Code.

The Corporation leases and operates the 174 licensed bed acute-care North Arkansas Regional Medical Center (the "Medical Center") located in the City of Harrison, Arkansas. The Medical Center was previously known as the Boone County Hospital and was owned and operated by Boone County, Arkansas (the "County") through a Board of Governors. The County has leased the Medical Center to the Corporation pursuant to a lease dated March 1, 1997, and subsequently amended. The lease has a stated term ending December 31, 2041. See the caption "SUMMARY OF PORTIONS OF THE LEASE AGREEMENT" within the Official Statement to which this Appendix A is attached.

Boone County Hospital was opened for operation in 1950 with 50 beds and was initially staffed with 51 employees and 7 physicians. An expansion in 1963 provided an additional 32 beds and enhancements to the Radiology, Laboratory, Surgery and Emergency Departments. In 1967, a second expansion project added 21 beds, as well as purchasing adjacent property for future growth. A third expansion project in 1969-70 added a four-bed coronary care unit, a fourth floor housing 33 new beds and a new power house. A fourth expansion project in 1980 provided 34 additional beds and ancillary service enhancements. In 1990, an 11,000 square foot state-of-the-art Radiation Therapy Institute was constructed, and in 1994 a 9,000 square foot Outpatient Imaging Center and Endoscopy Suite was opened. The Series 1999 Bonds provided a portion of the funds needed to finance (i) a 15,000 square foot expansion to and renovation of the Medical Center's emergency room facilities and (ii) a 30,000 square foot expansion to and renovation of the Medical Center's operating room facilities. A state-of-the-art patient tower of approximately 124,000 square feet, containing 71 private patient rooms, separate family waiting areas, and a floor for physical therapy, speech therapy, occupational therapy, rehabilitation, wellness and wound care, was financed by the Series 2006 Bonds.

As currently configured, the Medical Center is a four-story brick structure with seven detached brick office buildings on a campus of 20.3 acres. The main facility contains approximately 336,000 square feet, and the ancillary buildings contain a total of approximately 133,000 square feet.

Services available at the Medical Center include: ambulance, anesthesiology, cardiology, clinical laboratory, CT scan, dental and oral surgery, diabetes treatment, emergency medicine, education, EEG, EKG, family medicine, general surgery, gynecology, hospice, intensive care, magnetic resonance imaging, nuclear medicine, occupational therapy, oncology, orthopedic surgery, otolaryngology, outpatient surgery, pathology, pediatrics, pharmacy, physical therapy, pulmonology, radiation therapy, radiology, respiratory therapy, speech pathology, skilled nursing care, surgical and medical care, ultrasound, urology and wellness.

The present medical staff of the Medical Center is composed of 128 physicians, 65 mid-level providers and 4 dentists. Approximately 77% of such staff are board certified specialists.

During the Fiscal Years 2017 through 2021, the Medical Center experienced occupancy rates, based on the number of operating beds and including skilled nursing facility patients, but excluding newborns and observation patients, of 23.3%, 24.2%, 18.7%, 19.2% and 20.1%, respectively.

Other Facilities Operated by the Corporation

The Corporation leases space from private third parties to operate family practice medical clinics and a general surgery clinic. The Corporation purchased a 40,000 square foot building in 2019 that is currently undergoing renovations to accommodate 23 providers, and also owns a 15,000 square foot building to accommodate ambulance services. In addition, the Corporation leases from the County and operates medical clinics in the Cities of Marshall, Jasper and Lead Hill, Arkansas.

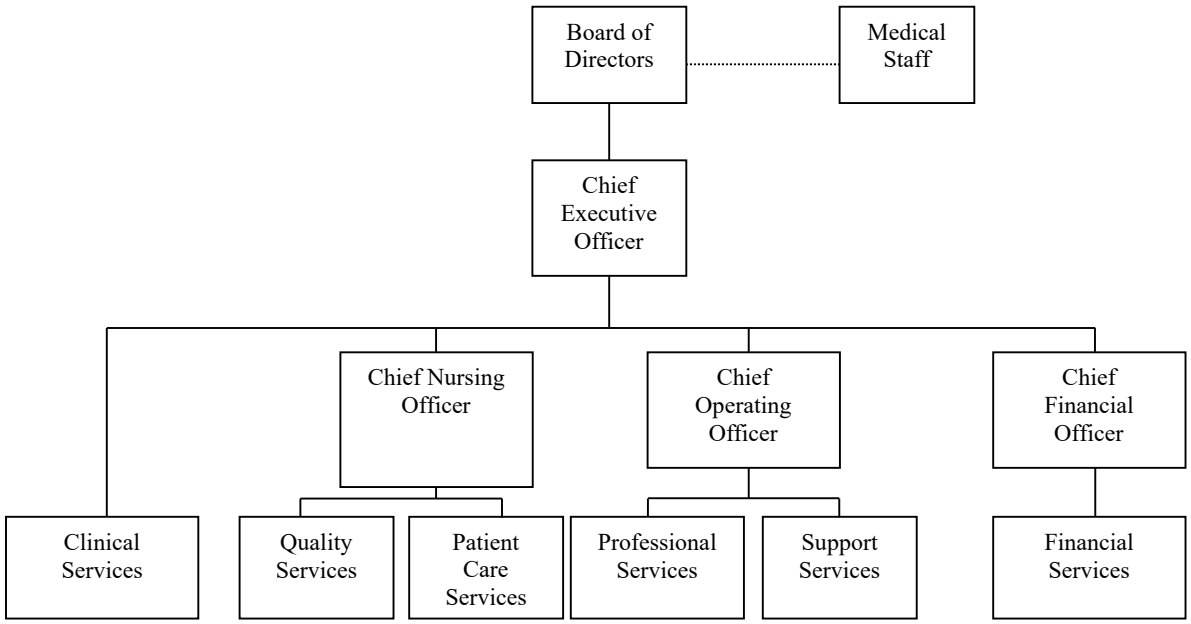
Accreditation and Licenses

The Medical Center operated by the Corporation is licensed by the Arkansas State Department of Health and is approved for participation in the Medicare and Medicaid programs by the United States Department of Health and Human Services and the State. The Corporation is a member of the American Hospital Association and the Arkansas Hospital Association.

GOVERNANCE

Organization

Set forth below is the current organizational chart for the Corporation:



Board of Directors

The Articles of Incorporation and By-Laws of the Corporation provide that its business and affairs shall be conducted by a Board of Directors (the "Board") comprised of nine members, each of which shall be a resident of Boone County, Arkansas. The Board meets on a monthly basis to hear reports from the administrative staff of the Corporation and to take such action as it deems appropriate based on such reports.

Seven directors are elected for six-year terms by the then serving members of the Board, subject to ratification by the Quorum Court of Boone County. Two physician members are elected for one-year terms by serving Board members and are also subject to ratification by the Boone County Quorum Court.

The current members of the Board of Directors, the dates of expiration of their terms, and their principal occupations are as follows:

Director	Term Expires	Principal Occupation
Matt Miller, Chair	December 2022	Business Owner
Sherri Billings, Vice Chair/Treasurer	December 2023	Retired Banker
Dan Bowers, Secretary	December 2024	Attorney
Kirk Campbell	December 2025	Business Owner
Brad Crawford	December 2021	Attorney
Ken Millburn	December 2026	Business Owner
Dr. Stephen Beeler	December 2025	Physician
Dr. Andrew Coble	December 2021	Physician
Dr. Kenneth Collins	December 2021	Physician

The standing committees of the Board include an Executive Committee, Finance Committee, Professional Relations Committee, Long-Range Planning Committee, Audit Committee and Compensation Committee. The Executive Committee, Long-Range Planning Committee, Audit Committee and Compensation Committee meet as needed, and the Finance Committee and Professional Relations Committee meet monthly. Members of all committees are appointed by the Chairman of the Board for a term of one year or until their successors are named.

Business Transactions with Members of Board of Directors. The Corporation has from time to time invested certain of its funds with, and procured goods and services from, institutions and companies affiliated with or controlled by various members of its Board of Directors. In the opinion of management of the Corporation, the fees and compensation paid to such persons as a result of such business transactions, along with the other material terms and conditions of agreements or arrangements with such persons, have been no less favorable to the Corporation than those which would have been obtained in transactions with unrelated or unaffiliated persons. The Corporation intends to continue to engage in business transactions with the members of its Board, and their affiliated institutions and companies, where the Corporation has a need for the goods or services offered by any such persons, institutions and companies, and where the terms and conditions of such transactions and the compensation paid therefor would be as favorable in all material respects as the Corporation could obtain from unaffiliated or unrelated persons.

Administration

The principal members of the administrative staff of the Corporation, their educational qualifications, recent work history, professional affiliations and ages are as follows:

Vincent Leist, age 67, has been the Medical Center's President and Chief Executive Officer since July 1, 2011. Mr. Leist earned a Bachelor of Arts degree from Ottawa University in 1980 and a Master of Public Administration degree from the University of Kansas in 1989. Mr. Leist has significant experience in program development, facilities construction and operations. Most recently, he served for six years as Chief Operating Officer at San Antonio Community Hospital, a 273-bed facility in Upland, California. He was responsible for overall operations of such facility and led a $150 million facility expansion project. Prior positions include Senior Vice President of Operations for Sunrise Hospital, a 683-bed tertiary care facility in Las Vegas, Nevada. Mr. Leist is an active member of the American College of Healthcare Executives. He has held adjunct faculty positions at universities in Kansas, Oklahoma and Nevada. In addition, he has served on various boards, including the Heart Association of Las Vegas, San Antonio Ambulatory Surgical Center, Baptist Medical Center Federal Credit Union and HCH National Cardiovascular Management Network. Mr. Leist is active in various professional and civic organizations.

Mr. Leist recently announced his retirement effective December 31, 2021. He has been working with the Board of Directors over the last several months to develop and implement a succession plan. He will remain as a consultant to the Corporation for some time after his official retirement to assist in leadership

transition. The Board is currently in the process of evaluating candidates and anticipates that the transition will be completed by March 1, 2022.

Sammie Cribbs, MSN, AGCNS-BC & APRN, age 40, has been the Medical Center's Chief Operating Officer and Chief Nursing Officer since July 2014. Ms. Cribbs holds an Associate's degree in Nursing from Louisiana Tech University, Bachelor's degree in Nursing from Northwestern State University and Master's degree in Nursing Adult Heath from Arkansas State University. Ms. Cribbs is a licensed Advanced Practice Nurse and holds a certification in healthcare finance. She currently serves on the board of the North Arkansas Partnership for Health Education and the Nursing Advisory Board for College of the Ozarks. A member of both the American Organization of Nurse Executives and the American College of Healthcare Executives, Ms. Cribbs was named one of Arkansas's Outstanding 40 Nurse Leaders Under 40 in 2015.

Kenneth Pannell, age 57, has been the Medical Center's Chief Financial Officer and Vice President Financial Services since July 2019. Mr. Pannell earned a Bachelor of Arts degree in Accounting from Fort Lewis College in 1986. He has significant experience in healthcare finance, budgeting and service line analysis and has held various financial roles with HCA and Community Health Systems prior to joining North Arkansas Regional Medical Center. Most recently he served with Community Health Systems as CFO in Bullhead City, Arizona. Mr. Pannell currently serves on the board of the North Arkansas Partnership for Health Education.

Josh Bright, PharmD, age 38, has been the Medical Center's Vice President of Operations since January 2020. Dr. Bright serves on the Board of Directors for the North Arkansas Partnership for Healthcare Education (NAPHE) and currently is a member of Arkansas Chamber of Commerce Leadership Arkansas Class XIV. He is an Apexus Certified 340B Expert. Dr. Bright also serves on the Board of Directors for the Arkansas Association of Health System Pharmacists as Chairperson of the Programs and Education Council. A native of Jasper, AR, he graduated Magna Cum Laude with a Bachelor of Science degree in Chemistry from Arkansas Tech University and received his Doctor of Pharmacy from the University of Arkansas for Medical Sciences in Little Rock. He is an active member of the American Society of Health-Systems Pharmacists, the Arkansas Association of Health-Systems Pharmacists (AAHP), and the Arkansas Pharmacists' Association (APA).

SERVICE AREA

Management defines the primary service area for the Medical Center as Boone, Newton and Searcy Counties in Arkansas. The primary service area contributed approximately 73% of total Medical Center admissions in Fiscal Year 2021. Carroll and Marion Counties are identified by management as the secondary service area for the Medical Center. The secondary service area contributed approximately 21% of total Medical Center admissions in Fiscal Year 2021. The combined estimated population of the primary service area is approximately 52,400 and the combined estimated population of the secondary service area is approximately 45,000.

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COMPETITION

Although there are no other hospitals located in the Medical Center's primary service area, there are several hospitals in the region that require the Medical Center to remain highly cognizant of competition. These hospitals and their locations are as follows:

Hospital	Location	Distance from Medical Center
Baxter County Regional Hospital	Mountain Home, AR	60 miles
Mercy Hospital Berryville	Berryville, AR	45 miles
Mercy Hospital Springfield	Springfield, MO	75 miles
Cox Medical Center	Springfield & Branson, MO	75/35 miles
Northwest Medical Center	Springdale, AR	75 miles
Washington Regional Medical Center	Fayetteville, AR	75 miles
Mercy Hospital Northwest Arkansas	Rogers, AR	80 miles

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HISTORICAL UTILIZATION

A summary of significant historical utilization data for the Medical Center during the five fiscal years ended March 31, 2021, according to Medical Center records, is set forth in the following table:

	2017	2018	2019	2020	2021
Licensed Beds	174	174	174	174	174
Beds in Service	130	130	130	130	130
Occupancy[(1) (2)]	23.3%	24.2%	18.7%	19.2%	20.1%
Admissions[(2)]	3,399	3,388	3,123	2,840	2,400
Patient Days[(2)]	11,048	11,465	8,853	9,130	9,531
Adjusted Patient Days[(2)]	40,977	45,406	47,518	41,928	40,713
Average Length of Stay (Days)	3.3	3.4	2.8	3.2	4.0
Average Daily Census	30	31	24	25	26
Emergency Room Visits	26,035	25,497	24,518	24,188	19,099
Inpatient Surgical Procedures	1,002	1,070	852	829	683
Outpatient Surgical Procedures	3,219	3,149	3,002	3,002	2,562
Staff FTEs	704.3	757.0	735.7	715.6	669.8
Case Mix Index	1.20	1.15	1.17	1.20	1.27

(1) Based on operating beds.

