Disclosure Statement

March 1, 2022

Alamance Extended Care, Inc.
d.b.a.
The Village at Brookwood

1860 Brookwood Avenue
Burlington, NC 27215
(336) 570-8400

In accordance with Article 64 of Chapter 58 of the NC General Statutes:

- **this Disclosure Statement may be delivered only through July 28, 2023, if not earlier revised;**
- **delivery of this Disclosure Statement to a contracting party before execution of a contract for the provision of continuing care is required;**
- **this Disclosure Statement has not been reviewed or approved by any government agency or representative to ensure accuracy or completeness of the information set out.**

TABLE OF CONTENTS

Definition of Terms……………………………………………………………………….….3

I. Organization………………………………………………………………….…..5

II. Facility Introduction and Information.………….……………………………...…...7

III. Policies………………………………………….…………………...………..14

IV. Services-Life Care – Standard, 50% and 90% Refundable……………………………....20

V. Services-Fee for Service – Standard……………………..…………………….….…22

VI. Fees…………………………………………….…………………...……..….23

VII. Financial Information……………………………………………….…...…………..25

VIII. Reserves, Escrow and Trusts……………………………………………………...….31

IX. Facility Development and Expansion…………………………………………..……....31

X. Residence and Services Agreements……………………………………..……………..32

XI. Miscellaneous…………………………………………………………..…………….32

Attachments:

A. Audited Financial Statements

B. Five Year Forecasted Statements

C. Un-audited Financial Statement

D. Residence and Services Agreement – Life Care

E. Residence and Services Agreement – Fee for Service

F. Reservation Agreement

G. Summary of Most Recent Actuarial Report

Definition of Terms

"Assisted Living" means a level of care that combines housing, supportive services, personalized assistance and healthcare designed to meet the individual's needs on a daily basis.

"Confidential Financial Statement" means a financial disclosure by the resident for the purpose of qualifying for admission to The Village at Brookwood.

"Continuing Care Retirement Community" (CCRC) also known as Life Plan Community means the provision of residential housing together with nursing services, medical services, or other health related services, under an agreement effective for the life of the individual.

"Co-Resident Fee" means the additional entrance fee and the additional monthly fee associated with two persons occupying the same residence.

"Direct Admission to the Health Care" means an agreement between a resident and The Village at Brookwood to enter Health Care directly for residency. Health related services are provided at the full per-diem rate and specified amenities are billable services as used.

"Entrance Fee" means a one-time payment at move-in that assures a resident a residence.

"Fee-for-Service contract" means a contract that provides housing, residential services, and priority access to health-related services in exchange for an entrance fee and a monthly fee. Health related services are provided at the full per-diem rate and specified amenities are billable services as used.

"Health Care Center" means the building where Assisted Living and Nursing Care are provided.

"Life Care Benefit" means the rate paid by a resident who has a "Life Care Contract" while residing in the Health Care Center. The rate at the time of transfer will apply to Assisted Living, Assisted Living Memory Care and Skilled Nursing accommodations.

"Life Care Contract" means a contract that provides housing, residential services, and priority access to health-related services in exchange for an entrance fee and a monthly fee. Unlimited access to long-term nursing care is available at little to no additional cost (Life Care Benefit), apart from periodic inflationary increases.

"Life Plan Community" also known as a CCRC means the provision of residential housing together with nursing services, medical services, or other health related services, under an agreement effective for the life of the individual.

"Non-refundable fee" means the portion of the fees paid to The Village at Brookwood that will not be refunded if the resident terminates the contract.

"Nursing Care" means the Skilled Nursing level of care as defined by the Nursing Home Rules and Regulations.

"Occupancy" means the time after which the resident pays their entrance fees, begins paying monthly fees, takes possession of the keys and moves into his/her residence at The Village at Brookwood.

"Provider" means the corporation, Alamance Extended Care, Inc., d/b/a The Village at Brookwood.

"Residence" means an Apartment, Garden Home or Assisted Living residence.

"Residence and Services Agreement" means the contract for continuing care between The Village at Brookwood and the resident.

"Residency" means approval by the Provider to move into the CCRC, based on age, health and financial qualifications of the prospective resident.

"Resident" means a purchaser of a Life Care or Fee for Service Residence and Services Agreement and residing on The Village at Brookwood campus.

"Residential Living" means the garden homes and apartment residences.

"Skilled Nursing" means the level of care that requires the oversight of a Registered Nurse.

"The Village" means The Village at Brookwood.

"Wellness Center" means the facility that houses all exercise equipment, aerobics/exercise room and swimming pool.

I. ORGANIZATION

The Village at Brookwood is a full-service retirement community that was sponsored and developed by ARMC Health Care. ARMC Health Care is the sole member of: Alamance Extended Care, Inc.; Alamance Regional Medical Center, Inc.; ARMC Physicians Care, Inc. and Alamance Regional Medical Center Foundation, Inc.

In December 2011, ARMC Health Care announced its intent to integrate with The Moses H. Cone Memorial Hospital (Cone Health) in Greensboro. Cone Health is a regional health care system with four hospitals in Greensboro and one in Reidsville, NC. A due diligence process was engaged, and the required regulatory approvals were obtained. The transaction was effective on May 1, 2013. This effective date accounts for the time necessary to obtain clearance from the Federal Trade Commission ("FTC"), which is a condition precedent for closing. Cone Health is the sole member of ARMC Health Care.

The Village at Brookwood functions as a separate, not-for-profit 501(c)(3) corporation named Alamance Extended Care, Inc. doing business as The Village at Brookwood. All financial and contractual obligations of The Village at Brookwood will be the sole responsibility of The Village; the member will not be responsible for any of these obligations.

ARMC Health Care and Cone Health are not-for-profit corporations chartered by the State of North Carolina.

In August of 2015, The Village at Brookwood and Well·Spring Services in Greensboro entered into an affiliation agreement that provides The Village an opportunity to collaborate on services such as dining, strategic planning and marketing. The goals of the affiliation are to develop an Exceptional Dining program utilizing The Village management versus contract management, develop a strategic plan sharing consultant resources and collaboration on marketing strategies to diversify each community's methods of attracting older adults. This affiliation does not affect governance, management or financial obligations of The Village.

On October 1, 2016, Cone Health restructured reporting relationships so that the health care services of The Village report directly to the Cone Health Corporate Director of Non-Acute and Transitional Care services and indirectly to the Executive Director of The Village.

On June 1, 2017, The Village at Brookwood and The Well·Spring Group in Greensboro entered into a management agreement. The Well·Spring Group and its affiliate, Well·Spring Management and Development, employ The Village's Executive Director, Healthcare Administrator and Director of Nursing. Well·Spring is not responsible for the financial and contractual obligations of The Village.

Alamance Extended Care, Inc. ("Extended Care") is the licensee operating The Village at Brookwood. Extended Care is a North Carolina nonprofit corporation, whose sole member is ARMC Health Care. ARMC Health Care is also the sole member of Alamance Regional Medical Center, Inc. (the "Medical Center"). Currently, the board of directors of Extended Care is appointed by the Medical Center's board of directors. The Moses H. Cone Memorial

Hospital ("Cone Health") is the sole member of ARMC Health Care and its affiliates, including Extended Care. Therefore, Cone Health is the ultimate parent entity of Extended Care.

Sentara Healthcare ("Sentara") and Cone Health have been negotiating a transaction pursuant to which Sentara will become the sole member of Cone Health, the ultimate parent entity of Extended Care, in accordance with the terms and conditions of the Affiliation Agreement (the "Proposed Affiliation"). The Proposed Affiliation will result in the affiliation of two diversified not-for-profit health care systems—Sentara and Cone—combining to form a fully-integrated health care delivery system. The Proposed Affiliation does not contemplate any material changes to the management or operation of Extended Care prior to closing. The current intent is that Cone Health will remain the parent organization of Extended Care. The current officers of Extended Care will remain in place following the closing of the Proposed Affiliation. There are no planned changes to the board of directors or management team of Extended Care as a result of the Proposed Affiliation prior to closing. Additionally, no changes in Extended Care's administrative staff are anticipated as a result of the Proposed Affiliation.

The legal entity known as "Alamance Extended Care, Inc." will remain in existence and will continue to operate the continuing care retirement community known as The Village at Brookwood. The assets of Extended Care will continue to be owned by Extended Care – there will not be a transfer of any assets (including patient records) to Sentara as a result of the Proposed Affiliation. In addition, Extended Care's tax identification number will not change as a result of the Proposed Affiliation. In short, Sentara currently has no plans to make material changes in Extended Care's business operations or corporate structure or management, other than as may arise in the ordinary course of business.

The closing of the Affiliation Agreement will take place on a mutually agreed upon date following the satisfaction of all conditions of the respective parties, including the receipt of the necessary governmental consents or approvals. After closing, Cone Health will become a fully functioning part of Sentara as a subsidiary of Sentara under the terms of the Affiliation Agreement.

The mission of Alamance Extended Care, Inc. is:

> ***Alamance Extended Care is a not-for-profit affiliate of ARMC Health Care committed to improving the health of the community through the provision of a high quality life-care retirement experience that integrates a continuum of retirement living, preventive wellness, and long term care services.***

The business address for The Village at Brookwood is 1860 Brookwood Avenue, Burlington, North Carolina, 27215. The main entrance is located off of Rockwood Avenue, north of Edgewood Avenue.

The Board of Directors for Alamance Extended Care, Inc. has been selected, nominated, and approved by the Community Advisory Board of Alamance Regional Medical Center. Alamance Regional Medical Center appoints the Chairperson and Vice-Chairperson who will serve until replaced. The power and authority of the Corporation shall be vested in its Board

of Directors, which shall have a minimum of eight (8) members and a maximum of seventeen (17) voting members.

II. FACILITY INTRODUCTION AND INFORMATION

The Village at Brookwood campus is approximately 47 acres located generally between Rockwood Avenue to the west, Hermitage Road to the east, Woodland Avenue and Arbor Drive to the north, and Edgewood Avenue to the south.

Construction of The Village at Brookwood began in November 2001, with occupancy of the retirement community on July 21, 2003.

The Community consists of 110 apartments in a five-story building; 45 one-story garden homes; a community center; and a health care center with 48 rooms of licensed Assisted Living, Memory Care, and Skilled Nursing care. In May 2009, The Village opened a Wellness Center with exercise rooms, swimming pool, Jacuzzi and locker rooms. The Community was originally designed to accommodate approximately 340 Residents.

The common areas are the center of activities for The Village and include a formal dining room, a café, private dining room, a living room and social lounge, an arts and crafts studio, a paint studio, an auditorium, a library, a bank, a beauty and barber shop, carpentry shop, a billiards room and a gift shop. Residents have the choice of using the community center amenities for everyday needs or travelling outside The Village at Brookwood to the greater Burlington community.

The Health Care Center consists of an outpatient clinic, 24 Assisted Living rooms which are licensed as Adult Care (Home for the Aged), with 12 of these rooms dedicated to dementia-memory care, and 24 Skilled Nursing rooms, licensed as Nursing Care.

To plan, finance and develop The Village at Brookwood, a team of professionals experienced in non-profit retirement community development were recruited. The Village at Brookwood was financed through a North Carolina Medical Care Commission tax-exempt bond issue (2001 Series A, B and C) in the amount of $58,060,000. To qualify for tax-exempt financing requires these items: a rigorous financial review and pro-forma; 70% of the Independent Living residences reserved by Residents with a 10% deposit of the Entrance Fee; and a guaranteed maximum price construction contract. These measures were required to insure the financial viability and sound operation of The Village at Brookwood.

On January 2, 2007, the series “C” variable rate bonds ($17 million) were retired. In May 2007, The Village at Brookwood re-financed a portion of the 2001 Series “A” and all of the “B” Bonds and included a $3 million loan from BB&T Bank into a new Fixed Rate 2007 Bond Issue.

On July 24, 2013 the outstanding 2001 bonds were redeemed. On November 20, 2013 the outstanding 2007 bonds were redeemed. The outstanding debt (prior to the redemption of the bonds) was refinanced by Cone Health, the parent corporation.

The Village at Brookwood is managed by its own Board of Directors composed of local experienced business and community representatives, and a professional administrative staff experienced in retirement community management.

A. The Board of Directors and Officers

1. **Jerry Bailey**
   Wells Fargo

   POSITION: Board Member

   BACKGROUND: Graduate of East Carolina University. Senior Vice President, Commercial Banking Leader, Wells Fargo. Service with the following boards: Alamance Community Foundation, Chair; Alamance Chamber, Chair; Alamance Community College Board of Trustees, Chair; Alamance Community College Foundation, Chair; Alamance County Community YMCA; New Leaf Society; Alamance Regional Charitable Foundation; and United Way of Alamance County, Campaign Chair. Member of First Presbyterian Church.

2. **Jeffrey S. Blaser**
   RetireCare Solutions/Raymond James

   POSITION: Finance Committee Chairperson

   BACKGROUND: Graduate of UNC at Chapel Hill. Certified Financial Planner, Registered Principal RetireCare Solutions/Raymond James. Service with the following boards: St. Marks Church; Alamance County Young Life; Loaves & Fishes; Hospice of Alamance Foundation; and Allied Churches of Alamance County.

3. **Bob Chandler**
   Chandler Concrete

   POSITION: Board Member

   BACKGROUND: Graduate of NC State University. Vice President, Chandler Concrete Co. Inc. Service with the following boards: Local Advisory Board Truist Bank; Alamance Community Foundation, Elon University Board of Trustees; Alamance Eldercare; Alamance County Chamber of Commerce; Twin Lakes Retirement Community; City of Burlington Parks and Recreation Commission. Member of Front Street United Methodist Church.

4. **William S. Chandler, Jr.**

   POSITION: Board Chairperson; Ex-officio on all committees.

BACKGROUND: Graduate of UNC at Chapel Hill. Retired, Vice President of Human Resources of Glen Raven, Inc. Service with the following boards: Burlington Christian Academy, Founding Board Member; Christian Counseling Center; Elon University Love School of Business; Alamance Country Club, President; Piedmont Health Coalition; and Pet and Animal Welfare Society (PAWS). Member of First Presbyterian Church, Elder.

5. **Rusty Holt**

POSITION: Board Member

BACKGROUND: Graduate of Davidson College. Property Manager, President/CEO Holt Hosiery Mills. Service with the following boards: Piedmont Health Coalition; Alamance Wildlife Club, President; Burlington Bio Diesel Co Op; Step Up Ministry; Company Shops Market; Positive Attitude Youth Center; and The Burlington School. Member of Saint Mark's Church.

6. **F.D. Hornaday**
Knit-Wear Fabrics, Inc.

POSITION: Ex-officio Board Member with Vote

BACKGROUND: Graduate of UNC at Chapel Hill. CEO of Knit-Wear Fabrics, Inc. Service with the following boards: Salvation Army Boys and Girls Club Advisory Council, Chair; Alamance Junior Tennis Foundation, Chair; United Methodist Foundation; Mid-Carolina Bank Board of Directors, Vice-Chair; UNC Board of Visitors; Trust Company of the South; and Alamance Country Club, President. Current Alamance Regional Medical Center, Chair. Member of Front Street United Methodist Church.

7. **Daryl Ingold**

POSITION: Board Member

BACKGROUND: Graduate of Elon University. President, Burlington Motors, Inc. (Burlington Lincoln-Mercury, Bill Ingold Mazda and Burlington Honda). Service with the following boards: Alamance County Crime Stoppers; Feed the Hunger; Meals on Wheels; Wachovia/Wells Fargo; United Way of Alamance County; and Alamance County Chamber of Commerce.

8. **Edward McCauley**

POSITION: Board Member, Resident

BACKGROUND: Graduate of Mars Hill College, North Carolina State University, Duke University and Virginia Commonwealth University. Retired North Carolina

Hospital Association: President Emeritus; President. Service with the following boards: Duke University Health System; Durham County Hospital Corporation; North Carolina Hospital Association; North Carolina Hospital Foundation; North Carolina Institute of Medicine; North Carolina Center for Hospital Quality and Patient Safety; North Carolina State University Alumni Association; North Carolina State University Foundation; University of North Carolina School of Public Health; Kate B. Reynolds Charitable Trust; and Mars Hill College.

9. **Chapman McQueen, MD, FACS**
   Alamance Ear, Nose & Throat

   POSITION: Ex-officio Board Member with Vote

   BACKGROUND: Graduate of UNC at Chapel Hill School of Medicine. Partner, Alamance Ear, Nose & Throat, LLP, Burlington. Service with the following boards: Alamance Regional Medical Center Board of Directors; Cone Health Board of Directors. Member of Graham Presbyterian Church, Elder.

