

Exhibit J



February 2, 2021

VIA EMAIL: alice.jackson@xcelenergy.com

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Xcel Energy -- Colorado
1099 18th Street, Suite 3000
Denver, Colorado 80202

**CONFIDENTIAL SETTLEMENT
COMMUNICATION – SUBJECT
TO COLO.R.EVID. 408**

Re: Notice of Claim and Demand for Payment re: Comanche Unit 3 Turbine
Failure

Dear Ms. Jackson:

This letter serves as notice by Intermountain Rural Electric Association (IREA) and Holy Cross Energy (HCE) to Public Service Company of Colorado (PSCo) of IREA's and HCE's claims for damages resulting from the prolonged outage of Comanche Unit 3 (Unit 3) beginning January 12, 2020 and ending January 11, 2021. IREA and HCE demand that they made whole for their losses caused by PSCo's breaches of its contractual obligations and held harmless from any repair costs yet to be billed.

Unit 3 tripped offline due to a blade failure in the steam turbine. The outage was extended when serious damage occurred from a lubrication system failure during an attempted start-up in June. As a result of these failures IREA and HCE believe they have incurred expenses for replacement energy and repair costs to date of \$30,580,060 and \$4,589,909, respectively. IREA and HCE also expect to incur significant additional expenses for the investigation and repair of the turbine, although we have not yet been provided complete information regarding those costs.

IREA and HCE have reviewed the limited information PSCo has made available regarding the root causes of the turbine failure and the subsequent lubrication failure. Based on the information available to date, it is clear that each of the failures of the steam turbine was a result of PSCo's failure to operate the facility in accordance with "Prudent Utility Practice" in violation of PSCo's obligations under the Second Amended and Restated Joint Ownership Agreement ("JOA") and the Second Amended and Restated Operations and Maintenance Agreement ("O&M Agreement").

Factual Background

1. The Contractual Arrangements Among the Parties.

IREA and HCE have been wholesale electric customers of PSCo for many years. Under the terms of their Power Purchase Agreements with PSCo, IREA and HCE each were granted the option to participate as an owner of any generation construction project undertaken by PSCo in Colorado which would be used by PSCo to supply wholesale power requirements. In April 2005, IREA entered into a Joint Ownership Agreement with PSCo for the proposed Unit 3 project, a 750-MW supercritical coal-fired generation facility which was to be located near Pueblo, Colorado. IREA's Power Purchase Agreement was subsequently amended to carve out IREA's electricity entitlement from Unit 3 from its purchase obligation, although PSCo remained obligated to provide, and IREA remained obligated to purchase, "Backup Power Service" under Rate Schedule B to the Amended Power Purchase Agreement to back up IREA's entitlement to capacity and associated energy from Unit 3.

The JOA was later amended and restated to include HCE as an owner of Unit 3. PSCo, IREA and HCE currently own 66 2/3%, 25 1/3 % and 8% ownership shares, respectively, in Unit 3.

JOA Section 5.1.1 provides that PSCo is the Operator of Unit 3 under the O&M Agreement. As Operator, PSCo is obligated to operate the facility for the benefit of the owners to ensure that each receives its entitlement to the output from that facility. The O&M Agreement describes PSCo's obligations as "Operator" of Unit 3. O&M Agreement Section 2.1.1 provides that:

From and after the Commercial Operation Date, unless otherwise expressly provided in this Agreement, Operator shall operate and maintain the Facility and the Common Facilities and shall perform its duties under this Agreement (collectively, the "O&M Services") for the benefit of the Owners and in accordance with this Agreement, applicable Laws, all applicable Government Approvals, Prudent Utility Practice and without adverse distinction as between and among the Parties.

"Prudent Utility Practice" is defined in both the JOA and the O&M Agreement as:

... the practices, methods, conduct and actions (including, but not limited to, the practices, methods, conduct and acts engaged in or approved by a significant portion of the power industry) that, at a particular time, in the exercise of reasonable judgment at the time a decision was made, could have been expected to accomplish the desired result in a manner consistent with applicable Law, standards, reliability, safety, environmental protection, good business practices, economy, and expedition. Prudent Utility Practice is not intended to be limited to the optimum practice, method or act to the exclusion of all others, but rather is a spectrum of possible practices, methods or acts which can fall within this description. In applying the standard of Prudent Utility Practice to any matter under this Agreement,

equitable consideration shall be given to the circumstances, requirements and obligations of each of the Parties.

JOA, Article 1, Definitions, at page 10; O&M Agreement, Article 1, Definitions, at page 8.