(2) Including skilled nursing facility patients; excluding newborns and observations.

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PROFESSIONAL STAFF AND EMPLOYEES

Physician Recruitment and Retention

The Chief Executive Officer of the Medical Center is responsible for assessing the adequacy, in number and mix of specialty, of the physicians and practicing at such facility.

The Corporation has instituted an active physician recruitment program which has resulted in the addition of a number of physicians to the Medical Center staff during the past five years in the following specialties: General Surgery, Family Practice, Internal Medicine, OB/GYN, Pediatrics and Anesthesia.

Recruitment searches are currently underway for physicians or providers in the Cardiology, Urology, OB/GYN and Family Practice fields.

Discharges by Physician Specialty

The following table presents a profile of fiscal year 2021 discharges by the active professional staff of the Medical Center by active physician specialties according to Medical Center records.

Utilization of Medical Center by Active Physician Specialty

FY 2021[(1)]

Specialty	Discharges	Percentage of Total
Cardiology	0	0.0%
Hospitalists	808	33.8%
Behavioral Health	84	3.5%
Emergency Medicine	0	0.00%
Family Practice & Pediatrics	394	16.5%
Internal Medicine	670	28.0%
Obstetrics & Gynecology	230	9.6%
Oncology	0	0.0%
Orthopedic	109	4.6%
Surgery	74	3.1%
Urology	24	1.0%
Totals:	2,393	100.0%

(1) Excludes newborns and observations.

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Discharges by Age Group

The number of fiscal year 2021 discharges and the percentage of total fiscal year 2021 discharges according to age group of the professional staff of the Medical Center are provided in the table below:

FY 2021 Discharges by Physician Age Group

Physician's Age in Years	Number of Discharging Physicians	Percentage of Total Discharging Physicians	Total FY 2021 Discharges*	Percentage of Total Discharges
30-39	4	16.0%	632	26.5%
40-49	7	28.0%	233	9.7%
50-59	8	32.0%	692	28.9%
60 and over	6	24.0%	836	34.9%
	25	100.0%	2,393	100.0%

The five physicians with the greatest number of discharges in fiscal year 2021 accounted for approximately 76.5% of total Medical Center discharges. These five physicians had an average age of 48 years. No single physician accounted for more than 33.8% of fiscal year 2021 discharges.

Nursing Staff

The nursing staff complement at the Medical Center, as of March 31, 2021, consisted of 129 full-time equivalent registered nurses and 34 full-time equivalent licensed practical nurses.

Employees

As of March 31, 2021, the Corporation employed 766 employees. A breakdown of the number of employees of the Corporation, by area of service, is as follows:

Area of Service	Number of Employees
Administrative and Clerical	123
Nursing	178
Home Care & Clinics	109
Ancillary Areas	160
Support Services	196
Total:	766

There are no collective bargaining agreements presently in effect with the Corporation employees, nor, to management's knowledge, have any attempts been made in the past to seek organized employee representation. Management considers its relations with employees to be good.

Pension Plan. The Corporation maintains a defined-contribution pension plan covering substantially all of its employees. The Corporation annually determines the amount, if any, of its contribution to the plan. A description of the plan can be found at Note 11 to the 2021 financial statements included in Appendix C to the Official Statement to which this Appendix A is attached.

Workers' Compensation and Employee Benefits. The Corporation is self-insured with respect to workers' compensation benefits for its employees in accordance with Arkansas law. The Corporation has established a reserve for payment of claims, and payments to the reserve are charged against income in the year paid. Both salary continuation benefits and medical benefits are available, and employees are permitted to use sickness and disability insurance benefits provided by the Corporation to supplement workers' compensation payments up to the limit of an employee's regular salary. The Corporation also provides hospitalization and major medical insurance, term life insurance, accidental death and dismemberment coverage, and long-term disability insurance for all permanent employees. See Note 1 (Self-Insurance) to the 2021 financial statements included in Appendix C to the Official Statement to which this Appendix A is attached.

SOURCES OF PATIENT SERVICE REVENUES

The Corporation maintains agreements with Blue Cross and Blue Shield of Arkansas, a mutual insurance company, the federal Medicare program, and the State of Arkansas' Medicaid program, and has entered into various managed care arrangements. These agreements and arrangements govern payments made to the Corporation for services rendered to patients covered by these programs and plans. Descriptions of the reimbursement methodologies employed by these third-party payors and summaries of legislation affecting those methodologies are included under the caption "REGULATION OF THE HEALTH CARE INDUSTRY" in the Official Statement to which this Appendix A is attached.

The following table summarizes net patient service revenue (after provision for uncollectible accounts) by payor source at the Medical Center for the fiscal years ended March 31, 2020 and 2021:

	Fiscal Years Ended March 31,			
	2020	2020%	2021	2021%
Medicare	$42,972,054	47.8%	$42,244,727	51.1%
Medicaid	9,500,564	10.5%	10,076,871	12.2%
Third-Party [(1)]	35,750,333	39.8%	29,253,103	35.4%
Self-Pay	1,683,633	1.9%	1,138,368	1.4%
Totals:	$89,906,584	100.0%	$82,713,069	100.0%

(1) Includes Blue Cross, Medicare Commercial Advantage Plans, other commercial insurance, CHAMPUS insurance and Veteran's Administration insurance.

Managed Care

Over the past several years, increased sensitivity to the cost of health care and the desire to reduce health care costs have led to substantial growth among health maintenance organizations, preferred provider organizations and other alternative delivery systems. This trend has had, and will continue to have, a profound impact on the source of Medical Center revenues. Net patient revenues derived from managed care arrangements accounted for approximately 39.8% and 35.4% of gross Medical Center revenues for the fiscal years ending March 31, 2020 and 2021, respectively.

FINANCIAL INFORMATION

Set forth in Appendix C to this Official Statement are the consolidated financial statements of North Arkansas Medical System and its subsidiaries for the fiscal years ended March 31, 2020 and March 31, 2021, which financial statements have been audited by BKD, LLP, Little Rock, Arkansas, independent certified public accountants, as stated in the Independent Auditor's Report of BKD, LLP appearing in Appendix C. The notes set forth in Appendix C are an integral part of such consolidated financial statements, and the statements and notes should be read in their entirety.

The consolidated financial statements of North Arkansas Medical System include financial information for the Corporation, as well as financial information for North Arkansas Medical Foundation and North Arkansas Medical Services. The Pledged Revenues securing the Bonds are derived from operations of the Medical Center by the Corporation only.

Following is a summary of the statements of operations of the Corporation only for the five fiscal years ended March 31, 2021. The following table should be read in conjunction with the audited consolidated financial statements and related notes in Appendix C.

NORTH ARKANSAS REGIONAL MEDICAL CENTER

CONDENSED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(DOLLARS IN THOUSANDS)

	2017	2018	2019	2020	2021
REVENUES, GAINS AND OTHER SUPPORT WITHOUT DONOR RESTRICTIONS					
Patient service revenue	$89,016,037	$93,721,484	$87,674,923	$89,906,584	$82,713,069
Net assets released from restrictions used for operations	0	0	0	0	0
Other	1,312,904	2,819,522	2,591,295	2,218,463	15,697,439
Total revenues, gains and other support without donor restrictions	90,328,941	96,541,006	90,266,218	92,125,047	98,410,508
EXPENSES AND LOSSES					
Salaries and wages	37,769,507	40,729,365	41,363,102	40,813,223	40,446,673
Employee benefits	9,266,428	11,198,097	13,417,897	9,584,622	7,459,147
Professional fees	5,974,483	5,720,824	5,633,090	5,963,921	5,265,465
Supplies and other	26,554,234	29,809,609	33,229,482	30,764,618	31,298,855
Contract labor	1,827,876	2,788,640	4,331,490	1,830,936	4,343,674
Provider assessment tax	1,069,546	1,061,402	1,080,292	1,070,705	1,192,938
Depreciation	3,365,298	3,355,323	3,092,817	2,882,550	2,827,857
Interest, net of interest rate swap activity	919,398	936,042	958,287	856,770	857,963
Total expenses and losses	86,746,770	95,599,302	103,106,457	93,767,345	93,692,572
OPERATING INCOME (LOSS)	3,582,171	941,704	(12,840,239)	(1,642,298)	4,717,936
OTHER INCOME (LOSSES)					
Investment return, net	749,424	1,389,686	1,297,120	(1,376,124)	7,851,024
Contributions received	1,747	14,936	121	51,102	160,568
Total other income (losses)	751,171	1,404,622	1,297,241	(1,325,022)	8,011,592
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	4,333,342	2,346,326	(11,542,998)	(2,967,320)	12,729,528
Investment return – change in unrealized gains and losses on debt securities classified as other than trading	1,797,738	961,481	550,242	417,034	(141,614)
Transfers (to) from affiliates	(846,858)	(985,411)	0	(90,571)	(227,589)
Contributions from North Arkansas Medical Foundation for property and equipment	55,474	0	0	0	0
INCREASE (DECREASE) IN NET ASSETS WITHOUT DONOR RESTRICTIONS	$5,339,696	$2,322,396	$(10,992,756)	$(2,640,857)	$12,360,325

Management Discussion of Fiscal Year 2020 and Fiscal Year 2021 Operating Results

Set forth below is a brief discussion by management of the Corporation concerning revenues and expenses and excess (or deficiency) of revenues over expenses attributable to the Medical Center for the fiscal years ended March 31, 2020 and 2021.

Revenues: Total revenues, gains and other support without donor restrictions of the Corporation increased from $92,125,047 in fiscal year 2020 to $98,410,508 in fiscal year 2021, for a total increase of approximately 6.8%. Management attributes this increase primarily to a decrease in net patient revenue of ($7,193,515) due to reduced patient volumes during the pandemic, offset by a $13,255,502 increase in revenue associated with various CARES Act initiatives for COVID-19 funding.

Expenses: Expenses and losses of the Corporation were essentially flat with a total of $93,767,345 in fiscal year 2020 compared to $93,692,572 in fiscal year 2021. Management attributes this result primarily to a decrease in benefit expense of ($2,125,475) associated with restructuring the self-funded benefit plan, a decrease in professional fees paid for physician services of ($698,456), and an increase of $2,512,738 in contract labor in nursing departments related to preparations for pandemic admissions.

Excess (Deficiency) of Revenues over Expenses: In fiscal year 2020, the Corporation experienced a deficiency of revenues over expenses of approximately ($2,967,320), compared with an excess of revenues over expenses of approximately $12,729,528 in fiscal year 2021. Management believes this increase was primarily attributable to COVID-19 funding of $13,255,502, improvement on investment returns of $9,227,148, and a loss of net patient revenue of ($7,193,515) due to the volume declines during the pandemic.

Following is a summary of the unaudited statements of operations and changes in net assets of the Corporation for the six-month periods ended September 30, 2021 and 2020.

NORTH ARKANSAS REGIONAL MEDICAL CENTER
CONDENSED STATEMENTS OF OPERATIONS
AND CHANGES IN NET ASSETS
(DOLLARS IN THOUSANDS)

	Six Months Ended September 30,	
	2020	**2021**
UNRESTRICTED REVENUES, GAINS AND OTHER SUPPORT		
Patient service revenue	$39,899,203	$47,468,877
Net assets released from restrictions used for operations	--	--
Other	7,268,335	5,192,121
Total unrestricted revenues, gains and other support	47,167,537	52,660,998
EXPENSES AND LOSSES		
Salaries and wages	19,434,601	20,801,539
Employee benefits	3,682,053	3,488,337
Professional fees	2,558,438	2,611,986
Supplies and other	15,085,474	18,002,013
Contract labor	1,540,080	4,168,209
Provider assessment tax	678,494	540,190
Depreciation	1,399,510	1,455,899
Interest, net of interest rate swap activity	423,737	417,429
Total expenses and losses	44,802,388	51,485,603
OPERATING INCOME (LOSS)	2,365,149	1,175,395
INVESTMENT RETURN	554,295	696,377
EXCESS OF REVENUES OVER EXPENSES	2,919,445	1,871,771
Investment return – change in unrealized gains and losses on		

	Six Months Ended September 30,	
	2020	2021
debt securities classified as other than trading	3,383,746	564,328
Contributions and Transfers	4,518	46,136
INCREASE IN NET ASSETS WITHOUT DONOR RESTRICTION	$6,307,709	$2,482,055

Management Discussion of Operating Results for the Six-Month Periods Ended September 30, 2020 and 2021

Set forth below is a brief discussion by management of the Corporation concerning revenues and expenses and excess of revenues over expenses for the six-month periods ended September 30, 2021 and 2020.

Revenues: Total unrestricted revenues, gains and other support of the Corporation increased from $47,167,537 for the six months ended September 30, 2020 to approximately $52,660,998 for the six months ended September 30, 2021, for a total increase of approximately 11.6%. Management attributes this increase primarily to a net patient service revenue increase of $7,569,675, as outpatient volumes returned, offset by a $1,770,428 reduction in COVID-19 funding.

Expenses: Total expenses and losses of the Corporation increased from approximately $44,802,388 for the six months ended September 30, 2020 to approximately $51,485,603 for the six months ended September 30, 2021, for a total increase of approximately 14.9%. Management attributes this increase primarily to an increase in labor cost of $1,366,938 due to wage adjustments, a $2,628,129 increase in utilization of contract nursing staff, and supply expense increases of $2,240,454 primarily related to pandemic supplies.

Excess of Revenues over Expenses: Total revenues over expenses decreased from a gain of $2,919,445 for the six months ended September 30, 2020 to a gain of $1,871,771 for the six months ended September 30, 2021. Management attributes this decrease primarily to an increase in net patient service revenue of $7,569,675, offset by a decrease in COVID-19 funding of $1,770,428 and increased operating expenses of $6,683,215 due to the pandemic.

Impact of COVID-19 Pandemic

In February 2020, the Centers for Disease Control and Prevention (the "CDC") confirmed the spread of COVID-19 to the United States. In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic (the "COVID-19 Pandemic"), and the United States federal government declared COVID-19 a national emergency. The COVID-19 Pandemic has had, and continues to have, numerous and varied medical, economic and social impacts, any and all of which may adversely affect the Corporation's business and financial condition.