10. **Marty Stadler**
    Sawyer Exterminating Service

    POSITION: Property Committee Chairperson

    BACKGROUND: Graduate of Appalachian State University. Realtor Relations and Market Development, Sawyer Exterminating. Service with the following boards: United Way of Alamance County; Alamance County Chamber of Commerce; Healthy Alamance; Hospice of Alamance-Caswell Counties; and The Salvation Army.

11. **Tom Steele**
    Pittman & Steele

    POSITION: Board Member

    BACKGROUND: Graduate of UNC at Asheville and UNC at Chapel Hill. Attorney at Law with Pittman & Steele Attorneys and Counselors at Law. Service with the following boards: Alamance District Eagle Board for Old North State Council Boy Scouts of America, Chair; United Methodist Retirement Homes, Inc., Vice President; United Methodist Retirement Homes Foundation; Alamance County Historical Museum; Elon University Love School of Business Accounting; North Carolina Bar Association Real Property Section, Chair; Board of Governors of the North Carolina Bar Association; North Carolina Bar Foundation, Secretary; Alamance County Bar, President; UNC at Asheville Alumni Association; UNC School of Law Alumni Association; Hospice and Palliative Care Center of Alamance-Caswell, LLC, Chair; Hospice of Alamance County Foundation; Habitat for Humanity of Alamance County; Alamance Battleground Friends; and Williams High School Booster Club, Treasurer. Eagle Scout. Member of Front Street Methodist Church.

12. Dr. Cindy Touloupas
Touloupas & Touloupas Dentistry

POSITION: Board Member

BACKGROUND: Graduate of UNC at Chapel Hill and Old Dominion University. General dentist with Touloupas and Touloupas Dentistry. Service with the following boards: Catholic Campus ministry, Elon University, Chair; Parents Council and Board of Visitors, Elon University; Parents Council, University of Chapel Hill; Ralph Scott Life Services. Member of Blessed Sacrament Church.

13. Alan J. White, Ed.D.

POSITION: Board Member

BACKGROUND: Graduate of Wake Forest University, UNC at Chapel Hill and Mississippi State. Retired Director of Athletics and Professor, Elon University. Professor Emeritus at Elon. Service with the following boards: YMCA; Alamance County Recreation Department; Alamance Regional Medical Center; Front Street Methodist Church Administrative Board; Bank of America local board; Alamance County Sports Development Council of the Chamber of Commerce; Alamance Rotary Club, President; Front Street Methodist Church Finance Committee; and NAIA Athletics Directors Association, National Chair. Member of Front Street Methodist Church.

14. Michael Garland, Executive Director
The Village at Brookwood

POSITION: Ex-Officio Board Member without Vote

BACKGROUND: Joined Well·Spring Management and Development in June 2017 and held the position of Health Care Administrator until May 2019, when he assumed his current role as Executive Director of The Village at Brookwood. Having grown up in the field of Long-Term Care, Michael has had the opportunity to serve older adults as a leader since 2013. He is a fellow of the Leading Age North Carolina Leadership Academy as of May 2019. Michael holds a Bachelor of Science from East Carolina University and is a licensed Nursing Home Administrator in the state of North Carolina.

15. Rene Smith, Director of Finance
Cone Health

POSITION: Treasurer

BACKGROUND: Responsible for non-hospital financial operations with total gross revenue of $275 million. In addition to the accounting responsibilities for Alamance Extended Care, Inc., she oversees the accounting for Cone Health's outpatient centers,

foundations and other entrepreneurial entities. Additionally, she oversees the accounting for all capital purchasing within Cone Health. She holds a Bachelor of Science in Accounting from Elon University and a Masters in Business Administration/Masters in Healthcare Administration from Pfeiffer University.

16. **April Mayberry, Healthcare Administrator**
    The Village at Brookwood

    POSITION: Secretary

    BACKGROUND: Bachelor's degree in Recreational Therapy from Western Carolina University and has been serving older adults for over 20 years. Her journey in healthcare includes Recreation Therapy Director, Behavioral Health Director and Associate Administrator before becoming a licensed Nursing Home Administrator in 2011. April joined Well·Spring Management and Development in September 2019 in the role of Health Care Administrator for The Village at Brookwood.

17. **President of Residents' Association**
    The Village at Brookwood Residents' Association

    POSITION: Resident, Non-voting attendee

B. Professional Staff and Consultants

The Village at Brookwood has professional, experienced staff to conduct the day-to-day management of The Village. The professional team responsible for the management of The Village at Brookwood includes:

1. **Ashley Day, Director of Resident Services**
   Ashley holds a Bachelor of Science from Elon University. She is an active member of the Burlington/Alamance community. Ashley began her employment with The Village at Brookwood in 2021.

2. **Cindy Youngblood, Accounting Manager**
   B.S. in Business Administration from Elon University. Has worked in Accounting since 1984 with Alamance Regional Medical Center and with the Village at Brookwood since 2007.

3. **Cindy Kroksh, Director of Clinical Services**
   Graduate of Watts Hospital School of Nursing. BS from Mars Hill College. Employed in Long Term Care since 1981 and have held the position of Director of Nursing since 1985. She has worked with The Village at Brookwood since 2017.

4. **Anthony Ricciuti, Director of Dining Services**
   Bachelor of Business Management, Memphis State University. Has worked in dining service in a Country Club, Assisted Living and CCRC's as a Chef and in Management positions. Anthony began his employment with The Village in January 2016.

5. **Betsy Huneycutt, Director of Sales & Marketing**
   Bachelor of Arts degree from the University of North Carolina at Greensboro. Has worked in sales and marketing and community relations since 1993. Also active in the greater Burlington community. Betsy joined The Village at Brookwood in 2016.

6. **Cary Hinely, Director of Facilities Services**
   Graduate of Southern Alamance High School. Part of Alamance Regional Medical Center's plant operations since 1997. Cary joined the facility services leadership team when The Village at Brookwood was being built in 2003.

Neither the professional staff, the Board of Directors, nor the consulting professionals have a significant financial interest in The Village at Brookwood as defined by North Carolina G.S. 58-64-20(a)(3)(b):

"The name and address of any professional service firm, association, trust, partnership, or corporation in which this person has, or which has in this person, a ten percent (10%) or greater interest and which it is presently intended shall currently or in the future provide goods, leases, or services to the facility, or to residents of the facility, of an aggregate value of five hundred dollars ($500.00) or more within any year, including a description of the goods, leases, or services and the probable or anticipated cost thereof to the facility, provider, or residents or a statement that this cost cannot presently be estimated; and…"

No member of the Board of Directors or professional staff has been convicted of a felony or pleaded *nolo contendere* to a felony charge or has been held liable or enjoined in a civil action by final judgment.

No member of the Board of Directors or professional staff is subject to a currently effective injunctive or restrictive court order, or within the past five years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department.

III. POLICIES

A. Residency – Health and Financial Criteria

Generally, all Residents of Residential Living at The Village at Brookwood are required to live independently at the time of residency and/or settlement and to have the financial resources to pay the Entrance and Monthly Service Fees. Residents are also encouraged to subscribe to Medicare Parts A and B and any other hospital or medical insurance benefit program which supplements Medicare or other comparable insurance accepted by

Provider. The Resident shall provide Provider with evidence of such coverage or of an acceptable substitute insurance plan, and the Resident shall pay all premiums.

The process for residency and the financial and medical requirements are specifically outlined in the forms for residency given to every person interested in joining The Village.

The Resident may become a part of the Friends Advantage Program (FAP) by payment of a $1,200 application fee. Of that fee, $1,000 will be credited toward the entry fee; $200 will be retained for administrative costs. Members of the Friends Advantage Program will receive advance notice of openings and will have priority in residence choices over all other prospective residents.

When a desired residence is available, the resident shall enter into the Reservation Agreement and place a 10% reservation fee on the residence that has been chosen. This will reserve the residence during the application approval process.

The Resident shall submit for approval by the Provider, an Application for Residency, which includes a confidential personal and health history and a financial disclosure, all on forms furnished by The Village. The application forms will be submitted to The Village within fourteen (14) days after the execution of the Reservation Agreement.

Upon receipt of the completed application forms, the Provider will review the forms submitted by the Resident for initial acceptance to The Village. Based on entrance criteria and policies established by the Board of Directors of the Provider, the Provider will approve or deny the application for initial acceptance within fourteen (14) days of receipt of the completed application forms. The Resident will be promptly notified of the decision of the Provider.

Provider will notify the Resident forty-five (45) days in advance of the date on which the Residence is available for occupancy. The Balance of the Entrance Fee and the first month’s Monthly Fee are payable by the date of occupancy.

Prior to admission to The Village, the Provider requires the Resident to receive a health assessment conducted by our healthcare team. The Resident shall also submit a report of a physical examination of the Resident made by a physician selected by the Resident within Sixty (60) Days prior to occupancy. The report shall include a statement by the physician that the Resident is in good health and is capable of independent living (able to provide self-care in activities of daily living). The Resident shall be responsible for the cost of such physical examinations. If the health of the Resident as disclosed by such physical examination differs materially from that disclosed in the Resident's Application for Admission and Personal Health History, Provider shall have the right to decline admission of the Resident to the Residence and may offer occupancy in the Health Care Center as described below.

The Resident must have assets and income which will be sufficient to pay the financial obligations of the Resident under the Residence and Services Agreement and to meet their

ordinary living expenses. Provider, at its discretion, may require the Resident(s) to furnish additional, current financial information.

The Resident affirms that the representations made in the Application for Residency, which includes a confidential personal and health history and a financial disclosure, are true and correct and may be relied upon by the Provider as a basis for entering into the Residence and Services Agreement.

If it is determined by the Provider that the Resident is unable to live independently in the residence, such resident may be offered direct admission to the Health Care Center. Such Resident shall pay the current Direct Admission Entrance Fee and shall pay monthly fees equal to the current private pay rate (per diem market rate) in the Health Care Center (for the required level of care, Assisted Living, Skilled Care or Memory Care). Residents directly admitted to the Health Care Center shall complete a separate Direct Admission Agreement and applications as required by the Provider and North Carolina licensure statutes. The Co-Resident or spouse of a Resident who qualifies for direct admission shall continue to be governed by the terms of the Residence and Services Agreement as a single occupant of the Residence.

If the Resident experiences a subsequent change in health status that would allow the Resident to again qualify for admission to an independent residence, the Resident shall be allowed to apply for admission into any vacant independent residence that the Resident qualifies for. If the resident has a spouse or significant other, the resident will then pay the second person fee for the residence occupied. If the resident is single and there are no residences available that the resident qualifies for, the resident will be put on a wait list for admission to such residence according to the Priority Number assigned to the Resident upon entering the Residence and Services Agreement.

B. Cancellation/Termination

1. **Cancellation of Contract Prior to Occupancy:** The 10% deposit under the Residence and Services Agreement, Section VI., makes the following provisions regarding cancellation:

   a. **Termination by Resident Prior to Occupancy.** The Residence and Services Agreement may be terminated by the Resident for any reason prior to occupancy by giving written notice to Provider. In the event of such termination, the Resident shall receive a refund of the 10% Deposit paid by the Resident, less any expenses incurred by The Village and less a nonrefundable fee equal to 2% of the total amount of the selected Entrance Fee option.

      If a resident dies before occupying the Residence, or if, on account of illness, injury, or incapacity, a resident would be precluded from occupying the Residence under the terms of the Residence and Services Agreement, the Residence and Services Agreement is automatically canceled. The nonrefundable fee (equal to 2% of the total amount of the selected Entrance Fee

option) will not be charged, however, if such termination is because of death of a Resident, or because the Resident's physical, mental or financial condition makes the Resident ineligible for entrance to The Village.

Any such refund shall be paid by The Village within sixty (60) days following receipt of notification of such termination. Provider requires that such notification be in writing.

b. **Termination by The Village.** The Village at Brookwood may terminate the Residence and Services Agreement prior to occupancy if there has been a material misrepresentation or omission made by the Resident in the Resident's information provided prior to Residency, within the Personal Health History, or the Confidential Financial Statement; or if the Resident's financial status changes such that Resident no longer meets The Village's financial requirements for residency. In the event of termination for any such causes, the refund of the Entrance Fee paid by the Resident shall be determined in the manner described in Section III.C. below (Entrance Fee Plans).

2. **Cancellation of Contract Pursuant to Occupancy and Termination Other Than Death:** The Residence and Service Agreement, in, Section VI., makes provisions for cancellations and terminations after the Resident occupies a residence, as follows:

a. **Voluntary Termination after Occupancy.** At any time after occupancy, the Resident may terminate the Residence and Services Agreement by giving Provider thirty (30) days written notice of such termination. Such notice effectively releases the Residence to The Village. Any refunds of the Entrance Fee due to the Resident shall be calculated based upon the Entrance Fee option chosen by the Resident and as described in Section III.C. Any refund due the Resident under this paragraph will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

b. **Termination upon Death.** In the event of death of the Resident at any time after occupancy, the Residence and Services Agreement shall terminate and the refund of the Entrance Fee paid by the Resident shall be calculated based upon the Entrance Fee option chosen by the Resident and as described in Section III.C. Any refund due to the Resident's estate will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

c. **Termination by The Village.** The Village may terminate this Agreement at any time if there has been a material misrepresentation or omission made by the Resident in the Resident's Application for Admission, Personal Health History, or Confidential Financial Statement; if the Resident fails to make payment to Provider of any fees and charges due The Village within sixty (60) days of the date when due; or if the Resident does not abide by the rules and regulations adopted by Provider or breaches any of the terms and conditions of this Agreement. Any refunds of the Entrance Fee due to the Resident shall be calculated based upon the Entrance Fee option chosen by the Resident and as described in Section II.A. Any refund due the Resident under this paragraph will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

3. **Rescission Period.** Notwithstanding anything herein to the contrary, this Agreement may be rescinded by the Resident giving written notice of such rescission to The Village within thirty (30) days following the later of the execution of this Agreement or the receipt of the Disclosure Statement that meets the requirements of Section 58-64-25, et.seq. of the North Carolina General Statutes. In the event of such rescission, the Resident shall receive a refund of the Entrance Fee paid by the Resident, less 2%. The Resident shall not be required to move into The Village before the expiration of such thirty (30) day period. Any such refund shall be paid by The Village within sixty (60) days following receipt of written notice of rescission pursuant to this paragraph.

C. Entrance Fee Plans

Four Entrance Fee Plans are available to the Resident according to the terms listed below. The Entrance Fee Refund Plan is chosen by the Resident and may be changed up to the date of payment of the final balance.

1. **Standard Life Care** Entrance Fee (less an initial 6% nonrefundable fee) accrues to The Village at a rate of 2% per month of occupancy or portion thereof for 47 months. The Resident will be due a refund of the Entrance Fee less: 2% thereof for each month of occupancy, plus any costs owed to The Village by the Resident, plus the amount necessary to restore the Residence to an acceptable condition except for reasonable wear and tear to the Residence. Refunds will be payable to the Resident at such time as such Resident's Residence shall have been reserved by a prospective Resident and such prospective Resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs.

2. **Life Care 50% Refundable** Entrance Fee (less an initial 6% nonrefundable fee) accrues to The Village at a rate of 2% per month of occupancy or portion thereof for 22 months until 50% of the entrance Fee has been accrued by The Village. Thereafter, any refund to the Resident will be guaranteed at 50% of the Entrance Fee originally paid less a sum equal to any costs owed to The Village by the Resident, plus the amount necessary to restore the Residence to an acceptable condition except for reasonable wear and tear to the Residence. Refunds will be payable to the Resident at such time as such Resident's Residence shall have been reserved by a prospective Resident and such prospective Resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs.

3. **Life Care 90% Refundable** Entrance Fee (less an initial 6% nonrefundable fee) accrues to The Village at a rate of 2% per month of occupancy or portion thereof for 2 months until 10% of the Entrance Fee has been accrued by The Village. Thereafter, any refund to the Resident will be guaranteed at 90% of the Entrance Fee originally paid less a sum equal to any costs owed to The Village by the Resident, plus the amount necessary to restore the Residence to an acceptable condition except for reasonable wear and tear to the Residence. Refunds will be payable to the Resident at such time as such Resident's Residence shall have been reserved by a prospective Resident and such prospective Resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs.

4. **Standard Fee for Service.** The Entrance Fee (less an initial 6% nonrefundable fee) accrues to The Village at a rate of 2% per month of occupancy or portion thereof for 47 months. The Resident will be due a refund of the Entrance Fee less: 2% thereof for each month of occupancy, plus any costs owed to The Village by the Resident, plus the amount necessary to restore the Residence to an acceptable condition except for reasonable wear and tear to the Residence. Refunds will be payable to the Resident at such time as such Resident's Residence shall have been reserved by a prospective Resident and such prospective Resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. The Residence and Services Agreement for this type of contract outlines the services that are included in the fees (Section V. of the Disclosure Statement applies to this type of contract). All Healthcare Services are provided at the prevailing per diem rate. Medicare and approved insurances may be used to pay for these services, however, when Medicare and insurances do not provide coverage the resident will be charged the per diem rate.