Although IREA and HCE participate in the Operating Committee, the O&M Agreement makes clear that neither IREA nor HCE has any operational rights or obligations with respect to Unit 3; their sole obligations are to pay a proportionate share of capital and operating expenses and to receive and pay for their Operating Capacity Output of electricity from the facility. The sixth recital on page 1 of the O&M Agreement states that PSCo shall, “as Operator, operate and maintain the Facility,” and O&M Agreement Section 2.1.2 states that “Operator shall have care, custody and operating control of the Facility.” Section 2.1.3 states that PSCo operates Unit 3 as an independent contractor, not as a partner, joint venturer or agent of any other Owner.

PSCo’s general duty to operate and maintain Unit 3 in accordance with Prudent Utility Practice is further defined, without limitation, in O&M Agreement Section 2.2, which specifically calls out duties to:

- Employ and supervise personnel, “exclusively responsible for all operating personnel matters,” including training (Section 2.2.1);
- Operate and maintain Unit 3 consistent with the Operating Manuals (defined as manuals and procedures developed by PSCo in accordance with Prudent Utility Practice to ensure proper operation and maintenance) and Scheduled Maintenance (routine corrective and preventative maintenance) (Section 2.2.3);
- Maintain Unit 3 in good condition in accordance with Prudent Utility Practice (Section 2.2.4);
- Make all necessary repairs and replacements of equipment (Section 2.2.5);
- Procure the equipment, apparatus and machinery necessary to operate the plant (Section 2.2.6);
- Establish operating and performance parameters (Section 2.2.11); and
- Prepare and maintain an information system to manage operating data.

Unit 3 achieved commercial operation in July 2010 and PSCo has operated the plant since then. Unit 3 has not consistently operated at a high level. IREA and HCE have been advised at various times of management changes and internal Xcel Energy operating reviews, but there has been no sustained improvement. The two events in 2020 that give rise to this claim resulted in a full year of lost production. Although we have not yet received full disclosure of much relevant information, sufficient relevant circumstances are known to demonstrate PSCo’s failure to operate the plant as required by the project agreements.

1. PSCo’s Acts and Omissions Resulting in the Turbine Failures.

a. The January 12, 2020 steam turbine failure.

On January 12, 2020 Unit 3 tripped offline due to the failure of a low-pressure turbine (L-1) blade in the steam turbine. In response to this event, PSCo engaged a consultant with

substantial experience evaluating steam turbine failures, Structural Integrity Associates, Inc.,(SI) to conduct a root cause analysis. PSCo's consultant submitted its findings in a report dated April 23, 2020 (the "SI Report"). This report confirmed that the cause of the failure was pit-induced stress corrosion in the turbine blades and concluded that the predominant and most probably root cause of this condition was a lack of any chemistry shut down protection using dehumidified air. (SI Report, p. 3). Other major contributing factors identified in the SI Report include:

- "chemists/operators ignoring alarm and shutdown limits and maintaining operation during contamination events,"
- "not using optimum chemistry treatments (OT)," and
- "unreliable chemistry instrumentation."

The SI Report found that "overall chemistry has been poorly managed since 2010" and that the corrosion in the turbine blades was initiated by a March 2012 condenser contaminant event, after which PSCo failed to clean the interior surfaces of the turbine. The SI Report notes:

The [PSCo] operating practices were seriously deficient during this time: the chemistry alarm system was either not working, turned off or ignored, and most importantly the unit should have been shut down in accordance with any international shutdown guidelines. Deposition occurred preferentially at and near the snubber, leading to pitting in oxygenated moisture during multiple non-protective shutdowns between 2012 and 2019. Other possible contaminant events were investigated in detail and although there has not been similar contamination as the March 2012 condenser leak, there has been repetitive exceedances of sodium contamination in the main steam (MS) and hot reheat (HRH).

SI Report, at 3-4.

Finding that the L-1 blade failure was "cycle chemistry influenced," the SI Report noted that "for the first nine years of Comanche 3 operation the cycle chemistry was not optimum." SI Report at 9. This was due, in large part, to inadequate chemistry manuals and guidelines for operation and shutdown. Further, the SI Report found that PSCo's unit shutdown limits were "not in agreement with the international standards (IAPWS)," SI Report at 10, and that:

[T]he importance of cycle chemistry instrumentation, action and shutdown levels at Comanche have been minimized by operations and chemistry staff from early operation. The operators could not rely on them and have simply ignored alarms and most importantly action levels and unit shutdown situations.