Patient volumes and revenues were significantly impacted in 2020 due to governmental orders that halted elective surgeries and procedures and implemented stay at home, isolation and quarantine rules. Corporation management responded to the COVID-19 Pandemic by developing the mitigation plan described below.

Mitigation Plan. Corporation management developed a multi-pronged approach to deal with all aspects of the COVID-19 pandemic. A COVID Committee was developed with physician leadership to address patient care, infection prevention and safety concerns relating to the pandemic. The Medical Center opened a drive-through COVID testing site that served as the primary testing site for Boone County. The facility acquired the appropriate equipment to become a regional distribution site for the COVID vaccine. The Medical Center began planning for personal protective gear and other supply shortages and prepared for its response with pre-stocked disaster supplies. The Medical Center worked to both access all available special funding opportunities and identify cost savings measures to offset significant short-term declines in business activity. Finally, the Medical Center pursued an aggressive

communication plan with the public. This plan included communication regarding testing availability, safety precautions, and information on how to safely access healthcare services.

Financial and Operational Impact. The table below shows the impact of the COVID-19 Pandemic on certain of the Medical Center's utilization statistics:

	FY 2021 as % of FY 2020	09/30/2021 as % of 09/30/2020
Admissions	(15.5%)	(5.4%)
Inpatient Surgical Procedures	(17.6%)	(17.4%)
Outpatient Surgical Procedures	(14.7%)	21.1%
Emergency Room Visits	(21.0%)	18.9%

The Corporation responded and continues to respond to the challenges presented by the COVID-19 Pandemic. Elective surgical procedures were discontinued in April 2020 for a period of six weeks due to the pandemic. This, coupled with patients delaying some elective procedures throughout the pandemic has resulted in a decrease in total surgical procedures of 18.8% from FY 2020 to FY 2021. Emergency room visits declined significantly as patients elected not to come to the Medical Center for services during the pandemic. Volumes for the six-month period ending September 30, 2021 compared to September 30, 2020, are trending back to pre-pandemic levels.

Governmental Programs and Assistance. In 2020, a variety of federal, state and local efforts were initiated in response to the COVID-19 Pandemic, the largest of which is the CARES Act that was enacted on March 27, 2020. The CARES Act is a federal stimulus package designed to provide emergency assistance to individuals and businesses, including hospitals and healthcare providers. The Corporation has received approximately $14.066 million in Provider Relief Funds pursuant to the CARES Act to cover unreimbursed health-care-related expenses attributable to the public health emergency and lost revenue resulting from the COVID-19 Pandemic. In addition, the Corporation received approximately $4.949 million from the Coronavirus Relief Fund established by the CARES Act. $13.256 million of these funds were recognized as other operating revenue for the year ended March 31, 2021. See Note 16 to the System's fiscal year 2021 audited consolidated financial statements included in Appendix C to the Official Statement to which this Appendix A is attached. An additional $4.555 million in relief funding has been recognized as operating income during the six months ended September 30, 2021.

MISCELLANEOUS

Budgeting

The budgeting process for the Corporation is designed to control and monitor the daily operations of the Medical Center.

Beginning in January of each year, financial and operational data is reviewed by the Chief Financial Officer and the executive team. After consideration of external competitive data, expected physician activities and internal expectations, financial budgetary goals and data are set and the Finance Department develops and prepares the Medical Center capital and operating budgets. The budgets are reviewed by the executive team and any proposed adjustments are made before the budgets are presented to the Board of Directors for approval.

Professional Insurance and Casualty Insurance

The Corporation carries professional liability insurance with LAMMICO, The Doctors Company for Professional Liability and Westchester in the following categories and amounts:

(1) Institutional and Physician Professional Liability for Employees: $1,000,000 per occurrence and $3,000,000 in annual aggregate claims;

(2) Directors, Officers and Trustee Liability and Staff Privileges Protection: $5,000,000 per occurrence and $5,000,000 in annual aggregate claims; and

(3) Umbrella: $5,000,000 per occurrence and $5,000,000 in annual aggregate claims.

See Note 6 to the System's fiscal year 2021 audited consolidated financial statements included in Appendix C to the Official Statement to which this Appendix A is attached.

The Corporation also maintains business interruption insurance with a total limit of $315 million and commercial property insurance in the amount of $315 million.

Litigation and Other Potential Liability

Employee and Civil Rights Proceedings. The Corporation has no employee related non-civil rights lawsuits pending and no employee EEOC charges awaiting disposition. Management is not aware of any other pending claims for alleged employment discrimination by the Corporation or its affiliates.

Medical Malpractice Claims. The Corporation is a defendant or co-defendant with certain physicians in three separate claims for damages involving the provision of medical care to patients of the Medical Center. Each of these proceedings is being defended by counsel for insurance carriers, and as of the date of this Official Statement, management of the Corporation does not know of any facts or set of facts in connection with such claims from which liability might arise which individually or collectively would materially adversely affect the revenues of the Corporation. For additional information regarding professional liability claims, see Note 6 to the System's fiscal year 2021 audited consolidated financial statements included in Appendix C to the Official Statement to which this Appendix A is attached.

Other Material Litigation. The Corporation is a defendant with other civil parties for damages involving allegations of failure to comply with Arkansas Freedom of Information Act (FOIA). In 1997, Boone County Hospital was privatized and became North Arkansas Regional Medical Center. The hospital facilities had previously been operated as part of Boone County. A motion for dismissal has been filed by the Corporation pursuant to Arkansas Rule of Civil Procedure 12(b)(6) contending that the Corporation is not subject to FOIA under the circumstances presented. There is an additional litigation pending naming the Corporation as a defendant and alleging interference with contractual relationships or business expectancy and defamation.

The Corporation has engaged legal counsel to defend it in each of these matters in conjunction with its insurance carriers. The Corporation contends that these claims are invalid and will continue to pursue their dismissal/resolution. Management does not know of any facts in connection with such claims that would materially adversely affect revenues of the Corporation.

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APPENDIX B

DEFINITIONS

Set forth below are the definitions of certain terms used in this Official Statement, the Loan Agreement and the Indenture.

"Accountants" with respect to the Corporation shall mean BKD, LLP, Little Rock, Arkansas, or such other independent certified public accountants of national standing selected by the Corporation and satisfactory to the Trustee.

"Act" shall mean Arkansas Code Annotated, Sections 14-164-401 *et seq*., as amended (1998 Repl. & Supp. 2019), and known as the Local Government Capital Improvement Revenue Bond Act.

"Additional Bonds" shall mean Bonds, other than the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds issued under and pursuant to the provisions of Article III of the Indenture.

"Additional Notes" shall mean Notes other than the Series 2006 Note, the Series 2011 Note and the Series 2021 Note issued under and secured by the Loan Agreement.

"Bonds" or *"bonds"* shall mean the Series 2006 Bonds, the Series 2011 Bonds and the Series 2021 Bonds from time to time outstanding under the Indenture, and all bonds issued on a parity therewith pursuant to the provisions of the Indenture and from time to time authenticated and delivered under the Indenture.

"Bond Counsel" shall mean Kutak Rock LLP, or an attorney or firm of attorneys nationally recognized as having experience in matters relating to the issuance of tax-exempt obligations acceptable to the Trustee.

"Bond Fund" shall mean the fund so designated which is established by Section 5.01 of the Indenture in which there is created an Interest Account and a Principal Account.

"Bond Guaranty Agreement" shall mean the Bond Guaranty Agreement dated as of December 1, 2021, by and between the Corporation and the Trustee.

"Borrower" shall mean the Corporation.

"Business Day" shall mean a day of the year on which banks located in the city in which the principal corporate trust office of the Trustee is located, or in the City of New York, New York, are not required or authorized by law to remain closed.

"Code" shall mean the Internal Revenue Code of 1986, as amended, of the United States of America, and the regulations proposed or issued thereunder by competent authority.

"Completion Date" shall mean the date of completion of any Improvements certified by the Consulting Architect pursuant to Section 6.06 of the Indenture.

"Construction Fund" shall mean the fund so designated which is established by Section 6.01 of the Indenture.

"Consulting Architect" shall mean the architect or architectural firm at the time employed as such by the Corporation to supervise an Improvement.

"Continuing Disclosure Agreement" shall mean that certain Continuing Disclosure Agreement between the Corporation and the Dissemination Agent dated as of the date of issuance of the Series 2021 Bonds, as originally executed and as it may be amended from time to time in accordance with the terms thereof.

"Corporation" shall mean North Arkansas Regional Medical Center, an Arkansas not-for-profit corporation.

"Current Expenses" shall mean current expenses incurred by the Corporation in the operation of the Medical Center determined in accordance with generally accepted accounting principles, but shall exclude interest, depreciation and amortization.

"Debt Service Requirements" means, with respect to the period of time for which calculated, the aggregate of the payments due during such period in respect of principal (whether at maturity, as a result of mandatory sinking fund redemption, mandatory prepayment or otherwise) and interest and other payments on Outstanding Notes; provided that: (a) the amount of such payments for a future period shall be calculated in accordance with the assumptions contained in Section 10.15 of the Loan Agreement; (b) interest shall be excluded from the determination of the Debt Service Requirements to the extent that capitalized interest is available to pay such interest; and (c) principal of Notes shall be excluded from the determination of Debt Service Requirements to the extent that amounts are on deposit in an irrevocable escrow and such amounts (including, where appropriate, the earnings or other increment to accrue thereon) are required to be applied to pay such principal and such amounts so required to be applied are sufficient to pay such principal.

"Debt Service Reserve Fund" shall mean the fund so designated which is established by Section 5.01 of the Indenture.

"Debt Service Reserve Fund Requirement" shall mean the aggregate of the amounts determined with respect to each series of Bonds Outstanding as of any date of calculation, equal to the lesser of (i) the maximum annual Debt Service Requirements with respect to such series of Bonds, (ii) 125% of the average annual Debt Service Requirements with respect to such series of Bonds, or (iii) 10% of the initial stated principal amount of such series of Bonds.

"Defeasance Obligations" shall mean noncallable direct and general obligations of the United States of America.

"Fiscal Year" shall mean the period beginning April 1 of each year and ending on the March 31 next succeeding, or such other annual fiscal period as may hereafter be established by the Corporation.

"Government Obligations" shall mean direct and general obligations of the United States of America, or those which are unconditionally guaranteed as to the payment of principal and interest by the United States of America.

"Historical Debt Service Coverage Ratio" means, for any period of time, the ratio consisting of a numerator equal to the amount determined by dividing Net Income Available for Debt Service for that period by the Debt Service Requirements for such period and a denominator of one; provided that, in calculating the Debt Service Requirements for any completed period, the principal amount of any indebtedness included in such calculation which is paid during such period shall be excluded to the extent such principal amount is paid from the proceeds of other indebtedness incurred in accordance with the provisions of the Loan Agreement or from amounts deposited to provide for such payment pursuant to an amortization schedule established and maintained, which amounts were deposited in Fiscal Years prior to the Fiscal Year in which such principal became due.

"Hospital Consultant" shall mean any nationally recognized hospital consultant with experience in the preparation of hospital management studies or of feasibility studies for use in connection with the financing of hospitals, selected by the Corporation and satisfactory to the Issuer and the Trustee.

"Improvement Bonds" shall mean any Bonds issued to finance Improvements pursuant to Section 3.08 of the Indenture.

"Improvements" shall mean any additions, extensions, improvements, equipment, furnishings or other facilities with respect to the Medical Center financed with the proceeds of Improvement Bonds, as more particularly described in the supplemental indenture authorizing the issuance thereof.

"Indenture" shall mean the Trust Indenture dated as of May 1, 1999, as supplemented by a Supplemental Trust Indenture dated as of March 1, 2006, by a Second Supplemental Trust Indenture

dated as of November 1, 2010, by a Third Supplemental Trust Indenture dated as of December 1, 2011, by a Fourth Supplemental Trust Indenture dated as of March 1, 2013, and by a Fifth Supplemental Trust Indenture dated as of December 1, 2021, each by and between the Issuer and the Trustee, and any further supplements entered into in accordance with the provisions thereof.

"Interest Payment Date" shall mean, except as provided in the Supplemental Trust Indenture with respect to the Series 2006 Bonds, each May 1 and November 1 on which interest on the Bonds is required to be paid under the Indenture.

"Issuance Costs" shall mean all costs and expenses of issuance of a series of Bonds, including, but not limited to: (i) underwriter's discount and fees; (ii) counsel fees, including bond counsel, underwriter's counsel, Issuer's counsel, Corporation's counsel, and special tax counsel fees, as well as any other specialized counsel fees; (iii) financial advisor fees; (iv) rating agency fees; (v) trustee fees and trustee counsel fees; (vi) paying agent and certifying and authenticating agent fees related to issuance of the Bonds; (vii) accountant fees; (viii) printing costs of the Bonds and of a preliminary and final official statement; (ix) publication costs associated with the financial proceedings; and (x) costs of engineering and feasibility studies necessary to the issuance of a series of Bonds.

"Issuer" shall mean Boone County, Arkansas, a political subdivision of the State.

"Lease Agreement" shall mean the Assignment and Lease Agreement between the Issuer and the Corporation, dated as of March 1, 1997, as amended by an Amendment to Assignment and Lease Agreement dated as of November 1, 2010, providing for the lease of the Medical Center Site to the Corporation.

"Loan Agreement" shall mean the Loan Agreement dated as of May 1, 1999, as supplemented by a Supplemental Loan Agreement dated as of March 1, 2006, by a Second Supplemental Loan Agreement dated as of November 1, 2010, by a Third Supplemental Loan Agreement dated as of December 1, 2011, by a Fourth Supplemental Loan Agreement dated as of March 1, 2013, and by a Fifth Supplemental Loan Agreement dated as of December 1, 2021, each by and between the Corporation and the Issuer, securing the Notes, and any further supplements entered into in accordance with the provisions thereof.

"Maximum Annual Debt Service Requirement" means the largest total Debt Service Requirements for all Notes Outstanding for the current or any succeeding Fiscal Year; provided that, in applying the provisions of Section 10.15 of the Loan Agreement, the current year shall be deemed to include the Fiscal Year with respect to which historical debt service coverage is being calculated; and, provided further that, in calculating the Maximum Annual Debt Service Requirement for the purposes of applying such provisions, the principal amount of any Notes included in such calculation which is paid during the year, with respect to which historical debt service coverage is being calculated, shall be excluded to the extent such principal amount is paid from the proceeds of other Notes incurred in accordance with the provisions of the Loan Agreement, or from amounts deposited to provide for such payment pursuant to an amortization schedule, and which amounts were deposited in Fiscal Years prior to the Fiscal Year in which such principal was paid; provided further, that principal and interest payments on Notes due on the first day or first Business Day of a month shall be deemed payable during the preceding month if they are required to be fully deposited with the Trustee during such preceding month.