D. Moves and Transfers

The Residence and Services Agreement outlines the policies for transfers in Section V, "Transfers or Changes in Levels of Care," and should be consulted for a complete description of the policy concerning moves and transfers. The Resident may transfer from one Independent Living Residence to another or from an Independent Living Residence to the Health Care Center for Assisted Living, Memory Care or Nursing Services. Section V. of the Residence and Services Agreement makes the following provisions:

<u>Voluntary Transfer between Independent Residences</u>. The Resident may transfer from one independent Residence to another. The Resident shall comply with The Village's current Resident Transfer Advantage Program for selection of such Residence. There may be a refurbishment fee (for the residence being vacated) charged for such a transfer.

1. **<u>Transfer of Resident to a Larger Residence</u>.** If the Resident elects to transfer to a larger Residence, an additional Entrance Fee (according to the Entrance Fee Refund Option selected with the Date of Occupancy) equal to the difference between the Entrance Fee for the smaller Residence and the Entrance Fee for the larger Residence will be due to The Village. The Resident will also pay the Monthly Service Fee associated with the larger Residence.

2. **<u>Transfer of Resident to a Smaller Residence</u>.** The Resident may elect to transfer to a smaller Residence and pay the current monthly service fee for that Residence. The transfer to a smaller Residence shall not result in any entrance fee refund.

<u>Transfer to the Health Care Center</u>. The Resident agrees that Provider shall have authority to determine that the Resident be transferred from one level of care to another level of care within The Village. Such determination shall be based on the professional opinion of Medical Director and shall be made after reasonable efforts to consult with the Resident or the Resident's chosen and legal representative.

<u>Transfer to Hospital or Other Facility</u>. If it is determined by Provider that the Resident needs care beyond that which can be provided by The Village, the Resident may be transferred to a hospital or institution equipped to give such care; such care will be at the expense of the Resident. Such transfer of the Resident will be made only after consultation to the extent possible with the Resident, or a representative of the Resident's family.

<u>Surrender of Residence</u>. If a determination is made by Provider that any transfer as described above is likely to be permanent in nature, the Resident agrees to surrender the Residence upon such transfer. The Provider shall continue charging the monthly fees until such time that the unit is vacated. If Provider subsequently determines that the Resident can resume occupancy in a Residence or accommodation comparable to that occupied by the Resident prior to such transfer, the Resident shall have priority to such residence as soon as it becomes available.

E. Addition of a Co-Resident or Marriage

When a single Resident occupies a Residence in which The Village policy permits double occupancy, the Resident can allow another person to share occupancy of the Residence. The Village requires the new Resident to qualify for acceptance under the current Residence and Services Agreement type and refund option as the primary Resident.

F. Financial Assistance

Section VIII. of the Residence and Services Agreement makes the following provision for financial assistance:

> Provider declares that it is the intent of The Village to permit a Resident to continue to reside at The Village if the Resident is no longer capable of paying the prevailing fees and charges of The Village as a result of financial reversals occurring after occupancy, provided such reversals, in Provider's judgment, are not the result of willful or unreasonable dissipation of the Resident's assets. In the event of such circumstances, Provider will give careful consideration to subsidizing the fees and charges payable by the Resident so long as such subsidy can be made without impairing the ability of Provider to operate on a sound financial basis. Any determination by Provider with regard to the granting of financial assistance shall be within the sole discretion of Provider.

IV. SERVICES - Life Care: Standard, 50% and 90% Refundable

A. Standard Services Available

The Village at Brookwood is a full-service continuing care retirement community. Residents will pay a one-time Entrance Fee and a Monthly Service Fee. The fees are designed to cover virtually all living expenses incurred by Residents of The Village. The Monthly Service Fee covers the following basic services:

- one meal, per person, per day (at the choice of Resident during the month)
- weekly housekeeping
- maintenance of the residence
- maintenance of grounds and landscaping
- regularly scheduled local transportation including local medical appointments
- planned social and recreational activities
- all utilities (electric, gas, water and sewer)
- cable television (basic)
- high speed internet services (WIFI)
- 24-hour emergency call service and response
- 24-hour security services
- personal emergency pendants
- electronic check-in
- trash removal
- parking
- assistance with filing insurance claims
- assistance with transfer to hospitals or other special care facilities
- life care health care services

B. Services for an Extra Charge

Services that will require additional payment include:

- additional meals

- packaging and meal delivery to residence
- charges for special activities or trips
- personal parties or group events in the Community Center
- special, personal or group trip transportation
- beauty salon and barber shop services
- guest accommodations
- telephone including long distance
- expanded cable television
- charges for selected clinic health care services and wellness program activities
- charges for temporary health care services (more than 14 days a year in a healthcare accommodation) not covered by Medicare or other Insurance.

C. Absences

Residents away from The Village at Brookwood for fourteen (14) consecutive days or more, and who make arrangements in advance with The Village (excluding hospitalizations), will be credited with a current published dining services credit determined by The Village.

D. Health Care Services Available

Section I.G.13 of the Residence and Services Agreement outlines the services available in The Village at Brookwood Health Care Center. The payment for such services will be found in Section II. of the Residence and Services Agreement.

The Health Care Center includes licensed Assisted Living, Assisted Living Memory Care, and Skilled Nursing accommodations. A primary care clinic is located on site for use by Residents during scheduled hours.

The Life Care Benefit is the rate paid for residency in the Health Care Center. The rate at the time of transfer will apply to Assisted Living, Assisted Living Memory Care and Skilled Nursing accommodations.

The clinic will provide services such as certain examinations, consultations, checks, treatments and tests, as authorized by the staff and the Medical Director, and the cost of certain services may be the responsibility of the Resident as described in Section I.G.13(b) of the Residence and Services Agreements.

V. SERVICES – Fee for Service: Standard

A. Standard Services Available

The Village at Brookwood is a full-service Continuing Care Retirement Community. Residents will pay a one-time Entrance Fee and a Monthly Service Fee. The Monthly Service Fee covers the following basic services:

- 15 meals per person, per month
- housekeeping every other week

- maintenance of the residence
- maintenance of grounds and landscaping
- regularly scheduled local transportation
- planned social and recreational activities
- all utilities (electric, gas, water and sewer)
- cable television (basic)
- high speed internet service (WIFI)
- 24-hour emergency call service and response
- 24-hour security services
- personal emergency pendants
- electronic check-in
- trash removal
- parking
- assistance with filing insurance claims
- assistance with transfer to hospitals or other special care facilities
- health care services at the per diem rate

B. Services for an Extra Charge

Services that will require additional payment include:

- additional meals
- packaging and meal delivery to residence
- additional housekeeping services
- charges for special activities or trips
- personal parties or group events in the Community Center
- special, personal or group trip transportation
- beauty salon and barber shop services
- guest accommodations
- telephone including long distance
- expanded cable television
- charges for selected clinic health care services and wellness program activities
- charges for temporary health care services not covered by Medicare or Long Term Care Insurance

C. Health Care Services Available

Section I.G.13 of the Residence and Services Agreement (Fee for Service) outlines the services available in The Village at Brookwood Health Care Center, and payment for such services is set forth in Section II. F.1-2.

The Health Care Center includes licensed Assisted Living, Memory Care, and Skilled Nursing accommodations. A health clinic is located on-site for use by Residents during scheduled hours. All charges for health care related services will be at the per diem rate.

The clinic will provide services such as certain examinations, consultations, checks, treatments and tests, as authorized by the staff and the Medical Director, and the cost of certain services may be the responsibility of the Resident as described in Section I.G.13(b) of the Residence and Services Agreement.

VI. FEES

A. Residency Fees

Persons applying for residency will choose a type of residence and make a 10% deposit of the Entrance Fee (the amount of which is determined by both the residence type and the Entrance Fee Refund Option). Applications for residency will be provided and completed to determine eligibility. Once approved for residency, a Resident will be guaranteed admission to The Village regardless of change in their health status. If a Resident requires nursing services prior to being able to live independently in a Residence, as determined by The Village, they will be subject to the terms outlined in Section III.D of the Residence and Services Agreement, "Direct Admission to Health Care Center." The monthly fee is the prevailing Fee for Service per diem rate.

All funds are held in escrow and are refundable under the terms outlined in the Residence and Services Agreement.

B. Entrance Fee and Monthly Service Fee

The Village requires that two fees be paid for residency: an Entrance Fee and a Monthly Service Fee. These fees are reviewed annually to ensure the financial viability of the organization.

C. Health Care Center Fees – Life Care: Standard, 50% and 90% Refund

Health Care Center revenues are generated from services to Residents transferring from residential living areas, or Residents admitted directly into a nursing bed due to health condition changes since approved for residency in Independent Living.

Residents transferring from residential living areas to the Health Care Center on a permanent or temporary basis will be charged the Life Care Benefit rate at the time of transfer.

Fourteen (14) days of qualified respite care are available to Life Care Residents on an annual basis. This benefit applies to skilled nursing only.

D. Health Care Center Fees – Fee for Service

Charges for Health Care Services will be billed at the per diem rate. In addition to the Health Care fee and ancillary charges as described in Section II.F.1 of the Residence and Services Agreement, the resident will be charged the rate for the healthcare residence they occupy.

E. Fee Change Policies

The Residence and Services Agreement, Section II.D., makes the following provisions regarding the periodic adjustment of fees:

> "The Monthly Fee provides for the facilities, programs, and services described in this Agreement and is intended to meet the cost of the expenses associated with the operation and management of The Village. The Village shall have the authority and discretion to adjust the Monthly Fee during the term of this Agreement to reflect increases and changes in costs of providing the facilities, programs, and services described herein consistent with operating on a sound financial basis and maintaining the quality of services provided to Residents. At least a thirty (30) day notice will be given to the Resident before any adjustment in fees or charges."

F. Changes in Fees for the Previous Five Years

LIFE CARE

		2018	2019	2020	2021	2022
Apt. Residences	**Sq. Feet**					
Azalea	826	$2,519	$2,607	$2,705	$2,786	$2,925
Birch	1113	$2,739	$2,835	$2,941	$3,029	$3,181
Camellia	1206	$2,995	$3,100	$3,216	$3,312	$3,478
Dogwood	1352	$3,250	$3,364	$3,490	$3,595	$3,774
Elm	1596	$3,524	$3,647	$3,784	$3,898	$4,092
Garden Home Residences						
Holly	1692	$3,847	$3,982	$4,131	$4,255	$4,468
Magnolia/ Maple	1892	$4,026	$4,167	$4,323	$4,453	$4,675
Oak	1965	$4,142	$4,287	$4,448	$4,581	$4,811
Co-Resident		$1,225	$1,268	$1,315	$1,354	$1,422

FEE FOR SERVICE

Apt. Residences	Sq. Feet	2018	2019	2020	2021	2022
Azalea	826	$2,115	$2,189	$2,271	$2,339	$2,456
Birch	1113	$2,335	$2,417	$2,507	$2,582	$2,711
Camellia	1206	$2,589	$2,680	$2,780	$2,863	$3,007
Dogwood	1352	$2,869	$2,969	$3,081	$3,173	$3,332
Elm	1596	$3,145	$3,255	$3,377	$3,478	$3,652

Garden Home Residences	Sq. Feet	2018	2019	2020	2021	2022
Holly	1692	$3,172	$3,283	$3,406	$3,508	$3,684
Magnolia/ Maple	1892	$3,376	$3,494	$3,625	$3,734	$3,920
Oak	1965	$3,493	$3,615	$3,751	$3,864	$4,057
Co-Resident		$708	$733	$760	$783	$822

G. Miscellaneous Ancillary Charges

Additional charges may apply depending on the service received or the Residence and Services Agreement that was selected. Each September The Village distributes a Miscellaneous Rate Adjustment Memo to all residents for the following year.

VII. FINANCIAL INFORMATION

A. Overview

The Village financed the construction, equipment and initial working capital for the project with tax-exempt revenue bonds issued through the North Carolina Medical Care Commission ($32,560,000 Series 2001A (Fixed Rate), $8,500,000 Series 2001B (Adjustable Rate) and $17,000,000 Series 2001C (Variable Rate)). Initial seed and development funding was provided by Alamance Regional Medical Center, Inc., and $4 million was repaid to Alamance Regional Medical Center, Inc. at the closing of the 2001 tax-exempt revenue bond issue. A $3 million subordinated interest free loan with Alamance Regional Medical Center was reflected in the financial reports from 2001-2013. This intercompany loan was forgiven in March 2014 and is no longer shown in the financial statements.

The Series 2001C Bonds were retired on January 2, 2007. In connection with the retirement of the Series 2001C Bonds, a $3 million loan (20-year amortization with a 2 year payback) was attained from Branch Banking and Trust Company (the "Bank Loan") in December 2006 to assure adequate cash flow following such retirement.

In May of 2007, The Village refunded $11,960,000 of the Series 2001A Bonds, all of the Series 2001B Bonds and retired the Bank Loan through the issuance of $29,280,000 fixed rate tax-exempt refunding revenue bonds (the "Series 2007 Bonds"). BB&T Capital Markets in Richmond, Virginia served as underwriter for the Series 2007 Bonds.

The Alamance Extended Care Series 2001 and 2007 bonds were redeemed by Cone Health in two transactions. The 2001 bonds were redeemed in July 2013 and the 2007 bonds were redeemed in November 2013. Alamance Extended Care, Inc., no longer has debt. Cone Health, the parent company issued tax exempt bonds to refinance the outstanding debt.
A Promissory Note for $2.5 million was approved in 2008 by the Board of Directors of Alamance Extended Care, Inc. and the Board of Directors of Alamance Regional Medical Center to develop a Wellness Center on the campus of The Village at Brookwood. The Wellness Center includes exercise rooms, a pool and locker rooms. This was a 0% interest note, with the indebtedness due in full by January 2, 2032. As part of the agreement, the patients of Alamance Regional Medical Center receiving aquatic therapy will have the right to use the Wellness Center during specified times and under the direct care of a therapist. Alamance Regional is not charged for the use of the pool. In March 2014, this loan was forgiven and is no longer reflected in the financial statements.

B. Residents with Continuing Care Contracts

As of September 30, 2021, there were a total of 235 residents receiving continuing care services. There were 194 residents in Independent Living, 20 in Assisted Living and 21 in Skilled Nursing.

C. Current Financial Statements

The Village at Brookwood began operations on July 21, 2003. Audited financial statements for the last two full fiscal years ending September 2021 and September 2020 for Cone Health are included as Attachment A.

D. Five Year Forecasted Statement

See Attachment B for financial projection statements prepared for the fiscal years 2022-2026.