SI Report, at 12. Although PSCo asserted that failure to identify contamination within the system was a result of faulty instrumentation, the SI Report concluded that it "is of paramount importance that these vital instruments work on a continuous basis," and it

appeared that the analyzers were poorly calibrated and maintained by PSCo. SI Report at 21. Specifically, the SI Report states:

[T]he instruments are not calibrated and maintained on a regular basis, are not reliable, and are not audibly alarmed in the control room for the operators. The plant appears to have heavily relied on grab samples taken every four hours. This is not the way to operate the chemistry on a supercritical unit ...

SI Report, at 21.

In addition, the failure to follow proper shutdown procedures, including application of dehumidified air for shutdown periods of longer than three days, resulted in pitting on the turbine blade surfaces, which "are always the initiation centers for stress corrosion cracking (the failure mechanism at Comanche 3)." SI Report, at 16. The SI Report identified 35 separate outages of Unit 3 between 2012 and 2019 with a total of 446 days where the turbine blade surfaces were left unprotected from pitting. Based on this data, the SI Report concluded that "it is not surprising that the PTZ [Phase Transition Zone] blade surfaces [at Unit 3] are pitted." SI Report, at 16-17.

Finally, the SI Report identified at least seven instances of Repeat Cycle Chemistry Situations (RCCS) at Unit 3. Although an individual RCCS is not a major concern, "when multiples (more than 2 or 3) are allowed to continue then failure/damage has either occurred, as with the blade failure at Comanche, or is going to happen in the future." SI Report, at 26. Based on an analysis of more than 220 plant failures, SI concluded that "[i]t is very rare that SI identifies seven RCCS factors at a plant and therefore it is not surprising that the chemistry/operation has been poor and resulted in the L-1 blade failure" at Unit 3.

Following the January 2020 failure, a full train inspection was performed on the Unit 3 turbine. This inspection revealed rubbing on the rotating blade shrouds of stages 2 through 9 of the high pressure turbine with work hardening of the shrouds from heating on stages 7, 8 and 9. A report prepared by [REDACTED] of PSCo's Fleet Engineering group (the "Hunt Report") determined that this damage resulted from water induction into the turbine during two events in January and September 2018. The report suggests that this failure was caused by PSCo's failure to properly maintain actuated turbine drain valves and to address the resulting distortion of the casing and rotor for several years. Hunt Report, at 6. The report found that the HP Turbine shaft and turbine casing were bowed from water induction into the turbine during the two events in 2018. It appears this occurred as a result of PSCo's decision to isolate turbine drain valves that were leaking in service by closing manual isolation valves. Because the valves were closed manually and do not appear to have been reopened, steam used during operation did not properly drain out of the turbine during shutdown. See Hunt Report, at 5. The steam eventually turned to water, which cooled the inside of the turbine casing, likely causing a temperature differential between the inside and the outside of the turbine casing. This temperature differential caused the inside (or bottom) of the turbine casing to temporarily shrink or contract, which led to the damage when the blades rubbed up against the inside of the casing. See Hunt Report, at 6. Subsequent damage may have occurred during a third event in December of 2018, which resulted in high shaft vibration during start-up due to high eccentricity.

b. The June 2, 2020 restart attempt and lubrication system failure.

Following repairs to the turbine, PSCo attempted to restart the unit on June 2, 2020. During start-up, Unit 3 experienced a loss of lubrication oil to the turbine and generator rotor bearings when a Plant Specialist A (PSA) closed a valve and shut off all oil supply to the turbines, resulting in overheating and significant friction damage to the bearings, turbine blades, shaft and generator. We have not been provided any report done by an outside consultant to investigate the root cause of this event, which added seven months to the outage. We have, however, reviewed Xcel Energy's internal "Root Cause Investigation Report" (XES 2.600 A02, Revision 5.1), Xcel's undated "Human Performance Team Analysis" and various other documents provided in response to information requests made by us. Although we have not received full and complete responses to our data requests regarding this incident (such as identifying information regarding the individuals involved) the documents that have been provided clearly establish that the lubrication system failure resulted from PSCo's failure to operate the plant consistent with Prudent Utility Practice, including the failure to maintain proper procedures and to adequately train staff responsible for the operation of the lubrication system.