"Medical Center" shall mean the Medical Center Site and all hospital or healthcare facilities now or hereafter situated thereon, and all equipment and other personal property constituting a part of the Medical Center, and all substitutions and replacements therefor.

"Medical Center Site" shall mean the parcels of real estate consisting of (1) approximately 13.69 acres at 620 North Main Street, Harrison, Arkansas, (2) approximately 3.81 acres at 825 North Spring Street, Harrison, Arkansas, (3) approximately 24 acres located on Highway 43E in Harrison, Arkansas, (4) approximately one acre at West Court Street in Newton County, Arkansas, (5) certain property at Highway 62 in the City of Yellville, Arkansas, and (6) approximately 2 acres at 1 Airport Road in the City of Marshall, Arkansas, each as more particularly described in the Indenture; including all structures

now or hereafter constructed on the Medical Center Site; all capitalized equipment, furniture, appliances and apparatuses purchased by the Corporation for use on the Medical Center Site; and any additional parcels of real estate used by the Corporation in the operation of the Medical Center.

"Moody's" shall mean Moody's Investors Service and its successors.

"Net Income Available for Debt Service" shall mean, with respect to any Fiscal Year, the excess of revenues over the expenses of the Corporation determined in accordance with generally accepted accounting principles generally applicable to hospitals, including specifically any unrestricted gift, bequest, contribution, grant, or donation to which shall be added depreciation, amortization, and any other non-cash item, and interest expense, but excluding (i) any restricted gift, bequest, contribution, grant, or donation, (ii) any profits or losses on the sale or other disposition, not in the ordinary course of operations, of investments, or fixed or capital assets, (iii) revenues or expenses derived from the gain or loss resulting from the extinguishment of debt, (iv) adjustments for unrealized gains or losses on investments, and (v) investment income on restricted funds which is not available to make payments of principal of and interest on the Bonds.

"Notes" shall mean promissory notes issued under and secured by the Loan Agreement, and shall include the Series 2006 Note, the Series 2011 Note, the Series 2021 Note and any Additional Notes.

"Officer's Certificate" means a certificate signed, in the case of a certificate delivered by the Issuer, by the County Judge or any other elected official authorized to sign by resolution of the Boone County Quorum Court, and in the case of a certificate delivered by the Corporation, by the Chairman, President, any Vice President, Secretary or Treasurer, or any other officer authorized to sign by resolution of the Board of Directors of the Corporation, and, in the case of a certificate delivered by any other person, the chief executive or chief financial officer of such other person, in either case whose authority to execute such Certificate shall be evidenced to the satisfaction of the Trustee.

"Operating Fund" shall mean the fund so designated which is established by Section 5.01 of the Indenture.

"Outstanding" or *"outstanding"* when used with reference to Bonds shall mean as of any particular time all the Bonds authenticated and delivered by the Trustee under the Indenture, except

(a) Bonds theretofore cancelled by the Trustee or delivered to the Trustee cancelled or for cancellation;

(b) Bonds for the payment or redemption of which money in the necessary amount shall have been deposited with the Trustee, and with respect to Bonds to be redeemed prior to maturity, notice of such redemption shall have been given as provided in the Indenture; and

(c) Bonds in substitution for which other Bonds shall have been authenticated and delivered pursuant to the terms of Section 2.05 of the Indenture;

"Owner" or *"Bondowner"* and shall mean the registered owner of a Bond.

"Paying Agent" shall mean the Trustee in its capacity as paying agent or any additional or successor paying agent.

"Permitted Investments" shall mean any of the following:

(a) Cash (insured at all times by the Federal Deposit Insurance Corporation or otherwise collateralized with Government Obligations);

(b) Government Obligations;

(c) Obligations of any of the following federal agencies which obligations represent the full faith and credit of the United States of America: Export-Import Bank; Farm Credit System Financial Assistance Corporation; Farmers Home Administration; General Services Administration; US. Maritime Administration; Small Business Administration; Government

National Mortgage Association; U.S. Department of Housing & Urban Development; and Federal Housing Administration;

(d) Senior debt obligations rated "AAA" by S&P and "Aaa" by Moody's, issued by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation;

(e) (i) Federal funds, or banker's acceptances, maturing in not more than 270 days, issued or accepted by commercial banks which have a rating on their short-term certificates of deposit on the date of purchase of not lower than "A-1" by S&P or "P-1" by Moody's, (ii) U. S. dollar denominated certificates of deposit issued by commercial banks or savings and loans and fully insured by the Federal Deposit Insurance Corporation, or (iii) U.S. dollar denominated certificates of deposit issued by commercial banks or savings and loans, provided (a) the payment of principal of and interest on the certificates is fully secured by a pledge of Government Obligations and provided the issuer of the certificate of deposit has a rating described in (i), above, and (b) the Trustee receives an opinion of counsel satisfactory to the Trustee to the effect that the certificate holder holds a valid and legally effective security interest in the pledged Government Obligations;

(f) Commercial paper which is rated at the time of purchase in the single highest classification, "A-1+" by S&P and "P-1" by Moody's and which matures not more than 270 days after the date of purchase;

(g) Investments in a money market fund rated "AAAm" or "AAAm-G" or better by S&P and/or rated in the highest rating classification by Moody's; and

(h) Pre-refunded Municipal Obligations defined as follows: any bonds or other obligations of any state of the United States of America or of any agency, instrumentality or local governmental unit of any such state which are not callable at the option of the obligor prior to maturity or as to which irrevocable instructions have been given by the obligor to call on the date specified in the notice; and

(i) which are rated, based on an irrevocable escrow account or fund (the "escrow"), in the highest rating category of S&P, Moody's, or Fitch or any successors thereto; and

(ii) which are fully secured as to principal and interest and redemption premium, if any, by an escrow consisting of cash or obligations described in paragraph (i) above, which escrow may be applied only to the payment of such principal of and interest and redemption premium, if any, on such bonds or other obligations on the maturity date or dates thereof or the specified redemption date or dates pursuant to such irrevocable instructions, as appropriate; and

(iii) which escrow is sufficient, as verified by a nationally recognized independent certified public accountant, to pay principal of and interest and redemption premium, if any, on the bonds or other obligations described in this paragraph on the maturity date or dates specified in the irrevocable instructions referred to above, as appropriate.

"Pledged Revenues" shall mean all money, earnings, rents, issues, profits, income, revenues, investment earnings, receipts and proceeds or rights to the payment of money, receivables, accounts, contract rights and judgments derived in any fashion from the use and operation of the Medical Center at any time; and all proceeds from chattel paper, instruments, accounts and contract rights; but *excluding* gifts, donations, bequests, devises, legacies, contributions, pledges and grants restricted to an inconsistent purpose, proceeds from the Notes and the Bonds, unrealized gains and losses from investments, and proceeds from life insurance; all determined in accordance with generally accepted accounting principles.

"Qualified Project Costs" means costs and expenses of an Improvement to the Medical Center, but specifically excluding costs and expenses for portions of the Medical Center to be used (i) by any person that is not a "state or local governmental unit" or an "organization described in Section 501(c)(3) of the Code," both within the meaning of Section 150 of the Code or (ii) for activities constituting unrelated trades or businesses of the Corporation determined by applying Section 513(a) of the Code; provided, however, that Issuance Costs shall not be deemed to be Qualified Project Costs.

"Rebate Fund" shall mean the fund so designated which is established in Section 5.01 of the Indenture.

"Record Date" shall mean the fifteenth day of the calendar month next preceding any Interest Payment Date, or, if such day is not a Business Day, the immediately preceding Business Day.

"Refunded Bonds" means the remaining outstanding Series 2013 Bonds being refunded by the Series 2021 Bonds.

"Refunding Bonds" shall mean any Bonds issued pursuant to Section 3.09 of the Indenture.

"Revenue Fund" means the fund so designated which is established by Section 5.01 of the Indenture.

"S&P" shall mean Standard & Poor's Ratings Services, a Division of The McGraw-Hill Companies, Inc., and its successors.

"Series 2006 Bonds" shall mean the Issuer's Variable Rate Hospital Revenue Construction Bonds (North Arkansas Medical Center Project), Series 2006, dated March 1, 2006, from time to time outstanding under the Indenture.

"Series 2010 Bonds" shall mean the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Medical Center Project), Series 2010, dated November 1, 2010, from time to time outstanding under the Indenture.

"Series 2011 Bonds" shall mean the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Medical Center Project), Series 2011, dated December 1, 2011, from time to time outstanding under the Indenture.

"Series 2013 Bonds" shall mean the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Medical Center Project), Series 2013, dated March 1, 2013, from time to time outstanding under the Indenture.

"Series 2021 Bonds" shall mean the Issuer's Hospital Revenue Refunding Bonds (North Arkansas Medical Center Project), Series 2021, dated December 30, 2021, from time to time outstanding under the Indenture.

"Series 2006 Note" shall mean the promissory note so designated, dated the date of delivery of the Series 2006 Bonds, issued by the Corporation to the Issuer pursuant to the Loan Agreement.

"Series 2010 Note" shall mean the promissory note so designated, dated the date of delivery of the Series 2010 Bonds, issued by the Corporation to the Issuer pursuant to the Loan Agreement.

"Series 2011 Note" shall mean the promissory note so designated, dated the date of delivery of the Series 2011 Bonds, issued by the Corporation to the Issuer pursuant to the Loan Agreement.

"Series 2013 Note" shall mean the promissory note so designated, dated the date of delivery of the Series 2013 Bonds, issued by the Corporation to the Issuer pursuant to the Loan Agreement.

"Series 2021 Note" shall mean the promissory note so designated, dated the date of delivery of the Series 2021 Bonds, issued by the Corporation to the Issuer pursuant to the Loan Agreement.

"Sinking Fund Installment" shall mean any amount of money required to be paid on a specified date by the Issuer as provided in Section 3.04 of the Indenture, or in a supplemental indenture with respect to Additional Bonds, toward the retirement of any Term Bond, but not including any amount paid upon the maturity of a Term Bond.

"State" shall mean the State of Arkansas.

"System" shall mean North Arkansas Medical System, the parent company of the Corporation.

"Tax Regulatory Agreement" shall mean an agreement by and among the Issuer, the Corporation and the Trustee prescribing the procedures for compliance with Section 148 of the Code, which is applicable to the Bonds, the Loan Agreement and the Indenture.

"Trustee" shall mean Regions Bank, a banking corporation organized and existing under and by virtue of the laws of the State of Alabama and having a place of business in the City of Little Rock, Arkansas, as trustee under the Indenture, and its successors in trust.

"Underwriter" shall mean Stephens Inc. and its successors.

"Written Request" with (i) respect to the Corporation shall mean a request in writing signed by the Chairman or the Secretary of the Corporation, or by any other officer of the Corporation authorized by its Board of Directors and satisfactory to the Trustee; and (ii) with respect to the Issuer shall mean a request in writing signed by the County Judge of the Issuer, or by any other officer of the Issuer authorized by its Quorum Court.

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APPENDIX C

Audited Consolidated Financial Statements of
North Arkansas Medical System
for the Fiscal Years ended
March 31, 2021 and March 31, 2020

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North Arkansas Medical System

Independent Auditor's Report and Consolidated Financial Statements

March 31, 2021 and 2020

North Arkansas Medical System

March 31, 2021 and 2020

Contents

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CPAs & Advisors

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Independent Auditor's Report

Board of Directors
North Arkansas Medical System
Harrison, Arkansas

We have audited the accompanying consolidated financial statements of North Arkansas Medical System (the System), which comprise the consolidated balance sheets as of March 31, 2021 and 2020, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of North Arkansas Medical System as of March 31, 2021 and 2020, and the results of its operations, changes in its net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in *Note 15* to the consolidated financial statements, in 2021, the System adopted ASU 2016-02, *Leases* (*Topic 842*). Our opinion is not modified with respect to this matter.