E. Material Differences between Forecasted Financial Data and Actual Results

Narrative describing material differences between forecasted financial data as shown in previous Disclosure Statement and Audited Actual Results. (Pages 27 – 30)

As of 9/30/2021		Explanation: Variance of 10% or greater than $150,000			
		Amounts shown in Thousands			
	Audited	Forecast	Variance	% change	**Explanations
CASH FLOWS FROM OPERATING ACTIVITIES					
Decrease in net assets	(1,456)	(973)	483	-33%	1
Adjustments to Reconcile Decrease in Net Assets to Net Cash Used by Operating Activities:					
Depreciation	2,930	2,797	(133)	-5%	
Amortization of Entrance Fees	(3,279)	(2,430)	849	-26%	2
Accounts Receivable (net)	89	(181)	(270)	-303%	3
Inventories	-	(13)	(13)		4
Other Current Assets	516	206	(310)	-60%	5
Increase (Decrease) in Current Liabilities:					
Accounts Payable	(117)	57	174	-149%	6
Accrued Expenses	228	161	(67)	-29%	7
Grants Payable	(557)	(825)	(268)	48%	8
Net Cash Used by Operating Activities	(1,646)	(1,201)	445	-27%	
CASH FLOWS FROM INVESTING ACTIVITIES					
(Increase) Decrease in Investments	-	(2,211)	(2,211)		9
(Increase) Decrease in Assets Limited as to Use	(303)	(299)	4	-1%	
Acquisition of Property and Equipment	(2,139)	(2,000)	139	-6%	10
Net Cash Used by Investing Activities	(2,442)	(4,510)	(2,068)	85%	
CASH FLOWS FROM FINANCING ACTIVITIES					
Entrance Fees Received	3,279	2,846	(433)	-13%	11
Entrance Fees Refunded	(718)	(488)	230	-32%	12
Net Cash Used by Financing Activities	2,561	2,358	(203)	-8%	
INCREASE (DECREASE) IN CASHE AND CAH EQUIVALENTS	(1,527)	(3,353)	(1,826)	120%	
Cash and Cash Equivalents - Beginning of Year	**10,346**	**10,346**	**-**	0%	
CASH AND CASH EQUIVALENTS - END OF YEAR	**8,819**	**6,993**	**(1,826)**	-21%	13
****EXPLANATIONS:**					
1 cash higher than forecast, patient payments, less invested					
2 higher entrance fees and amortization of those than forecasted					
3 Patient A/R lower than expected as payments received & cash higher					
4 All inventory used					
5 Investments, Patient A/R and Cash all lower than forecasted					
6 E liabilities higher than forecasted (Accrued vendor payables & payroll)					
7 not a major difference					
8 Grants payable reduced or paid out sooner than forecasted					
9 Investment projected did not occur					
10 Slightly more property capitalized than anticpated					
11 More and higher entrance fees received than anticipated					
12 More turnover so more refunds than anticipated					
13 Higher actual cash than forecasted					

As of 9/30/2021	ASSETS	Explanation: Variance of 10% or greater than $150,000			
		Amounts shown in Thousands			
	Audited	Forecast	Variance	% change	**Explanations
CURRENT ASSETS:					
Cash and cash equivalents	8,819	6,993	1,826	20.71%	1
Patient Accounts Receivable	194				
Allowance for Uncollectibles	(1)				
Net Accounts Receivable	193	464	(271)	-140.41%	2
Supplies Inventory	23	36	(13)	-56.52%	3
Other Receivables	0	0	0		
Intercompany Receivables (Payables)		0	0		
Prepaid Expenses	20	330	(310)		
Other Current assets	43	366	(310)	-720.93%	4
Total Current Assets	9,055	7,823	1,232	13.61%	
	Audited	Forecast	Variance	% change	
Assets Limited to Use					
Investments-board designated	0	0	0		
Other trustee held funds	0	0	0		
Debt Service Reserve	0	0	0		
Statutory Operating Reserve	3,015	3,010	5	0.17%	
Total	3,015	3,010	5		
PROPERTY, PLANT & EQUIPMENT:					
Land & Land Improvements	9,421		9,421		
Buildings & Fixed Equipment	65,417		65,417		
Movable Equipment	2,054		2,054		
Construction in Progress/Equipment in Progress	1,518		1,518		
Property, Plant & Equipment	78,410	50,749	27,661		
Accumuated Depreciation	(26,093)		(26,093)		
Total	52,317	50,749	1,568	3.00%	5
Investments	0	2,211	(2,211)	100.00%	6
Other Assets		0	0		
TOTAL ASSETS	64,387	63,793	594	0.92%	

EXPLANATIONS:

1 Cash is transferred periodically to Conehealth Treasury Management. Transfers out were less than anticipated in Forecast.

2 Accounts receivable are less than forecast due to closing of Edgewood Place.

3 Did not see increase in Inventory as forecasted due to lower census.

4 Cash was paid at year end to close out intercompany receivables

5 New assets/projects were higher than forecast

6 The Village at Brookwood had no investments in 2021

As of 9/30/2021	ASSETS	Explanation: Variance of 10% or greater than $150,000			
		Amounts shown in Thousands			
LIABILITIES AND NET ASSETS:	**Audited**	**Forecast**	**Variance**	**% change**	**Explanations**
CURRENT LIABILITIES					
Accounts Payable	1,095	198	897	81.92%	7
Accrued Expenses	1,818	3,232	(1,414)	-77.78%	8
Deferred Revenue	1,940	2,841	(901)	-46.44%	9
Due to Others	2,975	0	2,975	100.00%	10
COVID Grant Payable	267	0	267	100.00%	11
Total Current Liabilities	8,095	6,271	1,824	22.53%	
	Audited	**Forecast**	**Variance**	**% change**	**Explanations**
LONG TERM LIABILITIES					
Deferred Revenue from Entrance Fees	8,388	3,976	4,412	52.60%	12
VALUATION WRITE DOWN DEF INC-AEC	(3,758)	0	(3,758)	100.00%	13
Refundable Fees	9,764	10,999	(1,235)	-12.65%	14
Other non-current liabilities	70	316	(246)	-351.43%	15
Total LT Liabilities	14,464	15,291	(827)	-5.72%	
TOTAL LIABILITIES	22,559	21,562	997	4.42%	
NET ASSETS:					
UNRESTRICTED NET ASSETS	41,545	42,014	(469)	-1.13%	16
TEMPORARILY RESTRICTED FUNDS	283	217	66	23.32%	17
NET ASSETS	41,828	42,231	(403)	-0.96%	
LIABILITIES AND NET ASSETS	64,387	63,793	594	0.92%	

EXPLANATIONS:

7 Accounts Payable year end accruals were higher than forecasted as paybles were not paid out before 9/30/2021

8 Accrued expenses were less than forecasted for 2021 and due to others is lower than forecast. Timing of TDA annuity paid to employee retirement is the other difference.

9 Higher deferred revenue in LT and less in ST at year-end due to higher than forecasted new resident occupancy

10 Due to others includes due to Cone Health and sales tax payable - not recognized in forecast due to the balance was intentionally paid off

11 No COVID Grant funds were forecasted for 2021

12 Higher deferred revenue in LT and less in ST at year-end due to higher than forecasted new resident occupancy

13 Valuation write down was required by auditors and not included in forecast

14 Refundable fees lower due to old residents have met contractual obligations fully amortized and are no longer owed refunds

15 Other non-current liabilities is the Friends Advantage Program deposits

16 The net assets fell due to the sale/disposals of remaining Edgewood Place assets

17 Resident donations to the Employee Holiday fund were higher than forecasted

As of 9/30/2021	ASSETS	Explanation: Variance of 10% or greater than $150,000			
		Amounts shown in Thousands			
	Audited	Forecast	Variance	% change	Explanations
Monthly Service Fees:					
Residential living	6,257				
Health care	3,871	10,145	(17)	-0.17%	
Amortization of entrance fees	1,940	2,430	(490)	-25.26%	18
Investment income		41	(41)	0.00%	
Contributions and Gifts	646	786	(140)	-21.67%	19
Other revenues	1,125	461	664	59.02%	20
Total Revenues, Gains and Other Support	13,839	13,863	(24)		
Expenses:					
Health care	3,549	2,894	655	18.46%	21
Resident services	717	548	169	23.57%	22
Dietary	2,231	1,490	741	33.21%	23
Plant operations	1,983	1,632	351	17.70%	24
Laundry	31	22	9	29.03%	25
Housekeeping	564	361	203	35.99%	26
General and administrative	3,284	5,092	(1,808)	-55.05%	27
Interest	0		0		
Amortization	0		0		
Depreciation	2,926	2,797	129	4.41%	
Total Expenses	15,285	14,836	449	2.94%	
Operating Income (loss)	(1,446)	(973)	(473)		
Non-Operating Income					
Other non-operating income	42		42	100.00%	28
Investment Income	28		28	100.00%	29
Total Non-Operating Income	70	-	70		
Excess of Revenue, Gains and Other Support Over Expenses	(1,376)	(973)	(403)		

EXPLANATIONS:

18 Resident independent move-ins to Independent Living were lower than forecast

19 COVID funds received in 2021 were lower than forecast

20 Other revenue includes termination income, dining, and other ancillary income

21 Healthcare wages, OT, & special salaries were higher than forecast

22 Resident services activities resumed after COVID

23 Food costs & wages were higher than forecast

24 Repairs, upgrades for new move-ins higher than forecast

25 Cone switched to another laundry services resulting in higher costs

26 Salaries and cleaning supplies higher than forecast

27 COVID expenses were lower than forecast

28 No other non-operating forecasted

29 No other investment forecasted

VIII. RESERVES, ESCROW AND TRUSTS

A. Trustee-Held Funds

There are no Trustee-held funds.

B. Operating Reserves

As required by North Carolina G.S. 58-64-33:

The Village maintains operating reserves equal to twenty-five percent (25%) of the total operating costs projected for the 12-month period following the period covered by the most recent annual statement filed with the North Carolina Department of Insurance. The required forecasted statements shall serve as the basis for computing the operating reserve. In addition to total operating expenses, total operating costs will include debt service but will exclude depreciation, amortized expenses, and extraordinary items approved by the Commissioner of Insurance. The operating reserves may be funded by cash, invested cash, or investment grade securities.

The Operating Reserve Fund is held by the Corporation in an interest-bearing Certificate of Deposit accounts and the reserve can only be released for use by the provider upon written request to and approval by the Commissioner of Insurance.

C. Board Designated Funds

The Board has established a resident assistance fund to be used at the discretion of the Executive Director and the Board of Directors to provide financial assistance to Residents who are unable to meet their financial responsibilities.

D. Investment Accounts

The Village does not maintain investment accounts. All bank accounts are managed by Cone Health. Cone Health's investments are managed by an Investment Committee led by an Investment Manager in the Corporate Office.

IX. FACILITY DEVELOPMENT OR EXPANSION

The initial construction of The Village at Brookwood consisted of 155 residential living residences (110 apartments and 45 garden homes) and 48 health care residences. The Wellness Center that includes exercise rooms, pool, Jacuzzi and locker rooms opened in May 2009. The site has been master planned to allow the addition of garden home residences, apartment residences and additional healthcare residences. Construction of two maple garden homes was completed January 2019.

X. RESIDENCE AND SERVICES AGREEMENTS

The Residence and Services Agreements (Standard Life Care, 50% and 90% refund; and Standard Fee for Service) are attached (Attachments D and E). All persons interested in residency at The Village at Brookwood should carefully review the selected Agreement.

The Village at Brookwood continually monitors the trends and new developments related to Residence and Services Agreements in the market. As new options become available and reviewed by management and approved by the Board of Directors, they will be submitted to the Department of Insurance for approval.

XI. MISCELLANEOUS

A. Marketing Incentives

Throughout the marketing of The Village at Brookwood, various incentives have been employed at times. Some of the initial Residents (referred to as "Founders' Club") were provided with financial (in the form of credits) and other incentives at the time of move-in to the Community. Other Residents were encouraged to reserve their residence with a Ten Percent (10%) Deposit even if they were uncertain as to their being ready at the time of opening (the "Ready List"); they were assured that they could leave their deposit with the Community and obtain a priority for future move-in when they decide to move in. There are several residence and services agreements that are no longer offered.

The Village at Brookwood reserves the right to offer at any time the same or similar incentives or any other incentives it may decide.

B. Wait List

The Wait List is called the Friends Advantage Program (FAP). Prospective residents will sign an agreement and make a $1,200 deposit ($200 of which is non-refundable) that will initiate the assignment of a reservation priority number for the purpose of holding a place in line for future availability of any residence that is not then-currently available. The Village will contact the prospective resident by order of reservation priority number and according to the choice of residence preferred when such a residence becomes available. Once notified of availability and the prospective resident has accepted the residence, then the Reservation Agreement must be completed, and a 10% entry fee deposit must be made.

C. Edgewood Place Divestiture

Alamance Extended Care (AEC) is an organization that includes Edgewood Place Skilled Nursing Facility and The Village at Brookwood Continuing Care Retirement Community. In early 2020, AEC announced its intent to sell the licenses for the 81 Edgewood Place Nursing beds housed on the AEC campus. Of the 81 beds, 22 were sold on July 27, 2020 to Peak Resources for $440,000 and 32 beds were sold on July 15, 2020 to Liberty

Healthcare for $640,000. Both Peak Resources and Liberty Healthcare are local institutions that aim to keep these beds in Alamance County. Twenty-seven (27) beds remain to be sold. Management has projected that the sale of the Edgewood Place Nursing bed licenses will not adversely affect the ongoing operation of The Village at Brookwood Continuing Care Retirement Community, which has its own sheltered nursing beds.

Attachment A
Audited Financial Statements

The Moses H. Cone Memorial Hospital and Affiliates

Consolidated Financial Statements as of and for the Years Ended September 30, 2021 and 2020, Consolidating Supplemental Schedules as of and for the Year Ended September 30, 2021 and Independent Auditors' Report

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

TABLE OF CONTENTS

	Page
INDEPENDENT AUDITORS' REPORT	1–2
CONSOLIDATED FINANCIAL STATEMENTS AS OF AND FOR THE YEARS ENDED SEPTEMBER 30, 2021 AND 2020:	
Balance Sheets	3
Statements of Operations	4
Statements of Changes in Net Assets	5
Statements of Cash Flows	6
Notes to Consolidated Financial Statements	7–44
CONSOLIDATING SUPPLEMENTAL SCHEDULES AS OF AND FOR THE YEAR ENDED SEPTEMBER 30, 2021:	45
Balance Sheet	46–47
Statement of Operations	48

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INDEPENDENT AUDITORS' REPORT

To the Board of Trustees of
The Moses H. Cone Memorial Hospital:

We have audited the accompanying consolidated financial statements of The Moses H. Cone Memorial Hospital and affiliates (dba Cone Health) (the "Health System"), which comprise the consolidated balance sheets as of September 30, 2021 and 2020, 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 Consolidated 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.

Auditors' 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 Health System'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 Health System'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.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of September 30, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Consolidating Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating supplemental schedules listed in the table of contents are presented for the purpose of additional analysis and are not a required part of the consolidated financial statements. These consolidating supplemental schedules are the responsibility of the Health System's management and were derived from and relate directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such consolidating supplemental schedules have been subjected to the auditing procedures applied in our audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such consolidating supplemental schedules directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such consolidating supplemental schedules are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Deloitte & Touche LLP

January 24, 2022

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED BALANCE SHEETS
AS OF SEPTEMBER 30, 2021 AND 2020
(In thousands of dollars)

	2021	2020
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 221,765	$ 328,671
Short-term investments	147,096	26,688
Patient accounts receivable	236,777	175,625
Inventories	48,392	39,414
Assets limited as to use—required for current liabilities	5,802	6,674
Other current assets	104,684	89,317
Total current assets	764,516	666,389
LONG-TERM INVESTMENTS	941,289	959,659
ASSETS LIMITED AS TO USE—Net of portion required for current liabilities	205,754	233,432
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	52,592	51,799
PROPERTY AND EQUIPMENT—Net	1,239,302	1,180,858
RIGHT OF USE ASSETS—Operating leases—net	75,181	70,582
RIGHT OF USE ASSETS—Finance leases—net	9,881	9,523
GOODWILL	9,832	9,832
OTHER ASSETS	108,230	97,986
TOTAL	$ 3,406,577	$ 3,280,060
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES:		
Accounts payable	$ 74,272	$ 63,376
Accrued expenses	255,662	284,847
Current portion of contract liabilities	123,590	149,407
Current portion of operating lease obligations	13,952	14,210
Current portion of finance lease obligations	4,139	5,904
Current portion of long-term debt	173,916	182,110
Total current liabilities	645,531	699,854
LONG-TERM DEBT—Net of current portion	422,655	445,762
OPERATING LEASE OBLIGATIONS—Net of current portion	64,693	59,406
FINANCE LEASE OBLIGATIONS—Net of current portion	5,382	3,841
LONG-TERM CONTRACT LIABILITIES—Net of current portion	14,394	15,047
OTHER NONCURRENT LIABILITIES	144,637	128,524
Total liabilities	1,297,292	1,352,434
NET ASSETS:		
Without donor restrictions:		
Moses H. Cone Memorial Hospital and Affiliates	2,083,873	1,909,647
Noncontrolling interests	5,925	2,634
Total net assets without donor restrictions	2,089,798	1,912,281
With donor restrictions	19,487	15,345
Total net assets	2,109,285	1,927,626
TOTAL	$ 3,406,577	$ 3,280,060

See notes to consolidated financial statements.

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED SEPTEMBER 30, 2021 AND 2020
(In thousands of dollars)

	2021	2020
NET PATIENT SERVICE REVENUE	$2,204,566	$2,011,613
OTHER REVENUE	129,232	130,196
PREMIUM REVENUE	174,875	149,491
NET ASSETS RELEASED FROM RESTRICTIONS	2,450	2,294
Total operating revenue	2,511,123	2,293,594
OPERATING EXPENSES:		
Salaries and wages	959,064	853,118
Fringe benefits	280,281	257,017
Supplies	488,157	441,759
Other direct expenses	599,948	517,313
Interest expense	16,010	15,849
Depreciation and amortization	122,771	145,802
Total operating expenses	2,466,231	2,230,858
INCOME FROM OPERATIONS	44,892	62,736
NONOPERATING INCOME (EXPENSE):		
Investment income	155,117	71,143
Other nonoperating (expense) income—net	(22,027)	15,731
Total nonoperating income	133,090	86,874
EXCESS OF REVENUES OVER EXPENSES FROM CONSOLIDATED OPERATIONS	177,982	149,610
(EXCESS) OF REVENUES OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTERESTS	(8,831)	(10,385)
EXCESS OF REVENUES OVER EXPENSES ATTRIBUTABLE TO MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES	$ 169,151	$ 139,225

See notes to consolidated financial statements.