The Unit 3 Turbine Lubrication Oil (TLO) system includes two oil coolers that moderate the temperature of the oil circulating through the TLO. Normally only one of the coolers is in use at any time and the manufacturer's documentation provided to us states that operation of both coolers simultaneously is not advised. Oil flow into and out of the coolers is controlled by two three-way valves, one directing flow into the coolers, the other directing outflow. They are connected by a shaft so that each valve operates in unison with the other. The valves were operated manually using a wheel that drove a worm gear actuator in a gear box attached to the bottom valve. The valve control mechanism was poorly marked; it had two hand drawn arrows marked "A" and "B," each pointing to the same point on the gear box. Although the manufacturer's documentation in PSCo's records showed a valve with a lever control mechanism, the valve had a wheel control.

Isolation of the turbine oil supply occurred when a PSA operated the valve to shut off oil supply to the turbine. The valve had been positioned to run oil through both coolers. The PSA, acting without instruction or approval and without communicating with control room personnel or following any established procedure (as there was none to follow), rotated the valve 180° from the center position that allowed flow through both coolers to the fully-closed position. Ninety degrees rotation in either direction would have redirected flow to one cooler or the other, but the PSA turned the valve twice as far as he should have. As the turbine was operating at 3600 rpm, isolation of the oil supply immediately burned out the bearings and caused other extensive damage.

The internal root cause report describes some of the actions of PSCo personnel leading up to this event. During start-up turbine lube oil was being run through both lube oil coolers, though standard practice is to use only one cooler at a time. According to the "Root Cause Report", a Control Specialist initiated a trip in response to a lube oil alarm. A Senior Operations Manager, Operations Manager and two PSAs responded by "troubleshooting" the TLO system. An unspecified operation was performed to address oil cooling. One of the PSAs placed oil absorbents and investigated "high TLO differential pressure." A

Control Specialist (“CS”) directed the two PSAs (PSA2 and PSA3) to adjust the turbine system to address cooling issues. A third PSA (PSA1) “heard some radio communications taken by the other individuals” but “had difficulty hearing due to loud noise around the turbine that exacerbated some level of hearing difficulty/loss.” PSA1 later communicated face-to-face with the other two PSAs, but “was not satisfied with the information provided” and went to investigate.

The “Human Performance Team Analysis” notes that PSA1 had worked at Unit 3 for only six months, had been through only two start-ups, and had received no valve operating procedure (as there was none). That report further notes that some operating personnel at the plant believed that changing valve configuration while the turbine was spinning posed a risk, and there was no procedural guidance in place to verify valve line-up upon start-up.

Upon arrival at the TLO skid, PSA1 “felt the pipe that transmitted oil; in his opinion, it felt cooler than it should have.” It does not appear that he relied on any instrumentation or communication with the control room in making this determination, only his sense of touch and his “opinion.” Based on this opinion, and without clear markings or a clear understanding of how the valve worked, he attempted to change the configuration to a single cooler. PSA1 then “waited, listened, and heard what sounded like oil flowing.” Although PSA1 “believed he could not isolate oil flow regardless of the valve configuration,” by rotating the valve 180° PSA1 did, in fact, isolate oil flow to the turbine. There was no oil flow instrumentation at the valve location and the PSA was not in communication with anyone in the control room regarding oil flow, nor was there a procedure in place requiring such communication, so PSA1 listened (in a noisy environment and though he apparently has a hearing impairment) for the sound of oil flow to verify his mistaken belief that he had properly manipulated the valve.

Following the incident, a broken carbon steel pin in the valve gearbox was discovered. The pin would have prevented PSA1 from rotating the valve to the fully-closed position. The information provided to us so far does not reveal a root cause investigation by PSCo regarding the cause of the pin shear. Photos of the pin show what appears to be a classic overload fracture surface, indicating that at some point excessive force was applied to the pin.

The Claims

PSCo failed to operate Unit 3 in accordance with Prudent Utility Practice in breach of its obligations under the JOA and O&M Agreement, resulting in a year-long shutdown. PSCo’s operation of Unit 3 required it to protect the turbine from corrosion and to ensure continued lubrication oil supply to the turbine during operation. Prudent Utility Practice under the project agreements required practices, methods, and actions expected to accomplish those results in a manner consistent with good business practices. There is much information that has not yet been provided, but there is enough in the records produced so far to show PSCo failed to fulfill this obligation.