BKD, LLP

Little Rock, Arkansas
June 16, 2021

North Arkansas Medical System
Consolidated Balance Sheets
March 31, 2021 and 2020

Assets

	2021	2020
Current Assets		
Cash	$ 19,883,224	$ 1,624,331
Assets limited as to use – current	1,047,336	1,064,945
Patient accounts receivable	10,906,281	11,536,264
Estimated amounts due from third-party payors	1,192,486	971,107
Supplies	3,253,201	2,137,783
Prepaid expenses	1,045,102	961,387
Other current receivables	28,662	130,834
Total current assets	37,356,292	18,426,651
Assets Limited as to Use		
Internally designated	41,410,309	31,393,049
Externally restricted by donors	25,262	28,834
Held by trustee – under indenture agreements	3,488,788	3,506,284
Held by trustee – workers' compensation	-	4,000
	44,924,359	34,932,167
Less amount required to meet current obligations	1,047,336	1,064,945
	43,877,023	33,867,222
Property and Equipment, Net	38,958,923	39,301,478
Other Assets		
Interest rate swap agreement	33,608	-
Right-of-use assets – operating leases	718,292	-
Other	324,933	471,108
	1,076,833	471,108
Total assets	$ 121,269,071	$ 92,066,459

See Notes to Consolidated Financial Statements

Liabilities and Net Assets

	2021	2020
Current Liabilities		
Current maturities of long-term debt	$ 1,091,286	$ 1,039,840
Current portion of operating lease liabilities	456,109	-
Current portion of contract liabilities	4,419,872	-
Accounts payable	5,271,241	4,076,627
Accrued expenses	10,000,076	5,931,639
Total current liabilities	21,238,584	11,048,106
Other Liabilities		
Interest rate swap agreement	-	602,666
Operating lease liabilities	262,183	-
Other long-term liabilities	740,343	-
Long-term debt, net	22,733,794	23,825,374
Contract liabilities	6,102,371	-
Total liabilities	51,077,275	35,476,146
Net Assets		
Without donor restrictions	70,166,534	56,561,479
With donor restrictions	25,262	28,834
Total net assets	70,191,796	56,590,313
Total liabilities and net assets	$ 121,269,071	$ 92,066,459

North Arkansas Medical System
Consolidated Statements of Operations
Years Ended March 31, 2021 and 2020

	2021	2020
Revenues, Gains and Other Support Without Donor Restrictions		
Patient service revenue	$ 82,713,069	$ 89,906,584
Other	15,697,439	2,218,463
Total revenues, gains and other support without donor restrictions	98,410,508	92,125,047
Expenses and Losses		
Salaries and wages	40,492,156	40,874,279
Employee benefits	7,476,728	9,594,865
Professional fees	5,265,465	5,963,921
Supplies and other	30,630,393	30,372,728
Contract labor	4,343,674	1,830,936
Provider assessment tax	1,192,938	1,070,705
Depreciation	3,062,272	3,073,123
Interest, net of interest rate swap activity	487,905	1,636,529
Total expenses and losses	92,951,531	94,417,086
Operating Income (Loss)	5,458,977	(2,292,039)
Other Income (Losses)		
Investment return, net	7,851,160	(1,375,251)
Contributions received	436,532	193,895
Total other income (losses)	8,287,692	(1,181,356)
Excess (Deficiency) of Revenues over Expenses	13,746,669	(3,473,395)
Investment return – change in unrealized gains and losses on debt securities classified as other than trading	(141,614)	417,034
Increase (Decrease) in Net Assets Without Donor Restrictions	$ 13,605,055	$ (3,056,361)

North Arkansas Medical System

Consolidated Statements of Changes in Net Assets

Years Ended March 31, 2021 and 2020

	2021	2020
Net Assets Without Donor Restrictions		
Excess (deficiency) of revenues over expenses	$ 13,746,669	$ (3,473,395)
Investment return – change in unrealized gains and losses on debt securities classified as other than trading	(141,614)	417,034
Increase (decrease) in net assets without donor restrictions	13,605,055	(3,056,361)
Net Assets with Donor Restrictions		
Contributions received	-	4,789
Recoveries of (provision for) uncollectible contributions receivable	(3,652)	3,180
Investment return	80	1,497
Increase (decrease) in net assets with donor restrictions	(3,572)	9,466
Change in Net Assets	13,601,483	(3,046,895)
Net Assets, Beginning of Year	56,590,313	59,637,208
Net Assets, End of Year	$ 70,191,796	$ 56,590,313

North Arkansas Medical System
Consolidated Statements of Cash Flows
Years Ended March 31, 2021 and 2020

	2021	2020
Operating Activities		
Change in net assets	$ 13,601,483	$ (3,046,895)
Items not requiring (providing) cash		
Depreciation and amortization	3,090,893	3,104,325
Net realized and unrealized (gains) losses on investments	(6,778,716)	1,755,685
Change in fair value of interest rate swap agreement	(636,274)	602,666
Restricted contributions and investment income received	(80)	(6,286)
Recoveries of uncollectible contributions receivable	3,652	(3,180)
Changes in		
Patient accounts receivable	629,983	(66,122)
Accounts payable and accrued expenses	2,719,218	111,530
Deferred revenue	3,284,176	-
Estimated amounts due to/from third-party payors	(221,379)	(943,164)
Other current assets	(1,096,961)	(768,222)
Physician receivables	146,175	72,292
Contract liabilities	10,522,243	-
Net cash provided by operating activities	25,264,413	812,629
Investing Activities		
Purchase of investments	(18,336,412)	(11,357,537)
Proceeds from disposition of investments	15,119,284	13,680,735
Purchase of property and equipment	(2,719,717)	(4,872,851)
Net cash used in investing activities	(5,936,845)	(2,549,653)
Financing Activities		
Proceeds from restricted contributions and investment income	80	6,286
Proceeds from issuance of long-term debt	-	4,500,000
Principal payments on long-term debt	(1,068,755)	(1,606,943)
Net cash provided by (used in) financing activities	(1,068,675)	2,899,343
Increase in Cash	18,258,893	1,162,319
Cash, Beginning of Year	1,624,331	462,012
Cash, End of Year	$ 19,883,224	$ 1,624,331
Supplemental Cash Flows Information		
Interest paid	$ 1,111,493	$ 1,629,506

North Arkansas Medical System
Notes to Consolidated Financial Statements
March 31, 2021 and 2020

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations and Principles of Consolidation

North Arkansas Medical System (the System) primarily earns revenues by providing inpatient, outpatient, psychiatric and emergency care services to patients in Boone County and surrounding areas of northwest Arkansas. It also operates a home health agency, a hospice, rural health clinics and physician clinics in the same geographic area. The consolidated financial statements include the following:

Organization	Primary Business Activity	Tax Status
North Arkansas Medical System (the System)	Parent corporation	Not-for-profit 501(c)(3)
North Arkansas Regional Medical Center (Medical Center)	Acute care medical center and physician clinics	Not-for-profit 501(c)(3); the System is sole member
North Arkansas Medical Services (Medical Services)	Real estate holding company in support of the activities of the Medical Center	Not-for-profit 501(c)(3); the System is sole member
North Arkansas Medical Foundation (Foundation)	Solicit contributions for the benefit of the Medical Center and affiliates	Not-for-profit 501(c)(3); the System is sole member

All significant intercompany accounts and transactions have been eliminated in consolidation.

The Medical Center entered into a five-year lease agreement with Boone County, Arkansas, for the hospital property and equipment on March 1, 1997, with automatic annual renewals after the initial term. On October 1, 2010, the agreement was amended to provide an additional term through December 31, 2041. Title to the existing leased property and all leasehold improvements will remain with the county. Upon termination of the lease, all rights and title to the leased premises and all major improvements return to Boone County, Arkansas. These assets have been included in the consolidated financial statements.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues, expenses, gains, losses and other changes in net assets during the reporting period. Actual results could differ from those estimates.

Cash Equivalents and Restricted Cash

The System considers all liquid investments, other than those limited as to use, with original maturities of three months or less to be cash equivalents. At March 31, 2021 and 2020, cash equivalents consisted primarily of money market mutual funds. Uninvested cash and cash equivalents included in investment accounts and assets limited as to use are not considered to be cash and cash equivalents.

At March 31, 2021, the System's cash accounts exceeded federally insured limits by approximately $21,328,000.

Assets Limited as to Use

Assets limited as to use include: (1) assets held by trustees, (2) assets restricted by donors and (3) assets set aside by the board of directors (the Board) for future capital improvements over which the Board retains control and may at its discretion subsequently use for other purposes. Amounts required to meet current liabilities of the System are included in current assets.

Patient Accounts Receivable

Patient accounts receivable reflects the outstanding amount of consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs) and others. As a service to the patient, the System bills third-party payors directly and bills the patient when the patient's responsibility for co-pays, coinsurance and deductibles is determined. Patient accounts receivable are due in full when billed. Bad debt expense was not significant for the years ended March 31, 2021 and 2020.

Contract Assets and Liabilities

Amounts related to heath care services provided to patients which have not been billed and that do not meet the conditions of an unconditional right to payment at the end of the reporting period are contract assets. There were no such amounts for the years ended March 31, 2021 and 2020.

Amounts received related to health care services that have not yet been provided to patients are contract liabilities. Contract liabilities consist of Medicare accelerated payments received under the provisions of the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act). In general, advanced amounts will be recouped from remittances starting 12 months after the advance is made. See *Note 16*.

Estimated Amounts Due to/from Third-Party Payors

The System records amounts due to or from third-party payors as those amounts become estimable. These estimated amounts include settlements of current year cost reports as well as outstanding cost report and billing settlements and retroactive adjustments from prior periods.

Supplies

The System states supply inventories at the lower of cost or net realizable value. Costs are determined using the first-in, first-out (FIFO) method.

Debt Investments

Debt securities held by the System generally are classified and recorded in the consolidated financial statements as follows:

Classified as	Description	Recorded at
Trading	Securities that are bought and held principally for the purpose of selling in the near term and, therefore, held for only a short period of time	Fair value, with changes in fair value included in excess (deficiency) revenues over expenses
Other than trading	Securities not classified as trading	Fair value, with unrealized gains and losses recorded below excess (deficiency) revenues over expenses

Purchase premiums and discounts are recognized in interest income using the interest method over the terms of the securities. Gains and losses on the sale of securities are recorded on the trade date and are determined using the specific identification method.

When the fair value of securities is below the amortized cost, the System's accounting treatment for an other-than-temporary impairment (OTTI) is as follows:

	Accounting Treatment for OTTI Components	
Circumstances of Impairment Considerations	Credit Component	Remaining Portion
Not intended for sale and more likely than not that the System will not have to sell before recovery of cost basis	Recognized in excess (deficiency) of revenues over expenses	Recognized below excess (deficiency) of revenues over expenses
Intended for sale or more likely than not that the System will be required to sell before recovery of cost basis	Recognized in excess (deficiency) revenues over expenses	

When a credit loss component is separately recognized in earnings, the amount is identified as the total of principal cash flows not expected to be received over the remaining term of the security, as projected based on cash flow projections.

Equity Investments

The System measures equity securities, other than investments that qualify for equity method of accounting, at fair value with changes recognized in excess revenues over expenses. Gains and losses on the sale of securities are recorded on the trade date and are determined using the specific identification method.

Net Investment Return

Investment return includes dividend, interest and other investment income; realized and unrealized gains and losses on investments carried at fair value; and realized gains and losses on other investments, less external and direct internal investment expenses.

Investment return that is initially restricted by donor stipulation and for which the restriction will be satisfied in the same year is included in net assets without donor restrictions. Other investment return is reflected in the consolidated statements of operations and changes in net assets as with or without donor restrictions based upon the existence and nature of any donor or legally imposed restrictions.

Property and Equipment

Property and equipment acquisitions over $2,500 are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization are charged to expense on the straight-line basis over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or respective estimated useful lives.

The estimated useful lives for each major depreciable classification of property and equipment are as follows:

Land improvements	5–25 years
Buildings and leasehold improvements	3–40 years
Equipment	3–25 years

Long-Lived Asset Impairment

The System evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset are less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value. No asset impairment was recognized in the years ended March 31, 2021 and 2020.

Debt Issuance Costs

Debt issuance costs represent costs incurred in connection with the issuance of long-term debt. The System records these costs as direct deductions from the related debt consistent with debt discounts or premiums. Such costs are being amortized into interest expense over the term of the respective debt using the straight-line method.

Refund Liabilities

The consideration the System has received for patients by other third-party payors for which it does not expect to be entitled is recorded as a refund liability.

Net Assets

Net assets, revenues, gains and losses are classified based on the existence or absence of donor restrictions.

Net assets without donor restrictions are available for use in general operations and not subject to donor restrictions. The governing board has designated, from net assets without donor restrictions, net assets for future capital improvements and has been invested in property and equipment, net of related debt as follows:

	2021	2020
Undesignated	$ 13,895,316	$ 11,037,293
Designated by the Board for future capital improvements	41,410,309	31,393,049
Invested in property and equipment, net of related debt	14,886,171	14,159,971
	$ 70,191,796	$ 56,590,313

Net assets with donor restrictions are subject to donor restrictions. Some restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity.

Patient Service Revenue

Patient service revenue is recognized as the System satisfies performance obligations under its contracts with patients. Patient service revenue is reported at the estimated transaction price or amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. The System determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the System's policies and implicit price concessions provided to uninsured patients.

The System determines its estimates of explicit price concessions, which represent adjustments and discounts based on contractual agreements, its discount policies and historical experience by payor groups. The System determines its estimate of implicit price concessions based on its historical collection experience by classes of patients. The estimated amounts also include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations by third-party payors.

Charity Care

The System provides care without charge or at amounts less than its established rates to patients meeting certain criteria under its charity care policies. Because the System does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as patient service revenue.

Contributions

Contributions are provided to the System either with or without restrictions placed on the gift by the donor. Revenues and net assets are separately reported to reflect the nature of those gifts—with or without donor restrictions. The value recorded for each contribution is recognized as follows:

Nature of the Gift	Value Recognized
Conditional gifts, with or without restriction	
Gifts that depend on the System overcoming a donor-imposed barrier to be entitled to the funds	Not recognized until the gift becomes unconditional, *i.e.*, the donor-imposed barrier is met
Unconditional gifts, with or without restriction	
Received at date of gift – cash and other assets	Fair value
Received at date of gift – property, equipment and long-lived assets	Estimated fair value
Expected to be collected within one year	Net realizable value
Collected in future years	Initially reported at fair value determined using the discounted present value of estimated future cash flows technique

In addition to the amount initially recognized, revenue for unconditional gifts to be collected in future years is also recognized each year as the present-value discount is amortized using the level-yield method.

When a donor-stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of operations as net assets released from restrictions. Absent explicit donor stipulations for the period of time that long-lived assets must be held, expirations of restrictions for gifts of land, buildings, equipment and other long-lived assets are reported when those assets are placed in service.

Gifts having donor stipulations which are satisfied in the period the gift is received are reported as revenue and net assets without donor restrictions.

Conditional contributions having donor stipulations which are satisfied in the period the gift is received are recorded as revenue and net assets without donor restrictions.

Excess (Deficiency) of Revenues over Expenses

The consolidated statements of operations include excess (deficiency) of revenues over expenses. Changes in net assets without donor restrictions which are excluded from excess (deficiency) of revenues over expenses, consistent with industry practice, include unrealized gains and losses on debt securities classified as other-than-trading and contributions of long-lived assets (including assets acquired using contributions that, by donor restriction, were to be used for the purpose of acquiring such assets).

Self-Insurance

The System maintains a self-insured health care plan (Plan) covering substantially all full-time employees. Premiums are paid by the System and its employees to a third-party administrator. Excess costs incurred for claims are funded by the System. Contributions are made to the administrator of the Plan as health care claims are incurred. A liability is accrued for claims reported and approved for payment and an estimate of claims incurred but not reported. Total claims paid for the years ended March 31, 2021 and 2020, was $3,920,000 and $6,377,000, respectively. As of March 31, 2021 and 2020, $658,000 and $949,000, respectively, was included in accrued expenses.

Professional Liability Claims

The System recognizes an accrual for claim liabilities based on estimated ultimate losses and costs associated with settling claims and a receivable to reflect the estimated insurance recoveries, if any. Professional liability claims are described more fully in *Note 6*.