(Continued)

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
FOR THE YEARS ENDED SEPTEMBER 30, 2021 AND 2020
(In thousands of dollars)

	2021	2020
NET ASSETS WITHOUT DONOR RESTRICTIONS:		
Excess of revenues over expenses from consolidated operations	$ 177,982	$ 149,610
Adoption of new accounting pronouncement unrealized gain on investments		66,118
Change in net unrealized gains and losses on investments	(15,770)	(44,976)
Change in the fair value of the floating-to-fixed swap agreements	16,368	(12,289)
Distributions to non-controlling interest	(5,660)	(5,583)
Other changes in net assets	4,597	7,404
Increase in net assets without donor restrictions	177,517	160,284
NET ASSETS WITH DONOR RESTRICTIONS:		
Contributions	5,201	3,945
Net assets released from restrictions	(2,450)	(2,294)
Other changes in net assets	1,391	(1,270)
Increase in net assets with donor restrictions	4,142	381
INCREASE IN NET ASSETS	181,659	160,665
NET ASSETS—Beginning of year	1,927,626	1,766,961
NET ASSETS—End of year	$ 2,109,285	$ 1,927,626

See notes to consolidated financial statements.

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED SEPTEMBER 30, 2021 AND 2020
(In thousands of dollars)

	2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	$ 181,659	$ 160,665
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Change in net unrealized gains and losses on investments	15,770	44,976
Adoption of new accounting pronouncement unrealized gain on investments		(66,118)
Change in fair value of the floating-to-fixed swap agreements	(16,368)	12,289
Net realized (gain) loss on sale of investments and unrealized (gain) loss on equity securities	(133,069)	(49,107)
Depreciation and amortization	122,771	145,802
Amortization of right-of-use assets	13,370	14,792
Asset impairment		4,555
Loss on disposal of property and equipment	2,978	1,595
Earnings of unconsolidated affiliates	(2,484)	(12,054)
Purchase of unconsolidated entities		(330)
Distributions from unconsolidated affiliates	1,691	7,822
Distributions to noncontrolling interests	5,660	5,583
CMS advanced (recoupment) payment	(25,456)	140,365
FICA deferral	8,871	20,791
Changes in:		
Patient accounts receivable	(61,153)	57,742
Other current assets	(15,367)	(16,771)
Inventories	(8,978)	(2,633)
Accounts payable and accrued expenses	(17,626)	309
Lease liability due to cash payments	(13,488)	(11,728)
Other operating assets	(11,163)	(13,116)
Other operating liabilities	18,238	3,176
Net cash provided by operating activities	65,856	448,605
CASH FLOWS FROM INVESTING ACTIVITIES:		
Additions to property and equipment	(170,618)	(142,198)
Disposal of finance right-of-use assets		36
Purchases of investments	(1,795,809)	(797,196)
Proceeds from sale of investments	1,835,739	803,338
Restriction of funds in Care-N-Care Inc.	89	(17,042)
Gain on sale of unconsolidated entities		15,097
Net cash used in investing activities	(130,599)	(137,965)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from debt issuances and refundable entrance fees	3,280	185,242
Repayments of debt and entrance fees refunded	(32,418)	(199,329)
Distributions to noncontrolling interests	(5,660)	(5,583)
Repayments of finance leases	(7,365)	(5,943)
Net cash used in financing activities	(42,163)	(25,613)
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(106,906)	285,027
CASH AND CASH EQUIVALENTS:		
Beginning of year	328,671	43,644
End of year	$ 221,765	$ 328,671
SUPPLEMENTAL INFORMATION:		
Cash paid during the year for interest—net of amounts capitalized	$ 15,482	$ 17,507
Right-of-use asset additions—operating	$ 17,969	$ 85,373
Right-of-use asset additions—finance	$ 7,521	$ 24,708
Debt to equity conversion	$	$ 10,719
Property and equipment purchases in accounts payable	$ 5,122	$ 9,282

See notes to consolidated financial statements.

1. DESCRIPTION OF ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING AND REPORTING POLICIES

Organization and Business—The Moses H. Cone Memorial Hospital (the "Parent Corporation"), a nonstock, not-for-profit, parent holding company and its affiliates: The Moses H. Cone Memorial Hospital Operating Corporation (the "Operating Corporation"); ARMC Health Care (ARMC); The Moses Cone Medical Services, Inc. ("Medical Services"); The Moses Cone Physician Services, Inc. ("Physician Services"); The Moses Cone Affiliated Physicians, Inc. (MCAP); The Wesley Long Community Health Services Inc. (WLCHS); Triad Healthcare Network, LLC (THN); The Cone Health Foundation (the "Foundation"); and The Alamance Community and Health Foundation (d/b/a "Impact Alamance") were established to provide health care services and community health programs to the residents of Guilford and Alamance Counties in North Carolina, and the surrounding regional area. The organization operates as an integrated network of health services called Cone Health (the "Health System"). The Health System seeks to provide affordable and superior health care to patients through continued expansion of acute care and nonhospital programs.

On October 1, 2012, the Health System entered into a management services agreement (the "Agreement") with Charlotte-Mecklenburg Hospital Authority, which does business as Atrium Health (Atrium) (formerly Carolinas HealthCare System). Under the Agreement, the top five executives on the leadership team became employees of Atrium, but continued to manage the Health System as a local team in Greensboro, North Carolina. The Health System reimbursed Atrium for the salary and benefits costs of these executives. The terms of the Agreement also called for the Health System to pay Atrium an annual management fee based on a percentage of net revenue. The Health System continued to be governed by its local and independent board of trustees.

Effective October 1, 2019, the Health System and Atrium signed a resolution agreement with the intent to change the relationship between the parties (the "Resolution Agreement"). The Agreement was amended and restated to a new relationship arising from a services agreement (the "Service Agreement"). As a condition to the effectiveness of this Resolution Agreement, the Service Agreement terminates and supersedes the Agreement as set forth in the Services Agreement. The top executives previously employed by Atrium are now employees of the Health System effective January 1, 2020. The annual management fee will be a flat annual fee.

In May of 2016, the Operating Corporation entered into a management services agreement with Randolph Hospital, Inc. ("Randolph"), a North Carolina not-for-profit corporation located in Asheboro, North Carolina. Operating Corporation provides management assistance and support for an annual management fee based on a percentage of Randolph's annual net revenue. Randolph continues to be governed by its local and independent Board of Trustees. In October 2020, American Healthcare Systems' bid to acquire substantially all of Randolph's operating assets had received bankruptcy court approval, which closed on July 1, 2021. After the close, the Health System moved its cancer services from Randolph. Medical oncology (chemotherapy, infusion services and injections) is provided at a new temporary location in Asheboro that opened on October 4, 2021. Radiation therapy remains at

Randolph and will eventually be moved to a new facility in Asheboro housing Cone Health Cancer Center at Asheboro.

On August 12, 2020, the Health System announced that it had signed a member substitution letter of intent to merge with Norfolk, Virginia based Sentara Healthcare. The merger was intended to create a combined organization with a value-based approach focused on keeping people healthy and well, while providing high-quality, accessible and affordable health care.

On June 2, 2021, the Health System announced that Cone Health and Sentara Healthcare had mutually decided not to move forward with an affiliation initially proposed in August 2020.

The Parent Corporation—The Parent Corporation was founded through a trust established by Mrs. Bertha Lindau Cone as a memorial to her late husband, Mr. Moses H. Cone. Following the death of Mrs. Bertha Lindau Cone, the cornerstone of The Moses H. Cone Memorial Hospital was laid on May 2, 1951, and the facility opened with 53 beds on February 25, 1953, in Greensboro, North Carolina. In 1985, the Parent Corporation reorganized and created the Operating Corporation to operate its health care facilities and provide health care services to the community. The Parent Corporation retained the real estate and other noncurrent assets, while the current assets and liabilities were transferred to the Operating Corporation. The real property is leased to the Operating Corporation pursuant to a lease of 10 years. The lease was renewed effective October 1, 2017, for a one-year term with an automatic renewal clause.

The assets of the Parent Corporation primarily include an investment portfolio and the hospitals' land, buildings, and fixed equipment. Additionally, the Parent Corporation holds the long-term debt and reports the related activity associated with financing certain hospital expansion projects. The majority of cash and investments held by the Parent Corporation have been invested in securities for the purpose of funding future capital requirements. Certain assets have been classified as noncurrent in the accompanying consolidated balance sheets due to these designations.

The Operating Corporation—Acute care hospital services are provided to the community by The Moses H. Cone Memorial Hospital, Wesley Long Hospital, The Cone Behavioral Health Hospital, and Annie Penn Hospital. In February 2020, The Women's Hospital of Greensboro closed and moved into the new Cone Health Women's & Children's Center on the campus of The Moses H. Cone Memorial Hospital. The former Women's Hospital of Greensboro campus was repurposed in April 2020 through March 2021 to care for severely ill novel coronavirus (COVID-19) patients. In September 2021, the building was sold.

In addition to services at the hospitals, the Operating Corporation includes long-term care services through Penn Nursing Center, oncology services at Cone Health Cancer Center, various outpatient services at MedCenter operations in Kernersville, High Point, Greensboro, Mebane, Burlington and Reidsville, outpatient rehabilitation services, retail pharmacy services, wellness services, and various physician office practices. Annie Penn Hospital receives support from a foundation, the Annie Penn Memorial Hospital Foundation.

ARMC—ARMC was founded primarily to coordinate and support the delivery of health services in Alamance County, North Carolina, and the surrounding area. The not-for-profit affiliates of the corporation include Alamance Regional Medical Center, Inc., a not-for-profit acute care hospital; ARMC Physicians Care, Inc., an 8-practice physician group entity; Alamance Extended Care, Inc. (AEC), a continuing care retirement community which includes accommodations and services at various levels of care—independent living, assisted living, and skilled nursing care; and ARMC Foundation, Inc., a

charitable foundation. The Parent Corporation became the sole member of the ARMC entities effective May 1, 2013. On July 14, 2020, AEC sold 32 skilled care licenses to an unrelated party and on July 27, 2020 AEC sold 22 skilled care licenses to an unrelated party. There are 27 skilled bed licenses remaining with AEC. Income from the sale of the licenses of approximately $1.1 million was recognized in other nonoperating (expense) income - net on the consolidated statements of operations for the year ending September 30, 2020.

Medical Services, Physician Services, and MCAP—These entities provide both administrative and clinical services to support Cone Health physician-related strategic initiatives. Services provided by these entities includes numerous specialty, primary care, ancillary and hospitalist services.

THN—THN is a clinically integrated network of community physicians and the Health System organized to improve health care in Guilford County, Alamance County, and the surrounding region through care management, evidence-based medical practices, and integrated information and data systems. THN is a designated accountable care organization.

The Foundation and Impact Alamance—The Foundation operates as a charitable foundation created to support and promote community health programs in concert with the Health System. The Foundation was capitalized with $50 million received in October 1997 from the Health System and $60 million received from the Health System in April 1999. In connection with the acquisition of ARMC, the Health System established Impact Alamance with a contribution of $54 million to support and promote community health programs in Alamance County in concert with other Health System activities. The grant activities of the Foundation and Impact Alamance are not considered core to the provision of health care services and therefore are included in nonoperating expense—net in the accompanying consolidated statements of operations.

WLCHS—WLCHS is a holding company for the Health System's taxable subsidiaries, including:

Care N' Care Insurance Company of North Carolina, Inc. (CNCNC)—CNCNC was established in 2015 as an 80% owned entity licensed to provide health insurance in North Carolina, with the remaining 20% held by an unaffiliated entity. CNCNC, in partnership with THN providing patient care management functions, provides insurance coverage through a Medicare Advantage plan called "Health Team Advantage". On August 31, 2017, the Health System purchased the remaining 20% ownership in CNCNC from the noncontrolling interest holder for $17.6 million.

Wellsmith LLC—Wellsmith LLC was organized in December 2015 as a 50% owned entity for the purpose of developing and licensing of proprietary technology for a web-based chronic disease management portal and consumer application. Wellsmith LLC is reported on a consolidated basis due to the Health System's majority control of the Wellsmith LLC board of directors. As of March 12, 2020, $10.7 million of debt was converted to equity, increasing WLCHS' ownership percentage to 76.96%. In October 2020, the Health System decided to end the relationship with Wellsmith and the company is in the process of being dissolved.

Insurance Casualty and Risk Enterprise, LTD—On August 14, 2017, the Health System created Insurance Casualty and Risk Enterprise, LTD, ("iCare"), a limited liability tax-exempt entity incorporated in the Cayman Islands, for the purpose of providing risk financing and claims management services to the Health System for medical malpractice and general liability claims up to the self-insured limit of $4 million per claim. The coverage was effective beginning October 1, 2017. iCare is domiciled in the Cayman Islands and regulated by the Cayman Islands Monetary Authority.

Principles of Consolidation—The consolidated financial statements include all subsidiaries for which the Health System has a controlling financial interest. All intercompany balances and transactions have been eliminated in consolidation.

Basis of Presentation—The consolidated financial statements of the Health System have been prepared on the accrual basis in conformity with U.S. generally accepted accounting principles (GAAP) and with the provisions of the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958, *Not-for-Profit Entities*.

Based on the existence or absence of donor-imposed restrictions, the Health System classifies resources into two categories: without donor restrictions and with donor restrictions.

Net assets without donor restrictions are free of donor-imposed restrictions. All revenues, gains, and losses that are not restricted by donors are included in this classification. All expenses are reported as decreases in net assets without donor restrictions. Net assets with donor restrictions are subject to donor-imposed restrictions that will be met either by actions of the Health System or the passage of time. These net assets include donor restricted endowments and unconditional pledges. Generally, donor-imposed restrictions of these assets permit the Health System to use all or part of the income earned on related investments only for certain general or specific purposes.

Expirations of donor restrictions on net assets (i.e., the donor stipulated purpose has been fulfilled and/or the stipulated time period has elapsed) are reported as net assets released from restrictions in the consolidated statements of changes in net assets.

Contributions which impose restrictions that are met in the same fiscal year they are received are reported as increases in net assets without donor restrictions.

Excess of revenues over expenses from consolidated operations reflect all transactions that change net assets without donor restrictions, except for contributions for capital improvements, investment return in excess of or less than amounts designated for current operations, nonperiodic changes in defined benefit plans, changes in the fair value of derivative financial instruments, losses on the extinguishment of debt, and certain nonrecurring items.

Use of Estimates—The preparation of consolidated financial statements in conformity with GAAP 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 and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents—Cash and cash equivalents include demand deposits and certain investments in highly liquid debt instruments with original maturities at the time of purchase of three months or less.

Short-Term Investments—Short-term investments include certain investments in mutual fund securities that are expected to be used in current operations.

Inventories—Inventories are stated at the lower of cost (first-in, first-out method) or net realizable value. Inventories include medical and surgical supplies and pharmaceuticals.

Long-Term Investments—Investments in equity securities with readily determinable fair values, investments in common/commingled/collective trusts, and all investments in debt securities are measured at fair value in the accompanying consolidated balance sheets.

Interests in alternative investments, whose operating and financial policies the Health System's management has virtually no influence over, are measured at market value in the accompanying consolidated balance sheets. Investment income (including realized gains and losses on investments, interest, and dividends) is included in excess of revenues over expenses in the accompanying consolidated statements of operations. Changes in unrealized gains and losses on equity investments are included as investment income in the accompanying consolidated statements of operations.

The Health System periodically evaluates investments that have declined below original cost to determine if the decline is other than temporary. If the investment decline in value below cost is determined to be other than temporary, the loss is recorded as a realized loss.

Assets Limited as to Use—Assets limited as to use include cash and investments held by the trustee under bond indenture agreements and certain long-term investments. The long-term investments include investments held by CNCNC required by regulators and investments designated to support and promote community health programs for the Foundation, Annie Penn Foundation, Impact Alamance, and ARMC Foundation. Assets limited as to use that are required for settlement of current liabilities are reported in current assets.

Other Current Assets—Other current assets consist primarily of third-party receivables, prepaid expenses, and sales tax receivables.

Contract liabilities—Contract liabilities includes Medicare advance payments under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and reservation deposits and nonrefundable portion of entrances fees paid by residents of AEC. The entrance fees vary according to the type and size of the residence and contract type. When the residents take occupancy, the nonrefundable portions are recognized as revenue based on amortization over the life expectancy of each resident in the independent living units.