a. The Blade Failure

Regarding the blade failure, PSCo's own consultant found there were years of substandard water chemistry management. The lengthy SI Report describes inadequate practices and procedures too numerous to address in this letter. The corrosion process was initiated when PSCo failed to open and clean the generator following condenser leak events in March 2012. The fundamentally flawed rationale for not taking that step at the time apparently was that the turbine had recently been opened for the warranty inspection, which obviously was not a decision that could have been expected to protect blades from corrosion. Sound operating practice at the time of the events called for this procedure irrespective of any previous work or inspection. The Seven Repeat Cycle Chemistry Situations noted in the SI Report virtually assured eventual blade failure. PSCo failed to identify and respond to the conditions causing those situations. Moreover, PSCo lacked sufficient guidelines and procedures to ensure proper water chemistry shutdown procedures, and the procedures it did have were out of date and failed to comply with accepted standards in the electric utility industry. There were "multiple [35!] non-protective shutdowns" of three days or more each. PSCo employees responsible for operating Unit 3 were insufficiently trained in the operation of a supercritical coal-fired electric generation facility,¹ failing to properly maintain and calibrate instrumentation, ignoring alarms, and improperly relying on "grab samples" to assess chemistry.

PSCo's own Hunt Report demonstrates additional failures, such as PSCo's failure to maintain drain valves, followed by its decision to manually close those valves, resulting in water intrusion that led to rubbing of the blade shrouds and bowing of the turbine shaft and casing. Turbine failure was inevitable from these actions and the many and ongoing failures to manage water chemistry properly for nearly ten years.

PSCo undertook the operation of a supercritical pulverized coal plant but did not implement the practices and procedures necessary to protect the turbine from corrosion and operational damage. PSCo breached specific obligations set forth in O&M Agreement Section 2.2, including (a) failure to properly supervise and train personnel; (b) failure to perform proper maintenance; (c) failure to develop appropriate manuals and procedures; (d) failure to maintain the facility properly; (e) failure to make necessary repairs and replacements of equipment, including failure to isolate, stop, and clean resulting leaks from the condenser tube leak to avoid possible damage and failure to perform proper maintenance immediately following the water induction events that occurred on January 20, 2018 and September 25, 2018 and the high vibration during start-up on December 7, 2018); (f) failure to procure equipment and machinery necessary for the performance of the O&M Services, particularly with respect to the failure to procure reliable instrumentation

¹ IREA has made numerous requests for information regarding PSCo's operations manuals and guidelines, as well as the experience and training of its employees responsible for the operation of Unit 3. To date, PSCo has failed to provide complete responses to IREA's requests, which prompted IREA to submit a Notice of Dispute regarding PSCo's failure to provide documents in accordance with its obligations under Articles 4 and 10 of the O&M Agreement.

regarding water chemistry and lubrication oil flow; and (g) failure to observe appropriate operating parameters.

b. The Lubrication Oil Failure

PSCo has not fully complied with its contractual obligation to make information available to IREA and HCE; however, the documents produced so far establish the immediate cause of the lubrication oil isolation and the consequent damage to the turbine and other plant components: a PSCo employee acting without benefit of established operating procedures, manipulated a poorly-marked valve the operation of which he obviously did not understand and shut off oil supply to the turbine. His manipulation of the valve was not consistent with Prudent Utility Practice by any measure. His actions were preceded by poor practices and a litany of failures that led to the error:

- The valve line-up after flush work on the coolers during the preceding outage was not documented or reviewed.
- No procedure for valve line-up upon start-up was developed.
- No operating procedures for use in manipulating the valve were developed (it was not even settled within the plant whether manipulation of the valve during turbine operation is appropriate).
- No communications protocols were established that would have required the PSA to obtain CS approval for the action or inform a CS of his actions, and in fact there was no approval for or communication regarding those actions.
- The PSA should have known that rotating the valve 180° from dual-feed would close the valve, indicating he was not properly trained to operate it.
- The method used by PSA1 to verify oil flow – listening for flow in a noisy environment – was not remotely adequate given the critical process involved.
- The valve was not adequately marked or labeled by PSCo.
- The carbon steel pin failure required significant force, but whatever event caused it was not noted or investigated.

PSCo seems to believe it may avoid responsibility for the June lubrication oil failure by characterizing the cause of the incident in its internal root cause report as the result of design defects (an inadequate stop pin and inadequate markings on the valve), although it does not address the cause of the pin failure and ignores its own failure to adequately mark the valve during ten years of plant operation. PSCo's report also seems to take the position that the Unit 3 design was deficient because the valve was a "single point of failure." The valve was sufficient for its purpose, however; the incident was caused by operator error, i.e., the actions of a PSCo employee, that in turn resulted from PSCo's failures to ensure that the critical valve would not be operated in a way that put the plant at risk.