Income Taxes

The System, Medical Center, Foundation and Medical Services have been recognized as exempt from income taxes under Section 501 of the Internal Revenue Code and a similar provision of state law. As such, they are required to file IRS Form 990 on an annual basis. The organizations are subject to federal income tax on any unrelated business taxable income and file tax returns in the U.S. federal jurisdictions.

Subsequent Events

Subsequent events have been evaluated through June 16, 2021, which is the date the consolidated financial statements were issued.

Note 2: Investments and Investment Return

Assets Limited as to Use

Assets limited as to use, at March 31, 2021 and 2020, include:

	2021	2020
Internally designated for capital improvements		
Cash and cash equivalents	$ 3,624,304	$ 2,642,199
Certificates of deposit	931,737	1,031,003
Equity mutual funds	9,150,769	2,372,177
U.S. Treasury obligations	5,858,729	5,076,676
Exchange-traded funds	2,099,418	4,270,368
Corporate obligations	8,895,897	7,543,445
Corporate equities	9,649,353	6,037,169
Mortgage-backed securities	1,099,478	2,326,700
Interest receivable	100,624	93,312
	41,410,309	31,393,049
Externally restricted by donors		
Cash	25,262	28,834
Held by trustee under indenture agreements		
Cash and cash equivalents	3,488,788	3,506,284
Held by trustee for workers' compensation		
Certificates of deposit	-	4,000
	$ 44,924,359	$ 34,932,167

Certain investments in debt securities are reported in the consolidated financial statements at an amount less than their historical cost. Total fair value of these investments at March 31, 2021 and 2020, was $5,915,168 and $1,757,493, respectively, which is approximately 13% and 5%, respectively, of the System's investment portfolio. These increases primarily resulted from recent decreases in market interest rates and overall market volatility.

Management believes the declines in fair value for these securities are temporary. The System expects the temporarily impaired debt securities to recover as they near maturity. Based on the System's ability and intent to hold those investments for a reasonable period of time sufficient for a forecasted recovery of fair value, the System does not consider those investments to be other-than-temporarily impaired at March 31, 2021 and 2020.

Should the impairment of any of these securities become other than temporary, the cost basis of the investment will be reduced and the resulting loss recognized in net income in the period the other-than-temporary impairment is identified.

The following table shows the System's debt investments' gross unrealized losses and fair value, aggregated by length of time that individual securities have been in a continuous unrealized loss position at March 31, 2021 and 2020:

	2021		2020	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Less than 12 months	$ 5,667,668	$ 261,093	$ 635,795	$ 126,080
12 months or more	247,500	3,540	1,121,698	8,735
	$ 5,915,168	$ 264,633	$ 1,757,493	$ 134,815

Investment Return

Total investment return is comprised of the following for the years ended March 31:

	2021	2020
Interest and dividend income	$ 930,910	$ 798,965
Realized gains	148,512	268,900
Change in unrealized gains and losses	6,630,204	(2,024,585)
	$ 7,709,626	$ (956,720)

Total investment return is reflected in the consolidated statements of operations and changes in net assets as follows for the years ended March 31:

	2021	2020
Without donor restrictions		
Other nonoperating income (loss)	$ 7,851,160	$ (1,375,251)
Change in unrealized gains and losses on debt securities classified as other than trading	(141,614)	417,034
With donor restrictions	80	1,497
	$ 7,709,626	$ (956,720)

Note 3: Concentrations of Credit Risk

The System grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at March 31 was:

	2021	2020
Medicare	41%	42%
Medicaid	7	8
Other third-party payors	38	39
Patients	14	11
	100%	100%

Note 4: Property and Equipment

Property and equipment at March 31 consisted of:

	2021	2020
Land and improvements	$ 3,588,271	$ 3,588,271
Buildings and leasehold improvements	59,020,558	59,020,558
Equipment	55,061,065	52,639,417
Construction in progress	63,928	16,626
	117,733,822	115,264,872
Less accumulated depreciation and amortization	78,774,899	75,963,394
	$ 38,958,923	$ 39,301,478

Note 5: Long-term Debt

	2021	2020
Revenue bonds (A)	$ 4,145,000	$ 4,890,000
Construction bonds (B)	4,700,000	4,700,000
Revenue bonds (C)	9,840,000	9,940,000
Note payable (D)	4,344,244	4,443,783
Note payable (E)	925,420	1,024,046
Note payable (F)	118,088	130,385
Finance lease obligations (G)	-	13,293
	24,072,752	25,141,507
Less current maturities	1,091,286	1,039,840
Less unamortized debt issuance costs	196,392	220,769
Less unamortized bond discount	51,280	55,524
	$ 22,733,794	$ 23,825,374

(A) Revenue bonds (the 2011 Refunding Bonds) consist of Hospital Revenue Refunding Bonds in the original amount of $9,965,000 dated December 1, 2011, which bear interest at 2.00% to 4.25%. The 2011 Refunding Bonds are payable in annual installments through May 1, 2025. Unamortized debt issuance costs were $55,759 and $69,142 at March 31, 2021 and 2020, respectively. The effective interest rate was 3.45% and 3.24% for the years ended March 31, 2021 and 2020, respectively. The Medical Center is required to make monthly deposits to the debt service fund of approximately $78,000.

Boone County, Arkansas (the County), issued the 2011 Refunding Bonds on behalf of the Medical Center. The 2011 Refunding Bonds are secured by the revenues of the Medical Center and the assets restricted under the bond indenture agreement. The 2011 Refunding Bonds have not been guaranteed by the County.

The indenture agreement requires that certain funds be established with the trustee. Accordingly, these funds are included in assets limited as to use held by trustee in the consolidated financial statements. The indenture agreement also requires the Medical Center to comply with certain restrictive covenants, including minimum insurance coverage, maintaining a historical debt-service coverage ratio of at least 1.20-to-1.0 and restrictions on incurrence of additional debt.

(B) The construction bonds (Construction Bonds) consist of tax-exempt Boone County, Arkansas, Variable Rate Hospital Revenue Bonds in the original amount of $25,000,000 dated March 16, 2006, which bear interest at a seven-day variable rate as determined by a remarketing agent. The interest rate at March 31, 2021 and 2020, was 3.00% and 4.50%, respectively. The interest rate determination method may be converted from time to time to a flexible rate for a period of not less than one day and no more than 270 days as determined by the remarketing agent, resulting in the lowest overall interest expense on the Construction Bonds. The Construction Bonds are also subject to a one-time conversion option to a fixed rate. The Construction Bonds are payable in annual installments through May 1, 2037. Unamortized debt issuance costs were $30,854 and $32,763 at March 31, 2021 and 2020, respectively. The effective interest rate was 5.14% and 4.87% for the years ended March 31, 2021 and 2020, respectively. The Medical Center is required to maintain certain funds with the trustee and make monthly deposits into a debt service fund. The amount required to be paid monthly varies with the interest rate and is approximately $12,000.

The indenture agreement also requires the Medical Center to comply with certain restrictive covenants, including minimum insurance coverage, limitations on additional debt and limitations on capital expenditures.

The County issued the Construction Bonds on behalf of the Medical Center. The Construction Bonds are secured by the revenues of the Medical Center, and the assets restricted under the bond indenture agreement. The Construction Bonds have not been guaranteed by the County.

The Construction Bonds can be redeemed at the discretion of the Medical Center, in whole or in part at any time at a redemption price equal to the principal thereof, plus any accrued interest.

The holder of any weekly rate bond may elect to tender such Construction Bonds for purchase at a purchase price equal to the principal amount thereof plus accrued and unpaid interest thereon to but not including the purchase date on any business day subject to certain timing limitations.

In order to secure its obligations under the indenture agreement, the Medical Center has obtained an Irrevocable Direct Pay Letter of Credit (Letter), which expires April 16, 2022.

The Letter consists of a principal amount of $4,731,548, which may be drawn upon with respect to payment of any unremarketed principal amount of the purchase price of the bonds. Draws on the Letter must be repaid within the earlier of the expiration of the Letter or 366 days. As of March 31, 2021 and 2020, no amounts were drawn on the Letter.

In order to obtain the Letter, the Medical Center entered into a Reimbursement Agreement (the Agreement) that requires the Medical Center to comply with certain restrictive covenants including maintaining a minimum quarterly debt service coverage ratio of at least 1.25-to-1.00 and maintaining liquid assets at all times in an amount sufficient to pay the daily operating expenses less noncash expenses of the Medical Center (days cash on hand) for a period of 100 days. Failure to meet these quarterly requirements could result in debt acceleration.

Amounts originally maturing in 2013 through 2024 and $579,600 of the 2025 maturity were refunded on December 1, 2011, with proceeds from the 2011 Refunding Bonds (see *(A)* above). Amounts originally maturing in 2025 through 2033, and $965,000 of the 2034 maturity was refunded on March 1, 2013, with proceeds from the 2013 Refunding Bonds (see *(C)* below).

(C) Revenue bonds (the 2013 Refunding Bonds) consist of Hospital Revenue Refunding Bonds in the original amount of $9,940,000 dated March 1, 2013, which bear interest at 3.00% to 4.50%. The 2013 Refunding Bonds are payable in annual installments beginning May 1, 2020 through May 1, 2033. Unamortized debt issuance costs were $109,779 and $118,864 at March 31, 2021 and 2020, respectively. The effective interest rate was 4.51% and 4.46% for the years ended March 31, 2021 and 2020, respectively. The Medical Center is required to make monthly deposits to the debt service fund of approximately $44,000.

The County issued the 2013 Refunding Bonds on behalf of the Medical Center. The 2013 Refunding Bonds are secured by the revenues of the Medical Center and the assets restricted under the bond indenture agreement. The 2013 Refunding Bonds have not been guaranteed by the County.

Certain indenture requirements of the 2013 Refunding Bonds are shared with the 2011 Refunding Bonds. See discussion of these requirements in *(A)*.

The Construction Bonds and the 2011 and 2013 Refunding Bonds were issued on a parity basis.

(D) Due September 15, 2039, principal payable monthly by Medical Services in amounts escalating from $8,031 to $19,549 with a balloon payment of $1,376,757 at maturity; bears variable interest of LIBOR plus 2.83%, which was 2.94% at March 31, 2021, and is updated monthly. Issued in conjunction with the interest rate swap described below and secured by the property purchased with the proceeds and rental revenue it produces.

(E) Due on demand, but if no demand, due September 10, 2028, payable $12,830 monthly including interest at 5.65%; secured by certain property. The bank has waived the due-on-demand provision of this note through April 1, 2022.

(F) Due on demand, but if no demand, due September 25, 2028, payable $1,612 monthly, including interest at 5.65%; secured by certain property. The bank has waived the due-on-demand provision of this note through April 1, 2022.

(G) Finance lease obligations, which bore interest at imputed rates of 5.00% to 5.75%, due through March 18, 2021, payable $1,120 monthly including interest, secured by certain equipment. Obligations were satisfied in full during 2021.

Property and equipment include the following property under finance leases at March 31, 2020:

Equipment	$ 457,212
Less accumulated depreciation	291,882
	$ 165,330

Aggregate annual maturities and sinking fund requirements of long-term debt, excluding finance leases, see *Note 15*, at March 31, 2021, are:

2022	$ 1,091,286
2023	1,128,034
2024	1,170,063
2025	1,218,263
2026	1,267,170
Thereafter	18,197,936
	24,072,752
Less unamortized bond issuance costs	196,392
Less unamortized bond discount	51,280
	$ 23,825,080

The System has a $1,000,000 revolving bank line of credit with a bank whose officers and directors include one System board member. The line provided for interest at 25 basis points above prime as published in the *Wall Street Journal*. The rate does not update more frequently than monthly. The System increased its revolving bank line of credit with the bank on March 18, 2020, to $2,000,000 at which point the spread also increased to 27 basis points. At March 31, 2021, the rate was 3.52%. The line expires August 27, 2021. As of March 31, 2021 and 2020, no amounts were outstanding against this unsecured line of credit.

Variable-to-Fixed Interest Rate Swap

On September 5, 2019, Medical Services entered into an interest rate swap agreement with a financial institution. The swap agreement has an effective date of September 6, 2019, with an initial notional amount of $4,500,000. Medical Services pays the swap counterparty a fixed interest rate of 4.57% and, in return the counterparty pays Medical Services a variable rate of interest based on one-month USD LIBOR plus 2.83%. The notional amount amortizes over 20 years and interest is settled monthly, with the monthly settlements included in interest expense. The swap was established to create a synthetically fixed interest rate on a variable rate term loan.

Medical Services is exposed to risk should the counterparty fail to perform under the swap contract as a result of either default or early termination of the agreement; however, Medical Services does not anticipate a failure by the counterparty. The agreement is recorded at its market value with subsequent changes in market value included in interest expense. The market value of the swap at March 31, 2021 and 2020, was a net receivable of $33,608 and a payable of $602,666, respectively, and is recorded on the consolidated balance sheets within other assets for the year ended March 31, 2021, and other liabilities for the year ended March 31, 2020. Amounts included in the consolidated statements of operations for the years ended March 31 related to the swap agreement were:

	2021	2020
Interest expense on note payable and swap payments	$ 186,940	$ 103,320
Change in fair value of interest rate swap agreement	(636,274)	602,666
Interest expense, net of interest rate swap activity	$ (449,334)	$ 705,986

Note 6: Professional Liability Claims

The System purchases medical malpractice insurance under a claims-made policy on a fixed premium basis. Under such a policy, only claims made and reported to the insurer during the policy term, regardless of when the incidents giving rise to the claims occurred, are covered. The System also purchases excess umbrella liability coverage, which provides additional coverage above the basic policy limits up to the amount specified in the umbrella policy.

Based upon the System's claims experience, an accrual is made for the System's estimated medical malpractice costs, including costs associated with litigating or settling claims. No such amounts were accrued as of March 31, 2021 and 2020. It is reasonably possible that this estimate could change materially in the near term.

Note 7: Operating Leases

The System leases equipment and facilities under operating leases that expire in various years. Total rent and lease expense was approximately $667,000 for the year ended March 31, 2020.

Note 8: Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs) and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, the System bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility and patient accounts receivable are due in full when billed. Revenue is recognized as performance obligations are satisfied.

Performance Obligations

Performance obligations are determined based on the nature of the services provided by the System. Revenue for performance obligations satisfied over time is recognized based on charges accumulated over the period of service. The System believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the System receiving inpatient acute care services or patients receiving certain services in its outpatient centers or in their homes (home care). The System measures the performance obligation from inpatient admission, or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services.

Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to its patients and customers in a retail setting (for example, pharmaceuticals and medical equipment) and the System does not believe it is required to provide additional goods related to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the System has elected to apply the optional exemption provided in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Transaction Price

The System determines the transaction price based on standard charges for goods and services provided, reduced by explicit price concessions which consist of contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the System's policy and implicit price concessions provided to uninsured patients. The System determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. The System determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Third-Party Payors

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare. Inpatient acute care services and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. The System is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicare administrative contractor.

Medicaid. Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology, subject to certain cost limitations. Outpatient services rendered to Medicaid beneficiaries are paid based on fee schedules. The System is reimbursed at tentative rates with final settlements determined after submissions of annual cost reports by the System and audits thereof by the Medicaid administrative contractor.

Based on its status as a private hospital, the System participates in the Arkansas Medicaid provider assessment program. This program assesses a fee, accounted for as an operating expense, of no more than 5.5% on the patient service revenue of private hospitals and allocates the proceeds to supplement Medicaid payments.

The federal government matches the assessment amount at a rate of approximately 3-to-1, and these amounts are allocated to private hospitals in Arkansas based on each hospital's share of total Medicaid discharges and outpatient payments. Operating expenses under this program for the years ended March 31, 2021 and 2020, were approximately $1,190,000 and $1,070,000, respectively. The payments received under the provider assessment program are considered variable consideration and are included in the determination of the transaction price. Such amounts were approximately $6,760,000 and $5,560,000 for the years ended March 31, 2021 and 2020, respectively.

Other. Payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the System. In addition, the contracts the System has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to cost report or other audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the System's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known based on newly available information or as years are settled or are no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price resulting from additional information relating to past Medicare and Medicaid settlements for the year ended March 31, 2021, were not significant. Adjustments arising from a change in the transaction price resulting from additional information relating to past Medicare and Medicaid settlements for the year ended March 31, 2020, were approximately $860,000.

Patient and Uninsured Payors

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The System also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The System estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions.

The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts and implicit price concessions based on historical collection experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the year ended March 31, 2020, changes in estimates of implicit price concessions, discounts and contractual adjustments for performance obligations satisfied in prior years reduced revenue by approximately $685,000. These amounts for the year ended March 31, 2021, were not significant.

Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. Therefore, the System has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances, such as co-pays and deductibles. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with those patients.

Patients who meet the System's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue.

Refund Liabilities

From time to time, the System will receive overpayments of patient balances from third-party payors or patients resulting in amounts owed back to either the patients or third-party payors. These amounts are excluded from revenues and are recorded as liabilities until they are refunded. As of March 31, 2021, the System has a liability for refunds to third-party payors and patients recorded of approximately $437,000 and is included in accrued expenses. These amounts were not significant for year ended March 31, 2020.

Revenue Composition

The System has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the following factors: payors and service lines. Tables providing details of these factors are presented below.

The composition of patient service revenue by primary payor for the years ended March 31 is as follows:

	2021	2020
Medicare	$ 42,244,727	$ 42,972,054
Medicaid	10,076,871	9,500,564
Commercial insurers	29,253,103	35,750,333
Uninsured	1,138,368	1,683,633
Total	$ 82,713,069	$ 89,906,584

Revenue from patients' deductibles and coinsurance is included in the categories presented above based on the primary payor.

The composition of patient service revenue based on service lines for the years ended March 31 is as follows:

	2021	2020
Acute care	$ 69,519,186	$ 77,829,758
Physician services	10,111,492	9,278,544
Post-acute care	3,082,391	2,798,282
	$ 82,713,069	$ 89,906,584

Revenue is recognized as health care services are provided over time. Revenue recognized at a point in time, such as retail pharmacy, is not material.

Contract Balances

The following table provides information about the Hospital's receivables from contracts with customers:

	2021	2020
Accounts receivable, beginning of year	$ 11,536,264	$ 11,470,142
Accounts receivable, end of year	10,906,281	11,536,264
Contract liabilities, beginning of period	-	-
Contract liabilities, end of period	10,522,243	-

Financing Component

The System has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the System's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the System does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Note 9: Functional Expenses

The System provides health care services primarily to residents within its geographic area. Certain costs attributable to more than one function have been allocated among the health care services and general and administrative functional expense classifications based on various methods. The following schedules present the natural classification of expenses by function as follows for the years ended March 31:

	2021		
	Health Care Services	General and Administrative	Total
Salaries and wages	$ 28,800,083	$ 11,692,073	$ 40,492,156
Employee benefits	6,655,902	820,826	7,476,728
Professional fees	5,265,035	430	5,265,465
Supplies and other	22,684,506	7,945,887	30,630,393
Contract labor	4,121,517	222,157	4,343,674
Provider assessment tax	1,192,938	-	1,192,938
Depreciation	1,083,029	1,979,243	3,062,272
Interest	172,557	315,348	487,905
	$ 69,975,567	$ 22,975,964	$ 92,951,531

	2020		
	Health Care Services	General and Administrative	Total
Salaries and wages	$ 30,779,235	$ 10,095,044	$ 40,874,279
Employee benefits	7,490,862	2,104,003	9,594,865
Professional fees	5,951,551	12,370	5,963,921
Supplies and other	22,995,412	7,377,316	30,372,728
Contract labor	1,753,044	77,892	1,830,936
Provider assessment tax	1,070,705	-	1,070,705
Depreciation	1,049,409	2,023,714	3,073,123
Interest	558,841	1,077,688	1,636,529
	$ 71,649,059	$ 22,768,027	$ 94,417,086

Note 10: Charity Care

In support of its mission, the System voluntarily provides free care to patients who lack financial resources and are deemed to be medically indigent. Because the System does not pursue collection of amounts determined to qualify as charity care, they are not reported in patient service revenue. In addition, the System provides services to other medically indigent patients under certain government-reimbursed public aid programs.

Management estimates that the cost relating to these services was approximately $594,000 and $350,000 for the years ended March 31, 2021 and 2020, respectively, using a Medicare-based reasonable cost methodology.

In addition to uncompensated care charges, the System also commits significant time and resources to endeavors and critical services that meet otherwise unfilled community needs. Many of these activities are sponsored with the knowledge that they will not be self-supporting or financially viable. Such programs include health screening and assessments, prenatal education and care, hospice programs, community educational services and various support groups.

Note 11: Pension Plan

The System has a defined-contribution pension plan covering substantially all employees. The System annually determines the amount, if any, of the System's contribution to the plan. Pension expense was approximately $1,057,000 and $484,000 for the years ended March 31, 2021 and 2020, respectively.

Note 12: Liquidity and Availability

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of March 31, 2021 and 2020, comprise the following:

	2021	2020
Financial assets at year-end		
Cash and cash equivalents	$ 19,883,224	$ 1,624,331
Patient accounts receivable	10,906,281	11,536,264
Estimated amounts due from third-party payors	1,192,486	971,107
Other current receivables	28,662	130,834
Assets limited as to use	44,924,359	34,932,167
Pledges receivable	66,080	48,780
Total financial assets	77,001,092	49,243,483
Less amounts not available to be used within one year		
Board designated with liquidity horizons greater than one year	41,410,309	31,393,049
Donor restricted	25,262	28,834
Funds held by trustee	3,488,788	3,510,284
Financial assets not available to be used within one year	44,924,359	34,932,167
Financial assets available to meet general expenditures within one year	$ 32,076,733	$ 14,311,316

The System has other assets limited to use for debt service. In addition, certain other board-designated assets are designated for future capital expenditures. These assets limited to use, which are more fully described in *Notes 1* and *2*, are not available for general expenditure within the next year. However, the board-designated amounts could be made available, if necessary.

As part of the System's liquidity management, it has a policy to structure its financial assets to be available as its general expenditures, liabilities and other obligations come due. In addition, the System invests cash in excess of daily requirements in short-term investments. To help manage unanticipated liquidity needs, the System has a committed line of credit, more fully described in *Note 5*, of $2,000,000, which it could draw upon.

Note 13: Disclosures About Fair Value of Assets and Liabilities

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. The hierarchy comprises three levels of inputs that may be used to measure fair value:

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities

Level 3 Unobservable inputs supported by little or no market activity and that are significant to the fair value of the assets or liabilities

Recurring Measurements

The following tables present the fair value measurements of assets and liabilities recognized in the accompanying consolidated balance sheets measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at March 31, 2021 and 2020:

		2021 Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
March 31, 2021				
Equity mutual funds	$ 9,150,769	$ 9,150,769	$ -	$ -
Money market mutual funds (included in cash equivalents)	6,392,439	6,392,439	-	-
U.S. Treasury obligations	5,858,729	5,858,729	-	-
Corporate obligations	8,895,897	8,895,897	-	-
Corporate equities	9,649,353	9,649,353	-	-
Mortgage-backed securities	1,099,478	-	1,099,478	-
Exchange-traded funds	2,099,418	2,099,418	-	-
Interest rate swap agreement	33,608	-	33,608	-
Total	$ 43,179,691	$ 42,046,605	$ 1,133,086	$ 0

		2020 Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
March 31, 2020				
Equity mutual funds	$ 2,372,177	$ 2,372,177	$ -	$ -
Money market mutual funds (included in cash equivalents)	2,998,551	2,998,551	-	-
U.S. Treasury obligations	5,076,676	5,076,676	-	-
Corporate obligations	7,543,445	7,543,445	-	-
Corporate equities	6,037,169	6,037,169	-	-
Mortgage-backed securities	2,326,700	-	2,326,700	-
Exchange-traded funds	4,270,368	4,270,368	-	-
Interest rate swap agreement	(602,666)	-	(602,666)	-
Total	$ 30,022,420	$ 28,298,386	$ 1,724,034	$ 0

The following is a reconciliation of investments carried at fair value and the System's total investments:

	2021	2020
Financial instruments carried at fair value	$ 43,179,691	$ 30,022,420
Financial instruments carried at fair value but not included in investments:		
Interest rate swap agreement	(33,608)	602,666
Financial instruments not carried at fair value:		
Certificates of deposit	931,737	1,035,003
Cash and cash equivalents	745,915	3,178,766
Interest receivable	100,624	93,312
Total System investments	$ 44,924,359	$ 34,932,167

Following is a description of the valuation methodologies and inputs used for assets measured at fair value on a recurring basis and recognized in the accompanying consolidated balance sheets, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the year ended March 31, 2021.

Investments

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Level 1 securities include money market funds, equity mutual funds, corporate equities, corporate obligations, exchange-traded funds and United States Treasury obligations. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market-based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections and cash flows. Such securities are classified in Level 2 of the valuation hierarchy. Level 2 securities include mortgage-backed securities. The System did not hold any Level 3 investments as of March 31, 2021 or 2020.

Interest Rate Swap Agreement

The fair value is estimated using the forward-looking interest rate curves and discounted cash flows that are observable or can be corroborated by observable market data and, therefore, are classified within Level 2 of the valuation hierarchy.

The System had no assets or liabilities measured at fair value on a nonrecurring basis at March 31, 2021 or 2020.

Note 14: Significant Estimates and Concentrations

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following:

Variable Consideration

Estimates of variable consideration in determining the transaction price for patient service revenue are described in *Notes 1* and *8*.

Professional Liability Claims

Estimates related to the accrual for professional liability claims are described in *Notes 1* and *6*.

Litigation

In the normal course of business, the System is, from time to time, subject to allegations that may or do result in litigation. Some of these allegations are in areas not covered by the System's self-insurance program (discussed elsewhere in these notes) or by commercial insurance—for example, allegations regarding employment practices or performance of contracts. The System evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of counsel, management records an estimate of the amount of ultimate expected loss, if any, for each of these matters. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Investments

The System invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, deposit and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investments securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying consolidated balance sheets.

Note 15: Leases

Change in Accounting Principle

In February 2016, FASB issued ASU 2016-02, *Leases (Topic 842)*. This ASU requires lessees to recognize a lease liability and a right-of-use (ROU) asset on a discounted basis, for substantially all leases, as well as additional disclosures regarding leasing arrangements. Disclosures are required to enable users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases. In July 2018, FASB issued ASU 2018-11, *Leases (Topic 842)*: Targeted Improvements, which provides an optional transition method of applying the new lease standard. Topic 842 can be applied using either a modified retrospective approach at the beginning of the earliest period presented or, as permitted by ASU 2018-11, at the beginning of the period in which it is adopted, *i.e.*, the comparatives under ASC 840 option.

The System adopted Topic 842 on April 1, 2020 (the effective date), using the comparatives under ASC 840 transition method, which applies Topic 842 at the beginning of the period in which it is adopted. Prior period amounts have not been adjusted in connection with the adoption of this standard. The System elected the package of practical expedients under the new standard, which permits entities to not reassess lease classification, lease identification or initial direct costs for existing or expired leases prior to the effective date. Also, the System elected to keep short-term leases with an initial term of 12 months or less off the balance sheet. The System elected the practical expedient to account for non-lease components and the lease components to which they relate as a single lease component for all. The System did not elect the hindsight practical expedient in determining the lease term for existing leases as of April 1, 2020.

The most significant impact of adoption was the recognition of operating lease ROU assets and operating lease liabilities of $1,316,238, while the accounting for existing capital leases (now referred to as finance leases) remained substantially unchanged. The standard did not significantly affect the consolidated statements of operations, change in net assets or cash flows.

Accounting Policies

The System determines if an arrangement is a lease or contains a lease at inception. Leases result in the recognition of ROU assets and lease liabilities on the consolidated balance sheets. ROU assets represent the right to use an underlying asset for the lease term, and lease liabilities represent the obligation to make lease payments arising from the lease, measured on a discounted basis. The System determines lease classification as operating or finance at the lease commencement date. Finance leases are included in property and equipment, current maturities of long-term debt and long-term debt in the consolidated balance sheets.

At lease inception, the lease liability is measured at the present value of the lease payments over the lease term. The ROU asset equals the lease liability adjusted for any initial direct costs, prepaid or deferred rent, and lease incentives. The System uses the implicit rate when readily determinable. As most of the leases do not provide an implicit rate, the System uses its incremental borrowing rate based on information available at the lease commencement date to determine the present value of lease payments. Incremental borrowing rates used to determine the present value of lease payments were derived by reference to recent borrowings corresponding to the lease commencement date.