Property and Equipment—Property and equipment are recorded at cost or, if donated, at fair market value at the date of receipt. Depreciation is recorded over the estimated useful life of each class of depreciable assets and is computed using the straight-line method for financial reporting purposes.

In accordance with ASC 360, *Property, Plant, and Equipment*, the Health System reviews its long-lived assets and certain identifiable intangibles for evidence of impairment whenever events or changes in circumstances indicate that the carrying amount of the assets may not be recoverable. See *Asset Impairment* below for information related to adjustments to carrying value of intangible assets in fiscal year 2020.

In 2018, the Health System began construction on the Cone Health Women's and Children's Center at Moses Cone Hospital, a new facility for women's and children's services on the Campus of Moses Cone Hospital. Upon completion of the facility in February 2020, the Health System moved clinical operations of the Women's Hospital to the new facility. As a result of the transfer of operations out of the Women's Hospital, the Health System determined the useful life of the Women's Hospital assets would end at the end of fiscal year 2020. The Health System recorded accelerated depreciation expense associated with the new useful life of the assets of $2.7 million for the year ended September 30, 2020.

In July 2020, AEC sold a portion of their bed licenses to operate skilled nursing home beds. There is no plan to continue to operate the skilled nursing home known as Edgewood Place, which is a division of AEC. Therefore, depreciation was accelerated so that all remaining equipment and real property were

fully depreciated. The depreciation on the equipment was $0.4 million and the real property was $5.4 million for the year ended September 30, 2020.

Right of Use Assets—Right of use assets represent the Health System's right to use the underlying assets for the lease term.

Goodwill—Goodwill represents the excess of purchase price over the assigned value of the net assets of acquired entities. Goodwill is assessed annually for impairment, or more frequently if events or circumstances indicate that assets might be impaired, by applying a fair value-based test. The Health System performed its annual goodwill impairment test as of September 30, 2021 and concluded there was no impairment of goodwill. During 2020, $0.3 million of goodwill was written off related to the sale of Advanced Home Care.

Noncontrolling Interests—Noncontrolling interests represent the minority stockholders' proportionate share of the net assets of certain consolidated subsidiaries. Revenues in excess of expenses are allocated to the noncontrolling interests in proportion to their ownership percentage and are reflected as (excess) of revenue over expenses attributable to noncontrolling interests in the consolidated statements of operations.

Impacts of COVID-19 Pandemic on Operations—In March 2020, the World Health Organization declared the outbreak of COVID-19 as a pandemic which continues to spread throughout the United States and the world. As a result of this pandemic and in an effort to preserve resources for patients infected with COVID-19, the Health System ceased elective surgeries from mid-March to May 2020, resulting in significant unexpected revenue declines during that period.

The CARES Act provided funding to the Department of Health and Human Services (DHHS) Public Health and Social Services Emergency Fund (Relief Fund), which provided funds to qualifying healthcare providers treating COVID-19 patients to replace lost revenues or reimburse for COVID-19 related costs. The Health System received approximately $28.1 million and recorded approximately $34.2 million of revenue from the Relief Fund within Other Revenue in the accompanying consolidated statements of operations in fiscal year 2021. The Health System received approximately $58.3 million and recorded approximately $52.2 million of revenue from the Relief Fund within Other Revenue in the accompanying consolidated statements of operations in fiscal year 2020. The unrecognized funds are recorded in current portion of contract liability in the accompanying consolidated balance sheets. Qualifying Relief Fund payments are subject to repayment if not supported by equivalent lost revenue and COVID-19 related costs and there are certain terms and conditions that must be met in order to qualify for the grant funds. The Health System expects to be qualified to retain substantially all payments received. Additionally, in 2020, DHHS Centers for Medicare and Medicaid Services (CMS) provided approximately $140.4 million of Medicare advance payments to the Health System, which are recorded in cash and current portion of contract liability in the accompanying consolidated balance sheets as of September 30, 2020; these advances are to be recouped by partial withholding on remittances beginning within one year of receipt. During 2021, $25.6 million of Medicare advance payments have been recouped and approximately $114.9 million are recorded in cash and short term investments and current portion of contract liability in the accompanying consolidated balance sheets as of September 30, 2021.

The Federal Emergency Management Agency (FEMA) provided funding through the State of North Carolina to reimburse certain non-profit entities for actions due to the COVID-19 pandemic to save lives or protect public health and safety. The Health System recorded approximately $9.6 million in other revenue in the accompanying consolidated statements of operations for the year ended September 30,

2020 relating to FEMA funding. Revenue recognized during the year ended September 30, 2020 that FEMA determined did not meet the reimbursement criteria was reversed during the year ended September 30, 2021, and accordingly the Health System recorded this reversal of approximately ($6.3) million net in other revenue in the accompanying consolidated statements of operations for the year ended September 30, 2021.

Beginning in fiscal year 2021, the Department of Health and Human Services (DHHS) began reimbursing providers the administrative costs of administering COVID-19 vaccinations and testing. The Health System recorded approximately $12.6 million for vaccinations and $4.8 million for testing in Other Revenue in the accompanying consolidated statements of operations for the year ended September 30, 2021.

The coronavirus pandemic continues to evolve, therefore the future impact to financial and operating results cannot be reasonably estimated at this time. However, should the pandemic intensify, the Health System may experience supply chain disruptions, including delays and price increases in equipment, pharmaceuticals, and medical supplies due to the pandemic. Staffing, equipment and pharmaceuticals and medical supplies shortages may impact our ability to admit and treat patients. The Health System has incurred, and may continue to incur, increased expenses arising from the COVID-19 pandemic, including additional supply chain and other expenditures.

Net Patient Service Revenue—Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Charity Care—The Health System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Health System does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Other Revenue—Other revenue consists of cafeteria revenue, childcare center revenue, contract pharmacy revenue, lease income and other non-patient-related revenues. Additionally, revenues on restricted grant funds are recognized only to the extent of expenditures that satisfy the restricted purpose of these grants. For the year ended September 30, 2021, grant revenue of $48.9 million, which includes $45.3 million COVID-19 funds described above, is included in other revenue in the accompanying statements of operations. For the year ended September 30, 2020, grant revenue of $65.6 million, which includes $61.8 million COVID-19 funds described above, is included in other revenue in the accompanying statements of operations.

Premium Revenue—CNCNC generates premium revenue from members enrolled in its Medicare Advantage Plan and the related revenue is recognized in the month in which members receive health care services.

Claims Expense—Claims expense related to insurance coverage offered by CNCNC is recognized in the period in which services are provided and includes an actuarially determined estimate of the cost of services which have been incurred but not yet reported (IBNR). Claims expense totaled $161.9 million and $128.1 million for the years ended September 30, 2021 and 2020, respectively, and is included in other direct expenses in the accompanying consolidated statements of operations.

The liability for unpaid health claims and IBNR was $18.1 million and $16.0 million as of September 30, 2021 and 2020, respectively, and associated medical claims payable was $0.8 million and $0.5 million as of September 30, 2021 and 2020, respectively. These balances are included in accrued expenses in the accompanying consolidated balance sheets. Such estimates are based on the most current historical claims experience of previous payments, changes in number of members, and estimates of health care trend (cost, utilization, and intensity of services) changes. Revisions in the estimate of IBNR claims are reflected in the accompanying consolidated statements of operations in the year the changes occur.

Grant Expense—The Foundation and Impact Alamance record grants as expense in the period in which the grants are authorized. Grant expense incurred by the Foundation and Impact Alamance of approximately $6.2 million and $1.8 million in fiscal years 2021 and 2020, respectively, is included in other nonoperating income—net in the accompanying consolidated statements of operations.

Estimated Malpractice Costs—The provision for estimated medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred, but not reported. These costs are included in accrued expenses and other noncurrent liabilities on the accompanying consolidated balance sheets.

Excess of Revenues over Expenses—Changes in net assets without donor restrictions, which are excluded from excess of revenues over expenses, include inherent contributions, unrealized gains and losses on investments and hedging derivative instruments, permanent transfers of assets to and from affiliates for other than goods and services, pension-related changes other than net periodic pension cost, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets).

Income Taxes—All Health System entities, with the exception of WLCHS, its subsidiaries and iCARE, have been recognized by the Internal Revenue Service as tax exempt under Internal Revenue Code 501(c)(3). As of September 30, 2021, and 2020, the Health System had no uncertain tax positions under FASB ASC 740, *Income Taxes*, requiring adjustments to its consolidated financial statements. The Health System does not expect that unrecognized tax benefits will materially increase within the next 12 months. Interest and penalties related to uncertain tax positions, if any, would be reported in the consolidated financial statements as income tax expense. Fiscal years 2018 through 2020 are subject to examination by the federal and state taxing authorities. There are no income tax examinations currently in process.

Fair Value Measurements—The Health System uses the framework established by the FASB for measuring fair value and disclosures about fair value measurements. The Health System uses fair value measurements in areas that include, but are not limited to, the valuation and impairment of short-term and long-term investments and financial instruments, including derivatives.

US GAAP defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants at the measurement date. Additionally, the inputs used to measure fair value are prioritized based on a three-level hierarchy. This hierarchy requires entities to maximize the use of observable inputs and minimize the use of unobservable inputs. The three levels of inputs used to measure fair value are as follows:

Level 1—Valuations based on unadjusted quoted prices for identical instruments in active markets that are available as of the measurement date

Level 2—Valuations based on quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement

US GAAP permits, as a practical expedient, a reporting entity to measure the fair value of certain investments without readily determinable fair values by using the reported net asset value (NAV) per share of the investment without further adjustment if the investment is in an entity that meets the description of an investment company whose underlying investments are measured at fair value as set forth in the ASC.

Transfers between Levels—The availability of market observable data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or valuation methodologies may require the transfer of financial instruments from one fair value hierarchy level to another. The Health System evaluates the significance of transfers based on the nature of the financial instrument and the size of the transfer.

Debt Issuance Costs—Debt issuance costs consist of underwriting costs, legal expenses, insurance, and other direct costs incurred in connection with the issuance of long-term debt. Such costs are reported within long-term debt in the consolidated balance sheets and amortized over the term of the bonds.

Valuation methods for the primary fair value measurements disclosed below are as follows:

Cash Equivalents, Patient and Other Receivables, and Accounts Payable—The carrying amount approximates fair value because of the short maturity of these instruments.

Investments—The Health System's investments in equity securities and debt and equity mutual funds are stated at fair value based on unadjusted quoted prices for identical assets in active markets that are available as of the measurement date. Investments in common/commingled/collective trusts, and alternative investments, which are recorded at fair value in the consolidated balance sheets, are generally measured using the NAV per share reported by the respective fund managers or the general partners.

The estimated fair values of certain alternative investments, such as private equity interests, are based on valuations performed prior to the consolidated balance sheet date by the external investment managers and adjusted for cash receipts, cash disbursements, and securities distributions through September 30. Because alternative investments are not readily marketable, their estimated fair value is subject to uncertainty and, therefore, may differ from the value that would have been used had a ready market for such investments existed. Such differences could be material.

The Health System's management, with the assistance of a third-party investment consultant, where appropriate, evaluates the NAV information and valuations provided by external fund managers or general partners for appropriateness through review of the most recently available annual audited financial statements and unaudited interim reporting for the respective funds, review of the methodologies used to determine fair value, and comparisons of fund performance to market benchmarks.

Interest Rate Swaps—The Health System is a party to three interest rate swap agreements. Swaps with negative values of $24.1 million and $45.5 million as of September 30, 2021 and 2020, respectively, are recorded in accrued expenses in the consolidated balance sheets. There were no swaps with positive

values as of September 30, 2021 and 2020. Interest rates swaps designated as cash flow hedges were assessed for effectiveness at inception of the contracts and on an ongoing basis thereafter. Unrealized gains and losses related to the effective portion of the swaps are recognized in other changes in net assets without restriction and gains or losses related to ineffective portions are recognized in the excess of revenue over expenses from consolidated operations. The unrealized gains and losses of interest rate swaps not designated as cash flow hedges are recognized within investment income on consolidated statements of operations.

The swaps are measured at fair value using pricing models, with all significant inputs derived from, or corroborated by, observable market data, such as interest rates, futures pricing, and volatility metrics, and accordingly are included in Level 2 of the fair value hierarchy.

In October 2005, the Health System entered into a floating-to-fixed swap agreement with a notional amount of $85.2 million for 30 years to hedge the floating-rate 2001 Series bonds. Under this agreement, the Health System receives a floating interest rate based on the three-month London InterBank Offered Rate (LIBOR) index and pays a fixed interest rate of 3.437%. The Series 2001 swap was considered effective on September 30, 2021 and 2020, and $6.8 million unrealized gain and $4.0 million unrealized loss, respectively, was reported in other changes in net assets without restriction. This resulted in a corresponding cumulative liability of $17.3 million and $24.1 million, respectively, included in accrued expenses on the accompanying consolidated balance sheets.

In August 2013, the Health System entered into a floating-to-fixed swap agreement with a notional amount of $48 million for 22 years to hedge the floating-rate 2011B Series bonds. Under this agreement, the Health System receives a floating interest rate based on the one-month LIBOR index and pays a fixed interest rate of 2.097%. The Series 2011B swap was considered effective on September 30, 2021 and 2020, and $2.0 million unrealized gain and $1.6 million unrealized loss, respectively, was reported in other changes in net assets without restriction, resulting in a corresponding cumulative liability of $3.0 million and $5.0 million, respectively. Should the fair value of the Series 2011B interest rate swap exceed negative $50 million, the Health System would be required to post collateral against the swap for amounts in excess of the $50 million threshold.

On October 6, 2016, the Health system entered into an interest rate swap agreement with a notional amount of $100 million, a forward starting date of October 1, 2018, and a maturity date of October 1, 2048, to hedge the expected issuance of variable-rate debt in fiscal 2018 to fund construction projects. The Health System pays a fixed rate of 1.336% and receives a variable rate of 70% of the one-month LIBOR index rate. The fair value of the swap of $3.7 million and $16.3 million as of September 30, 2021 and 2020, respectively, is included in other current assets in the consolidated balance sheet. In December 2017, the Health System issued $60 million of variable rate debt. At that time, the Health System de-designated $40 million of the interest rate swap. On September 30, 2021 and 2020, the remaining $60 million of the Series 2018A swap still designated as a cash flow hedge was considered effective. On September 30, 2021, the Health System reported realized gain of $3.8 million in investment income and $16.4 million in other changes in net assets without restriction. At September 30, 2020, the Health System reported realized loss of $5.0 million in investment income and $(12.3) million in other changes in net assets without restriction.

Asset Impairment—During 2018, Wellsmith LLC began developing an updated version of the company's proprietary technology for a web-based chronic disease management portal and consumer application. During 2020, management determined that the existing technology will not be marketed for sale or licensing. Accordingly, Wellsmith LLC's product does not provide future cash flows; and therefore, an

impairment charge to the software asset of $4.6 million was recorded and reported within other nonoperating expense—net in the consolidated statements of operations for the years ended September 30, 2020. No impairments were recorded during the year ended September 30, 2021.

Subsequent Events—The Health System evaluated events and transactions for potential recognition or disclosure through January 24, 2022, the date the consolidated financial statements were issued. On November 23, 2021, the Health System received approximately $10.6 million from the American Rescue Plan. On December 16, 2021, the Health System received $3.3 million from the CARES Act.