Although the sheared pin might have prevented the lubrication oil isolation, it did not cause the isolation. Nor did the pin shear itself; the pin failure clearly was the result of PSCo's failure to follow Prudent Utility Practice. PSA1 may have applied undue force to the valve and sheared the pin, an event that could not reasonably have happened without his knowledge that there was a problem, which he ignored if he sheared the pin. Or the pin may have been sheared by another event that should and would have been investigated

by a reasonably prudent plant operator. Pins such as the one at issue are known to shear from excessive force resulting from a failure to equalize pressure by venting the coolers. The manufacturer's operating procedures for the valve, which were provided by PSCo, state that pressure must be equalized on both sides of the valve installation and that the valve is not designed to withstand rapid fluctuations in pressure. The narrative accompanying PSCo's internal root cause analysis notes "high differential TLO cooler pressure" was at issue prior to the event. PSCo's root cause report makes no mention of venting the coolers, obscures the nature of the "troubleshooting" and "operation" performed by the team prior to the incident, and avoids addressing the cause of the shear.

The inadequate labeling of the valve was not a design defect, it was PSCo's responsibility to ensure equipment could be operated properly. Hand-drawn, cryptic arrows do not and in fact did not suffice. If PSCo chose to rely upon the poor labeling that existed, it should have provided the procedures and training necessary to ensure operators acted properly.

Nor is the fact that the valve was "a single point of failure" a design defect. The TLO valve installation at Unit 3 is common in the industry and was sufficient for its intended function. The critical nature of the valves is inculpatory, not exculpatory; PSCo should have been aware of the significance of the valve and should have acted accordingly when it established procedures marked at the valve and trained employees.

Finally, PSCo's root cause report notes that PSA1, who erroneously manipulated the valve, communicated with other PSAs but not with the Control Specialist before changing the valve setting. The author of the root cause report appears to attribute this failure to communicate to a PSCo directive that PSAs were not allowed into the control room due to COVID-19 precautions. The report further notes that the PSAs felt "disconnected and isolated because they were not in the control room and communicating with the [Control Specialist] as they typically would during start-up." While it is essential to adopt precautions to prevent the spread of COVID-19, it is likewise essential that a prudent plant operator ensure that adequate communications be maintained between PSAs and the Control Specialist even in a public health emergency such as COVID-19. Clearly no such communication plan was in place to ensure adequate communication among personnel operating the plant.

These failures resulted in the unavailability of Unit 3 for almost exactly one year, from January 12, 2020 until January 11, 2021, depriving IREA and HCE of their percentage shares of the capacity and energy output from the facility to which it is entitled under Section 2.2 of the JOA.

IREA and HCE have each incurred substantial damages as a result of PSCo's breaches of the JOA and O&M Agreement. To the extent those damages can be quantified based on currently available information, they are as follows:

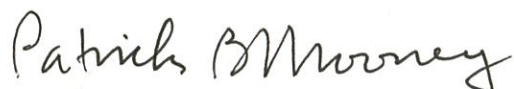
	IREA	Holy Cross
Fuel & Related Savings	(17,518,475)	(5,104,319)
Replacement Power Purchase	38,595,630	6,693,307
Blade failure damage	1,682,777	531,404
Lube oil failure damage	7,820,128	2,469,517
Total	\$30,580,060	\$4,589,909

The damage estimate above does not include the all costs to repair Unit 3 or the diminished capital value of Unit 3 resulting from the shortened lifespan of the facility due to equipment degradation. We have not included in our calculations credit for insurance reimbursement, as we do not yet have details of insurance claims or their disposition. IREA and HCE also may have incurred additional damages from lost production and downtime of Unit 3 prior to January 2020 because of PSCo's deficient operating practices since the facility commenced commercial operation, which is the subject of the Colorado PUC's current investigation. Therefore, total losses incurred by IREA and HCE may be significantly higher.

We doubt that there is much in this letter that is unexpected or new to you or your legal counsel, but we do hereby give notice that we wish to proceed with our claims. If this matter cannot be resolved, we will pursue whatever remedies we have, and in doing so will press for the information we have requested that has not been provided as of that time.

We are prepared to discuss this matter with you and other PSCo or Xcel representatives you wish to include, either with or without the formality of a Coordinating Committee meeting.

Sincerely,



Patrick B. Mooney
Chief Executive Officer
Intermountain Rural Electric Association



Bryan J. Hannegan
President and Chief Executive Officer
Holy Cross Energy

cc: Craig N. Johnson, Esq.