The lease term is the noncancelable period per the contract. Additionally, the lease term may include options to extend or to terminate the lease that the System is reasonably certain to exercise. Lease expense is generally recognized on a straight-line basis over the lease term.

The System has elected not to record leases with an initial term of 12 months or less on the consolidated balance sheets. The System has also not elected to account for the lease and nonlease components separately. Lease expense on such leases is recognized on a straight-line basis over the lease term.

Nature of Leases

The System has entered into the following lease arrangements:

Operating Leases

The System leases building space for clinics that expire in various years through 2024. Termination of the leases is generally prohibited unless there is a violation under the lease agreement.

The System leases equipment for various hospital departments that expire in various years through 2024. These leases generally contain renewal options for periods ranging from 3 to 5 years. Lease payments are stated in lease agreements and are set for the entire lease term. Termination of the leases generally are prohibited unless there is a violation under the lease agreement.

Short-Term Leases

The System leases certain equipment and space for terms shorter than 12 months. Total short-term lease expense included in operating expenses for the year ended March 31, 2021, was $25,791. As of March 31, 2021, there were no future commitments related to these short-term leases.

All Leases

The System has no material related party leases. The System has elected to not record inter-company leases that would be eliminated in consolidation. The System's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

Quantitative Disclosures

The lease cost and other required information for the year ended March 31, 2021, are as follows:

Lease cost		
Operating lease cost	$	642,870
Short-term lease cost		25,791
Total lease cost	$	668,661
Other information		
Cash paid for amounts included in the measurement of lease liabilities		
Operating cash flows from operating leases	$	642,870
Operating leases		
Weighted-average remaining lease term		1.81 years
Weighted-average discount rate		4.28%

Future minimum operating lease payments and reconciliation to the consolidated balance sheet at March 31, 2021, are as follows:

2022	$	476,429
2023		184,528
2024		87,173
Total future undiscounted lease payments		748,130
Less interest		29,838
Lease liabilities	$	718,292

Note 16: Financial Impacts from COVID-19 and CARES Act Funding

On March 11, 2020, the World Health Organization designated the SARS-CoV-2 virus and the incidence of COVID-19 (COVID-19) as a global pandemic. Patient volumes and the related revenues were significantly affected by COVID-19, as various policies were implemented by federal, state, and local governments in response to the pandemic that led many people to remain at home and forced the closure of or limitations on certain businesses, as well as suspended elective procedures by health care facilities.

While some of these policies have been eased and states have lifted moratoriums on non-emergent procedures, some restrictions remain in place, and some state and local governments re-imposed certain restrictions due to increasing rates of COVID-19 cases.

Starting in mid-March 2020, the System deferred all nonessential medical and surgical procedures and suspended elective procedures, which resumed at different dates during the fiscal year.

The System's pandemic response plan has multiple facets and continues to evolve as the pandemic unfolds. The System has taken precautionary steps to enhance its operational and financial flexibility and react to the risks the COVID-19 pandemic presents to its business, including the following:

- Implementation of targeted cost reduction initiatives.
- Reduction of certain planned projects and capital expenditures.
- Furlough of employees.
- During the year ended March 31, 2021, the System received approximately $10,522,000 of accelerated Medicare payments.
- During the year ended March 31, 2021, the System received approximately $13,766,000 in general and targeted Provider Relief Fund distributions and $2,813,000 in Coronavirus Relief Fund distributions, each as provided for under the *Coronavirus Aid, Relief, and Economic Security (CARES) Act.*
- During the year ended March 31, 2021, the System was approved to receive approximately $500,000 in Community Development Block Grants for assistance with the System's COVID-19 response.

The extent of the COVID-19 pandemic's adverse effect on the System's operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond the System's control and ability to forecast. Such factors include, but are not limited to, the scope and duration of stay-at-home practices and business closures and restrictions, government-imposed or recommended suspensions of elective procedures, continued declines in patient volumes for an indeterminable length of time, increases in the number of uninsured and underinsured patients as a result of higher sustained rates of unemployment, incremental expenses required for supplies and personal protective equipment, and changes in professional and general liability exposure.

Because of these and other uncertainties, the System cannot estimate the length or severity of the effect of the pandemic on the System's business. Decreases in cash flows and results of operations may have an effect on debt covenant compliance and on the inputs and assumptions used in significant accounting estimates, including estimated implicit price concessions related to uninsured patient accounts, and potential impairments long-lived assets.

CARES Act Relief Funds

During the year ended March 31, 2021, the System received approximately $13,765,913 from the $50 billion general distribution fund and targeted distributions from the CARES Act Provider Relief Fund (collectively, the "Provider Relief Fund"). In addition, the System received $2,813,000 from the $150 billion Coronavirus Relief Fund established through the CARES Act. These distributions from the Provider Relief Fund and the Coronavirus Relief Fund are not subject to repayment, provided the System is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19.

The System has elected to account for such payments as conditional contributions in accordance with ASC Topic 958-605 – *Revenue Recognition*. Payments are recognized as contribution revenue once the applicable terms and conditions required to retain the funds have been substantially met. Based on an analysis of the compliance and reporting requirements of the Provider Relief Fund, the Coronavirus Relief Fund, and the impact of the pandemic on the System's revenues and expenses through March 31, 2021, the System recognized $13,844,000 in other operating revenue in the accompanying consolidated statement of operations. The unrecognized amount of distributions from the Provider Relief Funds is recorded as accrued liabilities in the accompanying consolidated balance sheets.

The System will continue to monitor compliance with the terms and conditions of the Provider Relief Fund, the Coronavirus Relief Fund, and the impact of the pandemic on the System's revenues and expenses. The terms and conditions governing the Provider Relief Funds and the Coronavirus Relief Funds are complex and subject to interpretation and change. If the System is unable to attest to or comply with current or future terms and conditions, the System's ability to retain some or all of the distributions received may be impacted.

Medicare Accelerated and Advanced Payment Program

During the year ended, March 31, 2021, the System requested accelerated Medicare payments as provided for in the CARES Act, which allows for eligible healthcare facilities to request up to six months of advance Medicare payments for acute care hospitals or up to three months of advance Medicare payments for other healthcare providers. Claims for services provided to Medicare beneficiaries will be applied against the advance payment balance beginning April 2021, at varying rates, with full amount recouped by October 2022.

During the year ended Mach 31, 2021,the System received approximately $10,522,000 from these accelerated Medicare payment requests. The unapplied amount of accelerated Medicare payment requests is recorded in the accompanying consolidated balance sheets as current and long-term contract liabilities based on estimated repayment utilizing a weighted-average method.

Payroll Tax Deferral

The CARES Act provides for a deferral of payments of the employer portion of payroll tax incurred during the pandemic. The amount deferred as of March 31, 2021, was approximately $1,470,000 and is recorded as current and long-term accrued liabilities in the accompanying consolidate balance sheets. Deferred payroll taxes will be due in two equal installments on December 31, 2021, and December 31, 2022.

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APPENDIX D

Form of Bond Counsel Opinion

Upon delivery of the Series 2021 Bonds in definitive form, Kutak Rock LLP proposes to deliver its approving opinion in substantially the following form:

December __, 2021

Boone County, Arkansas
Harrison, Arkansas

Regions Bank, as Trustee
Little Rock, Arkansas

Stephens Inc.
Little Rock, Arkansas

$9,710,000
Boone County, Arkansas
Hospital Revenue Refunding Bonds
(North Arkansas Regional Medical Center Project)
Series 2021

Ladies and Gentlemen:

We have acted as Bond Counsel in connection with the issuance by Boone County, Arkansas (the "Issuer") of $9,710,000 Boone County, Arkansas Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2021 (the "Series 2021 Bonds"), pursuant to Arkansas Code Annotated Sections 14-164-101 et seq., as amended (the "Act"), and Ordinance No. 2021-51 adopted by the Quorum Court of the Issuer on October 12, 2021 (the "Authorizing Ordinance").

The Series 2021 Bonds are issued under and secured and entitled to the protection given by a Trust Indenture dated as of May 1, 1999, as amended and supplemented by a Supplemental Trust Indenture dated as of March 1, 2006, by a Second Supplemental Trust Indenture dated as of November 1, 2010, by a Third Supplemental Trust Indenture dated as of December 1, 2011, by a Fourth Supplemental Trust Indenture dated as of March 1, 2013, and by a Fifth Supplemental Trust Indenture dated as of December 1, 2021 (as amended and supplemented, the "Trust Indenture"), by and between the Issuer and Regions Bank, Little Rock, Arkansas, as trustee and paying agent (the "Trustee"). The proceeds of the Series 2021 Bonds will be loaned by the Issuer to the Corporation pursuant to the terms of a Loan Agreement dated as of May 1, 1999, as amended and supplemented by a Supplemental Loan Agreement dated as of March 1, 2006, by a Second Supplemental Loan Agreement dated as of November 1, 2010, by a Third Supplemental Loan Agreement dated as of December 1, 2011, by a Fourth Supplemental Loan Agreement dated as of March 1, 2013, and by a Fifth Supplemental Loan Agreement dated as of December 1, 2021 (as amended and supplemented, the "Loan Agreement"), by and between the Issuer and North Arkansas Regional Medical Center, an Arkansas nonprofit corporation (the "Corporation"). Pursuant to the Loan Agreement, the Corporation has delivered to the Issuer

(and the Issuer has assigned to the Trustee) the Corporation's promissory note in the amount of $9,710,000 (the "Note"), which provides for payments by the Corporation in amounts sufficient to pay the principal of, premium, if any, and interest on the Series 2021 Bonds as the same shall become due and payable. The Corporation's obligations under the Loan Agreement and the Note are secured solely by Pledged Revenues (as defined in the Loan Agreement) within the control of the Corporation.

In addition to the security provided by the Loan Agreement and the Note, the Corporation has executed and delivered to the Trustee a Bond Guaranty Agreement dated December 1, 2021 (the "Guaranty Agreement"), whereby the Corporation guarantees the payment of the principal of, premium, if any, and interest on the Series 2021 Bonds when due. The Corporation's obligations under the Guaranty Agreement are secured by and payable solely from Pledged Revenues within the control the Corporation.

Reference is hereby made to the Trust Indenture and to all amendments and supplements thereto for the provisions, among others, regarding the rights, duties and obligations of the Issuer, the Trustee and the holders of the Series 2021 Bonds, and the terms upon which the Series 2021 Bonds are issued and secured.

We have examined the law and such certified proceedings and other papers as we have deemed necessary to render this opinion. As to questions of fact material to our opinion, we have relied upon the representations of the Issuer and the Corporation contained in the Authorizing Ordinance, the Trust Indenture, the Loan Agreement and the Guaranty Agreement, and in the certified proceedings and certifications furnished to us by or on behalf of the Issuer and the Corporation (including certifications as to the use of Series 2021 Bond proceeds which are material to the opinions expressed below), without undertaking to verify the same by independent investigation.

Based upon the foregoing, we are of the opinion, under existing law, as follows:

1. The Issuer is duly created and validly existing as a political subdivision of the State of Arkansas with full legal right, power and authority to adopt the Authorizing Ordinance, to issue the Series 2021 Bonds, and to enter into and perform the agreements on its part contained in the Trust Indenture and the Loan Agreement.

2. The Trust Indenture and the Loan Agreement has been duly authorized, executed and delivered by the Issuer pursuant to the Act and are the valid and binding obligations of the Issuer enforceable upon the Issuer in accordance with their respective terms. Under the Trust Indenture, the Series 2021 Bonds are secured by a valid lien on and security interest in the Trust Estate (as defined therein) on a parity with that securing the Issuer's outstanding (i) Variable Rate Hospital Revenue Construction Bonds (North Arkansas Regional Medical Center Project), Series 2006 (the "Series 2006 Bonds"), (ii) Hospital Revenue Refunding Bonds (North Arkansas Regional Medical Center Project), Series 2011 (the "Series 2011 Bonds"), and (iii) other bonds hereafter issued, if any, under the provisions of the Trust Indenture.

3. The Series 2021 Bonds have been duly authorized, executed and delivered by the Issuer and are the valid and binding special obligations of the Issuer, payable solely from the

sources provided therefore in the Trust Indenture. Neither the Issuer, the State of Arkansas, nor any other political subdivision or agency of the State of Arkansas shall be obligated to pay the Series 2021 Bonds or the interest thereon, and neither the faith and credit nor the taxing power of the State of Arkansas, the Issuer or any political subdivision or agency thereof is pledged to the payment of the principal of or interest on the Series 2021 Bonds.

4. Under the laws, regulations, rulings and judicial decisions existing on the date hereof, interest on the Series 2021 Bonds is excludable from gross income for federal income tax purposes and is not a specific preference item for purposes of the federal alternative minimum tax. The opinions set forth in the preceding sentence assume the accuracy of certain representations by the Issuer and the Corporation and compliance by the Issuer and the Corporation with covenants designed to satisfy the requirements of the Internal Revenue Code of 1986, as amended (the "Code"), that must be met subsequent to the issuance of the Series 2021 Bonds. Failure to comply with such requirements could cause such interest on the Series 2021 Bonds to be included in gross income for federal income tax purposes retroactive to the date of issuance of the Series 2021 Bonds. The Issuer and the Corporation have covenanted to comply with such requirements. The Series 2021 Bonds are "qualified tax-exempt obligations" within the meaning of Section 265(b)(3) of the Code, and, in the case of certain financial institutions (within the meaning of Section 265(b)(5) of the Code), a deduction is allowed for eighty percent (80%) of that portion of such financial institution's interest expense allocable to interest on the Series 2021 Bonds. We express no opinion regarding other federal tax consequences arising with respect to the Series 2021 Bonds.

5. The interest on the Series 2021 Bonds is exempt from all state, county and municipal taxes in the State of Arkansas.

6. The Series 2021 Bonds are exempt from registration under the Securities Act of 1933, as amended, and the Trust Indenture is exempt from qualification under the Trust Indenture Act of 1939, as amended.

It is to be understood that the rights of the registered owners of the Series 2021 Bonds and the enforceability of the Series 2021 Bonds, the Authorizing Ordinance and the Trust Indenture and Loan Agreement may be subject to bankruptcy, insolvency, reorganization, moratorium and other similar laws affecting creditors' rights heretofore or hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Very truly yours,

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