New Accounting Pronouncements

In August 2017, the FASB issued ASU No. 2017-12, *Targeted Improvements to Accounting for Hedging Activities* ("ASU 2017-12"), which is intended to better align risk management activities and financial reporting for hedging relationships. The new standard eliminates the requirement to separately measure and report hedge ineffectiveness and generally requires the entire change in the fair value of a hedging instrument to be presented in the same income statement line as the hedged item. It also eases certain documentation and assessment requirements. ASU 2017-12 is effective for fiscal years beginning after December 15, 2019, and interim periods within fiscal years beginning after December 15, 2020. Early adoption is permitted. The adoption of this standard had no material impact on the Hospital System's consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework—Changes to the Disclosure Requirement for Fair Value Measurement ("*ASU 2018-13"*).* This update focuses on improving the effectiveness of disclosures in the notes to the financial statements by facilitating clear communication of the information required by U.S. GAAP that is most important to users of each entity's financial statements. Specifically certain disclosure requirements are removed (the amount of, and reasons for, transfer between Level 1 and Level 2 of the fair value hierarchy; the policy for timing of transfers between levels; the valuation processes for Level 3 fair value measurements) while it modifies and adds certain other disclosures (the changes in unrealized gains and losses for the period included in other comprehensive income for recurring Level 3 fair value measurements held at the end of the reporting period, and the range and weighted average of significant unobservable inputs used to develop Level 3 fair value measurements). The amendments regarding changes in unrealized gains and losses, the range and weighted average of significant unobservable inputs used to develop Level 3 fair value measurements, and the narrative description of measurement uncertainty should be applied prospectively for only the most recent period in the initial fiscal year of adoption. All other amendments should be applied retrospectively to all periods presented upon their effective date. ASU 2018-13 is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The adoption of this standard had no material impact on the Hospital System's consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-15, *Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract* (ASU 2018-15). The amendment addresses customer's accounting for implemented costs incurred in a cloud computing arrangement that is a service contract and aims to reduce complexity in the accounting for costs of implementing a cloud computing service arrangement. The amendments require a customer in a hosting arrangement that is a service contract to determine which implementation costs to capitalize as an asset related to service contract and which costs to expense. Additionally, it requires the customer to expense the capitalized implementation costs over the term of the hosting arrangement. ASU 2018-15 is effective for fiscal

years, and interim periods within those fiscal years, beginning after December 15, 2019. The Health System adopted ASU 2018-15 using a prospective approach and the adoption of this standard had no material impact on its consolidated financial statements.

In October 2018, the FASB issued ASU No. 2018-16, *Derivatives and Hedging (Topic 815): Inclusion of the Secured Overnight Financing Rate, Overnight Index Swap Rate as a Benchmark Interest Rate for Hedge Accounting Purposes* ("ASU 2018-16"), which provides guidance on risks associated with financial assets or liabilities permitted to be hedged. ASU 2018-16 is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted but FASB requires this standard to be adopted concurrently with ASU 2017-12. The adoption of this standard had no impact on the Health System's consolidated financial statements.

In November 2018, the FASB issued ASU 2018-18, *Collaborative Arrangements (Topic 808): Clarifying the Interaction between Topic 808 and Topic 606* ("ASU 2018-18"), which provides guidance on whether certain transactions between collaborative arrangement participants should be accounted for with revenue under Topic 606. The provisions of this update are to be applied retrospectively to the date of the initial application of Topic 606. The provisions of ASU 2018-18 are effective for reporting periods beginning after December 15, 2019, and interim periods within those fiscal years. The adoption of this standard had no impact on the Health System's consolidated financial statements.

In March 2021, the FASB issues ASU 2021-03, *Intangibles – Goodwill and Other (Topic 350): Accounting Alternative for Evaluation Triggering Events* ("ASU 2021-03"), which provides an accounting alternative to perform the goodwill impairment triggering event evaluation. ASU 2021-03 is effective on a prospective basis for fiscal years beginning after December 15, 2019. ASU 2021-03 should not be retroactively adopted for interim financial statements already issued in the year of adoption. The adoption of this standard had no impact on the Health System's consolidated financial statements

In January 2021, the FASB issued ASU 2021-01, *Reference Rate Reform (Topic 848)*, which clarifies that certain optional expedients and exceptions in Topic 848 for contract modifications and hedge accounting apply to derivatives that are affected by the discounting transition. The amendments in ASU 2021-01 were effective immediately for all entities. The adoption of this standard had no impact on the Health System's consolidated financial statements.

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* ("ASU 2016-13"). ASU 2016-13 provides guidance regarding the treatment of expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. ASU 2016-13 is effective for fiscal years beginning after December 15, 2019, including interim periods within those fiscal years. The adoption of this standard had no impact on the Health System's consolidated financial statements.

Not Yet Adopted— In January 2017, the FASB issued ASU 2017-04, *Intangibles—Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment* ("ASU 2017-04"). ASU 2017-04 simplified the subsequent measurement of goodwill by eliminating Step 2 from the goodwill impairment test. ASU 2017-04 is effective for fiscal years beginning after December 15, 2021. Early adoption is permitted for interim or annual goodwill impairment tests performed on dates after January1, 2017. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In October 2018, the FASB issued ASU No. 2018-17, *Consolidation (Topic 810): Targeted Improvements to Related Party Guidance for Variable Interest Entities* ("ASU 2018-17"), which allows a reporting entity to not apply VIE guidance to legal entities under common control if both the parent and the legal entity being evaluated for consolidation are not public business entities. The provisions of this update are to be applied retrospectively with a cumulative-effect adjustment to retained earnings. ASU 2018-17 is effective for fiscal years beginning after December 15, 2021. Early adoption is permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-14, *Compensation—Retirement Benefits—Defined Benefit Plans (Subtopic 715-20): Disclosure Framework—Changes to the Disclosure Requirements for Defined Benefit Plans* ("ASU 2018-14"), which is intended to identify and modify the disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. The provisions of this update are to be applied using a modified retrospective approach. ASU 2018-14 is effective for fiscal years beginning after December 15, 2021. Early adoption is permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In November 2019, the FASB issued ASU 2019-10, *Financial Instruments: Credit Losses (Topic 326), Derivatives and Hedging (Topic 815), and Leases (Topic 842)*, which addresses feedback regarding implementation challenges when adopting a major update. The FASB developed a philosophy to extend and simplify how effective dates are staggered between larger public companies and all other entities. ASU 2019-10 is effective for fiscal years beginning after December 15, 2020. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In November 2019, the FASB issued ASU 2019-11, *Codification Improvements to Topic 326, Financial Instruments: Credit Losses* ("ASU 2019-11"), which clarifies or addresses specific issues about certain aspects in ASU 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* ("ASU 2016-13") issued by FASB in June 2016. ASU 2016-13 provides guidance regarding the treatment of expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. ASU 2016-13 is effective for fiscal years beginning after December 15, 2022, including interim periods within those fiscal years. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In September 2020, the FASB issued ASU 2020-07, *Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets* ("ASU 2020-07"), which increases transparency of contributed nonfinancial assets for not-for-profit entities through enhancements to presentation and disclosures. The amendments in ASU 2020-07 are effective for fiscal years beginning after June 15, 2021 and should be applied on a retrospective basis. Early adoption is permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In July 2021, the FASB issued ASU 2021-05, *Lessors – Certain Leases with Variable Lease Payments (Topic 842)* ("ASU 2021-05"), which amends the lessor lease classification in Accounting Standards Codification ("ASC") 842 for leases that include variable lease payments that are not based on an index or rate. Under the amended guidance, lessors will classify a lease with variable payments that do not depend on an index or rate as an operating lease if the lease would have been classified as a sales-type lease or a direct financing lease under the previous ASU 842 classification criteria, and sales-type or direct financing lease classification would result in a Day 1 loss. ASU 2021-05 is effective for annual

periods beginning after December 15, 2021, and interim periods therein, with early adoption permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In October 2021, the FASB issued ASU 2021-08, *Business Combinations (Topic 805) – Accounting for Contract Assets and Contract Liabilities from Contracts with Customers* ("ASU 2021-08"), which requires that an entity recognize and measure contract assets and contract liabilities acquired in a business combination in accordance with Topic 606 and account for the related revenue contracts in accordance with Topic 606 as if it had originated the contacts. The amendments in ASU 2021-08 are effective for fiscal years beginning after December 15, 2022, including interim periods within those fiscal years. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In November 2021, the FASB issued ASU 2021-09, *Leases – Discount Rate for Lessees That Are Not Public Business Entities (Topic 842)* ("ASU 2021-09"), which allows lessees to make the risk-free rate election by class of underlying asset, rather than at the entity-wide level. The amendments in ASU 2021-09 are effective for fiscal years beginning after December 15, 2021, and interim periods within fiscal years beginning after December 15, 2022. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

2. OPERATING REVENUE

Net patient service revenue is reported at the amount reflecting the consideration to which the Health 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 includes variable consideration for retroactive adjustments under reimbursement agreements with third-party payors. Generally, the Health System bills patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Health System. For most services, revenue is recognized over time as the customer simultaneously receives and consumes the benefits of the services when provided. Performance obligations for outpatient services and physician office visits are generally satisfied over a period of less than one day. Revenue for performance obligations satisfied over more than one day, such as inpatient hospital services, is recognized based on charges incurred in relation to total expected (or actual) charges. The Health System believes this method provides a faithful depiction of the transfer of services to the patient. Revenue for performance obligations satisfied at a point in time, such as retail pharmacy prescriptions, is recognized when the goods are provided to the customer.

The Health System determines the transaction price based on its 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 Health System's policy, and implicit price concessions provided to uninsured patients and insured patients with copayment obligations. The Health System determines its estimates of contractual adjustments, discounts, and implicit price concessions based on contractual agreements, its discount policies, and historical experience. In determining these estimates, the Health System uses a portfolio approach as a practical expedient by accounting for patient contracts with common characteristics as collective groups rather than individually. The financial statement effects of using this practical expedient are not materially different from an individual contract approach.

Through its Triad Healthcare Network (THN) accountable care organization (ACO), the Health System enters into risk-based agreements with third-party payors for the care of various populations of patients. These arrangements represent potential variable consideration for the underlying contracts with patients and are considered in determining the transaction price for those contracts. As a participant in Medicare's Next Generation ACO Model, THN receives a benchmark spending target for Medicare patients in its network. If actual Medicare spending for these patients is less than the benchmark, THN shares in the savings with the federal government. Conversely, if spending is above the benchmark, THN must reimburse the federal government for the excess. THN also participates in similar risk agreements with insurers operating Medicare Advantage and Commercial insurance plans. Benchmark spending under these agreements varies with the premiums received as adjusted by patient risk factors and network quality measures.

The Health System has agreements with government and third-party payors that provide for payments to the Health System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors is as follows:

Medicare—Inpatient acute care services rendered to Medicare program beneficiaries are paid primarily at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors and cover both operating and capital costs. Outpatient services are generally reimbursed at prospectively determined rates. The Health System is reimbursed for cost-reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports by the Health System and audits thereof by the Medicare Administrative Contractor. The Health System's classification of patients under the Medicare program and the appropriateness of their admission are subject to review by an independent quality review organization.

The Health System's Medicare cost reports have been audited by the Medicare Administrative Contractor through September 30, 2016.

Medicaid—Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services were reimbursed based on 70% of actual costs incurred through June 30, 2021. The Health System's Medicaid cost reports have been settled through September 30, 2017.

Effective July 1, 2021, North Carolina changed its Medicaid program and moved most Medicaid beneficiaries to managed care plans. These managed care plans, known as Prepaid Health Plans, receive premium payments from the State based on enrolled beneficiaries and contract with hospitals and other providers of patient services. Rates paid to providers are subject to state-mandated floors that approximate the totals paid under the preceding Medicaid program. This includes the supplemental payments previously made through the Medicaid Reimbursement Initiative and GAP Assessment Plan described below, which are not available under a managed care program and therefore ended as of July 1, 2021.

Net revenue from the Medicare and Medicaid programs accounted for 13.8% and 11.9%, respectively, of the Health System's net patient service revenue for the year ended September 30, 2021, and 15.5% and 11.1%, respectively, of the Health System's net patient service revenue for the year ended September 30, 2020. Recorded estimates are subject to change as a result of complex laws and regulations governing the Medicare and Medicaid programs, which are subject to interpretation. In addition, Medicare Advantage plans accounted for 23.5% of net revenue for the year ended September 30, 2021, and 21.0% of net revenue for the year ended September 30, 2020. Medicare

beneficiaries may elect coverage through these plans that are based on Medicare benefit and payment terms but marketed and administered by commercial insurers.

The Health System has participated in the North Carolina Medicaid Reimbursement Initiative (the "MRI Plan") since 1996. In connection therewith, the Health System received and recognized as patient service revenue $25.3 million and $11.0 million from the MRI Plan during the years ended September 30, 2021 and 2020, respectively.

Beginning in 2012, the Health System began participating in the North Carolina Gap Assessment Plan (the "GAP Plan"). The GAP Plan is designed to fund hospitals for a portion of unreimbursed costs of treating Medicaid and uninsured patients. Under the GAP Plan, hospitals periodically pay an assessment to the state of North Carolina (the "State") and periodically receive Medicaid payments from the State. The total assessment payments made by the Health System were $24.1 million and $33.8 million for the years ended 2021 and 2020, respectively, and are reported as other direct expenses in the accompanying consolidated statements of operations. The total GAP Plan receipts for the Health System were $66.6 million and $93.4 million for the years ended 2021 and 2020, respectively, and are reported in patient service revenue (net of contractual adjustments) in the accompanying consolidated statements of operations.

Under the Medicare and Medicaid programs, the Health System is entitled to reimbursements for certain patient charges at rates determined by federal and state governments. Differences between established billing rates and reimbursements from these programs are recorded as contractual adjustments to arrive at net patient service revenue. Final determination of amounts due from Medicare and Medicaid programs is subject to review by these programs. Changes resulting from final determination are reflected as changes in estimates, generally in the year of determination. In the opinion of management, adequate provision has been made for any adjustments that may result from such reviews. Net patient service revenue increased approximately $6.0 million and $6.7 million for the years ended September 30, 2021 and 2020, respectively, due to prior-year retroactive adjustments that differed from amounts previously estimated.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters, such as licensure, accreditation, and government health care participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse statutes and/or regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Health System is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Commercial and Other Third-Party Payors—The Health System has entered into contracts with third-party payors providing coverage for individuals in its service area. Payment arrangements within these contracts include per case or per diem rates or amounts based on a percentage of Medicare payment or the Health System's charges. Payment rates vary based on coverage criteria established by the third-party payors and the products and copayment terms applicable to specific insured groups or individuals.

Charity Care—The Health System provides charity care to patients who are financially unable to pay for the health care services received and who are unable to access federal or state entitlement programs. The Health System does not pursue collection of amounts determined to qualify as charity care and does not report such amounts as revenue. Uninsured patients whose total annual household income is at or below 200% of the federal poverty level may be eligible for charity care. Uninsured patients whose income exceeds 200% of the federal poverty level also may be eligible for charity care if incurred charges are beyond the patient's ability to pay. The federal poverty level is established by the federal government and is based on income and family size. The Health System provided charity care at an estimated cost of approximately $91.9 million and $105.7 million for the years ended September 30, 2021 and 2020, respectively. The estimated costs of providing charity services are calculated based on the ratio of cost to charges from the Health System's consolidated financial statements applied to each period's gross uncompensated charges for charity care patients.

The composition of net patient service revenue by primary payor class for the years ended September 30, 2021 and 2020, is as follows (in thousands of dollars):

	2021	2020
Medicare and Medicare Advantage	$ 850,930	$ 759,765
Medicaid	255,782	215,233
Third-party payors	1,065,165	999,513
Self-pay	32,689	37,102
Net patient service revenue	$2,204,566	$2,011,613

The composition of net patient service revenue by primary service category for the years ended September 30, 2021 and 2020, is as follows (in thousands of dollars):

	2021	2020
Inpatient hospital services	$ 909,744	$ 801,312
Outpatient hospital services	819,956	759,596
Professional services	323,053	284,730
Long term care	18,465	28,855
Retail pharmacy	75,750	67,992
THN risk share revenue	57,598	69,128
Net patient service revenue	$2,204,566	$2,011,613

Other revenues for which performance obligations are satisfied at a point in time primarily include the provision of goods to customers such as pharmacy prescriptions, cafeteria and nursing home resident meals, and other goods. Services provided over time include medical services provided under contract to other entities, administrative and care management services provided by Triad Healthcare Network, management, and other services. Revenues from grants and rentals are not within the scope of ASC 606. Grant revenues are generally considered conditional promises to give and are recognized as conditions on which they depend are substantially met. Rental revenues, representing the Health System's lease of properties to third parties, are recognized over the lease term.

Amounts related to services provided to patients which do not meet the conditions of unconditional rights to payment at the end of the reporting period are contract assets. As of September 30, 2021, and 2020, the Health System did not have any contract assets.

3. LIQUIDITY AND AVAILABILITY

At September 30, 2021, financial assets available for general expenditures within one year of the balance sheet date, are as follows (in thousands of dollars):

	2021	2020
Cash and cash equivalents	$ 221,765	$ 328,671
Short-term investments	147,096	26,688
Patient receivables, net	236,777	175,625
Investments available to be liquidated	726,718	737,736
Financial assets available within one year	$ 1,332,356	$ 1,268,720

To help manage unanticipated liquidity needs, the Health Plan has committed lines of credit with a total borrowing capacity of $50 million at September 30, 2021 which it could draw upon.

The asset allocation of the Health Plan's investment portfolio is broadly diversified and is designed to maximize the probability of achieving the Health Plan's long-term investment objectives at an appropriate level of risk, while maintaining a level of liquidity to meet the needs of ongoing portfolio management. The nature of certain investments restricts the liquidity and availability of these investments to be available for the general expenditures of the Health Plan within one year of the combined balance sheet date. These investments have been excluded from the amounts above.

4. INVESTMENTS AND ASSETS LIMITED AS TO USE

The Health System's investments, including assets limited as to use, consist of cash and cash equivalents, marketable equity and fixed-income securities, hedge funds, and private investment funds.

Due to the adoption of ASU 2016-01 with further clarifications made with the issuance of ASU 2018-03 and 2018-04, as of September 30, 2020, the Health System's equity securities are measured at fair value with changes in fair value recognized through net income. As such, the adoption of these new standards as of October 1, 2019 resulted in certain investments that were previously recorded at cost being recorded at fair value. This resulted in a cumulative-effect adjustment of $66 million recorded to net asset without donor restriction on the accompanying consolidated balance sheets.

At September 30, 2021, the composition of the Health System's investments and assets limited as to use, is as follows (in thousands of dollars):

		Fair Value Measurement Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Fixed-income securities and funds	$ 709,912	$ 324,853	$ 385,059	$ -
Equity securities and funds	262,467	262,467		
Subtotal	972,379	$ 587,320	$ 385,059	$ -
Investments measured at net asset value	423,765			
Total investments and assets limited as to use	$ 1,396,144			

At September 30, 2020, the composition of the Health System's investments and assets limited as to use, is as follows (in thousands of dollars):

		Fair Value Measurement Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Fixed-income securities and funds	$ 801,169	$ 694,472	$ 106,697	$ -
Equity securities and funds	80,019	80,019		
Subtotal	881,188	$ 774,491	$ 106,697	$ -
Investments measured at net asset value	420,202			
Total investments and assets limited as to use	$ 1,301,390			

The investments and assets limited as to use are included in the captions in the consolidated balance sheets as of September 30, 2021 and 2020, are as follows (in thousands of dollars):

	2021	2020
Short-term investments	$ 147,096	$ 26,688
Long-term investments	941,289	959,659
Assets limited as to use:		
Foundation and Impact Alamance	140,842	164,783
AEC	3,014	2,711
Under bond indenture agreements held by trustee	5,475	19,584
CNCNC	39,136	39,226
ICARE	17,262	9,245
Other	5,827	4,557
Total assets limited as to use	211,556	240,106
Less assets limited as to use that are required for current liabilities	(5,802)	(6,674)
Assets limited as to use—net of portion required for current liabilities	205,754	233,432
Deferred compensation (within other assets)	96,203	74,937
Total investments and assets limited as to use	$ 1,396,144	$ 1,301,390

Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in risks in the near term could materially affect the Health System's investment balances reported in the consolidated balance sheets.

A summary of the investments measured at NAV as of September 30, 2021, is as follows (in thousands of dollars):

	Fair Value	Unfunded Commitment	Redemption Frequency	Redemption Notice Period
Investments in common, comingled, and collective trusts:				
Equity securities and funds	$ 50,074	$ -	Semi-monthly, and monthly	5 day to 30 days
	$ 50,074	$ -		
Alternative investment funds:				
Private equity	$ 211,337	$ 66,132	N/A–Illiquid	N/A–Illiquid
Private debt	36,385	23,559	N/A–Illiquid	N/A–Illiquid
Private debt	11,751	7,005	Monthly and Quarterly	45–90 days
Hedge funds	71,971		Monthly, Qtrly, Annual Qtr Anniversary	20–95 days
Hedge funds	17,121		Monthly, and Quarterly	3–90 days
Real estate	8,337	7,003	N/A–Illiquid	N/A–Illiquid
Real estate	44,860		Quarterly	90 days
	$ 401,762	$ 103,699		

A summary of the investments measured at NAV as of September 30, 2020, is as follows (in thousands of dollars):

	Fair Value	Unfunded Commitment	Redemption Frequency	Redemption Notice Period
Investments in common, comingled, and collective trusts:				
Equity securities and funds	$ 44,620	$ -	Semi-monthly, and monthly	5 day to 30 days
	$ 44,620	$ -		
Alternative investment funds				
Private equity	$ 150,698	$ 86,371	N/A–Illiquid	N/A–Illiquid
Private debt	32,838	23,008	N/A–Illiquid	N/A–Illiquid
Private debt	12,681	7,005	Monthly and Quarterly	45–90 days
Hedge funds	60,555		Monthly, Qtrly, Annual Qtr Anniversary	20–95 days
Hedge funds	50,561		Monthly, and Quarterly	3–90 days
Real estate	4,751	9,729	N/A–Illiquid	N/A–Illiquid
Real estate	63,498		Quarterly	90 days
	$ 375,582	$ 126,113		

Alternative investments include limited partnerships, limited liability corporations, and offshore investment funds. Included in investments of the limited partnerships are certain types of financial instruments, including, among others, futures and forward contracts, options, and securities sold not yet purchased, intended to hedge against changes in the market value of investments. These instruments may contain elements of both credit and market risks. Such risks include, but are not limited to, limited liquidity, dependence upon key individuals, emphasis on speculative investments (both derivatives and nonmarketable investments), and nondisclosure of portfolio composition. Because alternative investments are not readily marketable, their estimated value is subject to uncertainty and, therefore, may differ from the value that would have been used had a ready market for such investments existed. Such differences could be material.

Estimated fair values of private equity investments are based on a series of inputs that provide support to the valuations provided by the private equity managers, including analysis of the investment statements and supporting documents performed by management and its investment adviser, as well as audited consolidated financial statements provided by external independent auditors. Portfolio updates are provided by the managers at least quarterly and are updated more frequently for major events or new capital investment in the portfolio.

Other-Than-Temporary Impairment of Investments—The Health System evaluates the near-term prospects for improvement of unrealized investment losses in relation to the severity and duration of the loss for each individual investment by analyzing the earning trends and economic conditions and other sources of information. Based on this evaluation, the Health System recorded realized losses of $2.98 million on investments that were other-than-temporarily impaired at September 30, 2021. The total amount of unrealized losses remaining at September 30, 2021, was $6.3 million, of which $0.2 million relates to investments that have been in a continuous unrealized loss position for more than 12 months. The Health System recorded realized losses of $4.3 million on investments that were other-than-temporarily impaired at September 30, 2020. The total amount of unrealized losses remaining at September 30, 2020, was $9.5 million, of which $2.3 million relates to investments that have been in a continuous unrealized loss position for more than 12 months.

At September 30, 2021, the fair value and gross unrealized losses of available-for-sale securities were as follows (in thousands of dollars):

	September 30, 2021					
	Less than 12 Months		12 Months or Longer		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
US equity securities and funds	$ 98,669	$ (3,662)	$ -	$ -	$ 98,669	$ (3,662)
International equity securities and funds	28,071	(1,038)	-	-	28,071	(1,038)
Total	$ 126,740	$ (4,700)	$ -	$ -	$ 126,740	$ (4,700)

At September 30, 2020, the fair value and gross unrealized losses of available-for-sale securities were as follows (in thousands of dollars):

	September 30, 2020					
	Less than 12 Months		12 Months or Longer		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
International equity securities and funds	$ -	$ -	$ 10,814	$ (1,346)	$ 10,814	$ (1,346)
Total	$ -	$ -	$ 10,814	$ (1,346)	$ 10,814	$ (1,346)

Investment income and gains and losses for the years ended September 30, 2021 and 2020, consist of the following (in thousands of dollars):

	2021	2020
Dividend and interest income	$ 22,048	$ 21,521
Unrealized gain (loss)—equity securities	78,510	$ 515
Realized gain (loss)—net	54,559	49,107
Total	$ 155,117	$ 71,143

Investments in Unconsolidated Affiliated Entities—The Health System's investment in unconsolidated affiliated entities reflects the Health System's ownership interests in various health care-related entities accounted for primarily through the equity method.

A summary of investments, ownership percentages, investment amounts, and the Health System's share of net income for the years ended September 30, 2021 and 2020, is as follows (in thousands of dollars):

	Percent Ownership		Investment Balance		Health System's Share of Net Income	
	2021	2020	2021	2020	2021	2020
Investment name:						
Diagnostic Radiology and Imaging, LLC	50.00 %	50.00 %	$ 735	$ 724	$ 1,196	$ 1,112
AuthoraCare Collective (previously Hospice at Greensboro)	50.00	50.00	32,929	27,935	4,994	10,696
Advanced Homecare, Inc.	34.73	34.73	8,988	7,917	1,071	92
Health Care Casualty Insurance Limited	25.00	25.00	2,459	(128)	2,587	(607)
Health Care Casualty Risk Retention Group, Inc.	25.00	25.00		630	(219)	50
Randolph Cancer Center, LLC	40.00	40.00	(371)	6,102	(6,473)	221
Other			7,852	8,619	(672)	470
Total			$ 52,592	$51,799	$ 2,484	$ 12,034

Financial information related to investments in unconsolidated affiliated entities at September 30, 2021 and 2020, is summarized as follows (in thousands of dollars):

	2021	2020
Assets	$ 162,439	$ 183,875
Liabilities	45,071	58,811
Equity	117,378	125,064
Total revenue	115,146	259,309
Total expenses	121,872	184,026
Net income	(6,725)	75,284
Health System's share of net income	2,484	12,034

5. PROPERTY AND EQUIPMENT

A summary of property and equipment at September 30, 2021 and 2020, is as follows (in thousands of dollars):

	Depreciable Lives	2021	2020
Land and land improvements	10–15 years	$ 112,687	$ 105,410
Buildings and leasehold improvements	5–40 years	1,629,626	1,563,844
Equipment	3–15 years	482,379	503,835
Software	3–8 years	83,172	86,067
		2,307,864	2,259,156
Less accumulated depreciation		(1,191,686)	(1,146,400)
		1,116,178	1,112,756
Construction in progress		123,124	68,102
Total		$ 1,239,302	$ 1,180,858

Depreciation and amortization expense for the years ended September 30, 2021 and 2020, amounted to $122.8 million and $145.8 million, respectively.

The Health System had unexpended project contractual commitments at September 30, 2021 and 2020, of $55.2 million and $90.7 million, respectively.

6. ACCRUED EXPENSES

A summary of accrued expenses at September 30, 2021 and 2020, is as follows (in thousands of dollars):

	2021	2020
Accrued salaries and wages	$ 115,881	$ 126,724
Accrued benefits	66,056	60,094
Interest rate swaps	24,058	45,484
Self-insurance and medical insurance liabilities	28,184	27,114
Other current liabilities	21,483	25,431
Total	$ 255,662	$ 284,847

7. CONTRACT LIABILITIES

A summary of contract liabilities at September 30, 2021 and 2020, is as follows (in thousands of dollars):

	2021	2020
CMS Liability	$ 116,884	$ 141,442
AEC refundable deposits	540	641
AEC nonrefundable deposits	2,908	2,200
Other	3,258	5,124
Total current contract liabilities	$ 123,590	$ 149,407
AEC refundable deposits	$ 9,764	$ 10,643
AEC nonrefundable deposits	4,630	4,404
Total long term contract liabilities	$ 14,394	$ 15,047

Contract liabilities includes Medicare advance payments under the CARES Act of $116.9 million and $141.4 million as of September 30, 2021 and 2020, respectively. The funds provided under this program represent advances on payments for future goods or services to be provided to Medicare patients. The liability will be reduced over time as revenue is recognized for claims submitted for services provided after the recoupment period begins. On October 1, 2020, the Continuing Appropriations Act, 2021 and Other Extensions Act (the "Act") was passed, which revised the Medicare advance payment repayment terms and interest rate for amounts received between the passage of the CARES Act and the end of the COVID-19 public health emergency. The Act delayed the beginning of the recoupment of the advance payments to twelve months after the receipt of Medicare advance payment funds and extends the full repayment term to twenty-nine months. In addition, the Act caps recoupments at 25% for the first eleven months of repayment and 50% for the following six months. The interest rate is capped at 4% for amounts that remain outstanding at the end of the revised recoupment period. During fiscal year 2021, $25.5 million of the 2020 balance was recognized as net patient service revenue in the accompanying consolidated statements of operation. During fiscal year 2020, $3.3 million of the 2019 balance was recognized as net patient service revenue in the accompanying consolidated statements of operation.

The current and long-term AEC refundable and nonrefundable deposits represent entrances fee deposits paid by residents of AEC that vary according to the type and size of the residence and contract type. When the residents take occupancy, the deposits become nonrefundable and are amortized into other revenue based on the life expectancy of each resident in the independent living units. During fiscal year 2021, $2,414 of the 2020 balance was recognized into income in other revenue in the accompanying consolidated statements of operations. During fiscal year 2020, $2,459 of the 2019 balance was recognized into income in other revenue in the accompanying consolidated statements of operations.

8. LONG-TERM DEBT

Long-term debt at September 30, 2021 and 2020, consists of the following (in thousands of dollars):

	2021	2020
Series 2001A and 2001B, payable in annual installments increasing in fiscal year 2024 through fiscal year 2035, interest payable monthly at variable rates (0.05% and 0.11% at September 30, 2021 and 2020, respectively)	$ 85,200	$ 85,200
Series 2004A, payable in annual installments in fiscal year 2016 through fiscal year 2035, interest payable monthly at variable rates (0.05% and 0.13% at September 30, 2021 and 2020, respectively)	42,885	44,080
Series 2011A, payable in annual installments in fiscal year 2014 through fiscal year 2024, interest payable semiannually at fixed rates of 3.2% to 5.0%		21,690
Series 2011B, payable in annual installments in fiscal year 2016 through fiscal year 2036, interest payable monthly at variable rates (0.40% and 0.47% at September 30, 2021 and 2020, respectively)	38,635	40,860
Series 2013A, payable in annual installments in fiscal year 2024 through fiscal 2045, interest payable monthly a fixed rate of 3.08%	88,775	88,775
Series 2013B, payable in annual installments in fiscal year 2014 through fiscal 2023, interest payable monthly at a fixed rate of 2.24%	4,945	7,080
Series 2013C, payable in annual installments in fiscal year 2014 through fiscal 2023, interest payable monthly at a fixed rate of 2.26%	3,246	4,645
Series 2017, payable in annual installments in fiscal year 2026 through fiscal 2046, interest payable semiannually at a fixed rate of 4.33%	50,000	50,000
Series 2017A, payable in annual installments in fiscal year 2021 through fiscal 2046, interest payable semiannually at a fixed rate of 2.79%	99,180	100,000
Series 2017B, payable in annual installments in fiscal year 2033 through fiscal year 2046, interest payable monthly at variable rates (0.83% and 0.48% at September 30, 2021 and 2020, respectively)	60,000	60,000
Note payable to a commercial bank with interest due monthly and a final payment due September 25, 2023 at a variable rate (1.05% at September 30, 2021)	92,750	92,750
Note payable to a commercial bank in annual installments beginning in fiscal year 2013, with the remaining balance due in fiscal year 2023 at a fixed rate of 2.73%	14,620	15,480
Note payable to a commercial bank with principal and interest due monthly and a final payment due March 2, 2026 at a fixed rate of 2.49%	17,940	18,860
Note payable, payable in annual installments 2015 through 2022, interest payable monthly at fixed interest 3.5%	521	975
	598,697	630,395
Less scheduled payments due within one year	10,986	15,390
Less additional portion of Series 2001A and 2001B, 2004A, and 2011B classified as current	162,930	166,720
Less unamortized debt issuance costs	2,126	2,523
Total long-term debt	$ 422,655	$ 445,762

The Obligated Group for the debt consists of the Parent Corporation; the Operating Corporation; the Foundation; Impact Alamance; Alamance Regional Medical Center, Inc.; and ARMC Health Care (excluding AEC). The weighted-average interest rate on the Health System's Master Indenture Trust debt was approximately 2.58% and 2.56% in fiscal years 2021 and 2020, respectively.

The Health System has set aside approximately $5.5 million and $19.6 million at September 30, 2021 and 2020, respectively, in a debt service interest fund designated to meet scheduled interest payments as well as $8.0 million of trustee-held 2017B bond fund. These amounts are included in assets limited as to use in the accompanying consolidated balance sheets at September 30, 2021 and 2020.

Certain puttable variable-rate debt instruments are included in the current portion of long-term debt because of subjective acceleration clauses or due-on-demand provisions in the respective liquidity facilities from the supporting financial institutions. The future annual scheduled principal payment requirements of long-term debt at September 30, 2021, are as follows (in thousands of dollars):

Years Ending September 30	
2022	$ 10,986
2023	115,715
2024	10,120
2025	15,910
2026	29,400
Thereafter	416,566
Total	$ 598,697

On August 1, 2011, the Health System issued the second amended and restated master trust indenture (the "Indenture"). The Indenture provides that the members of the obligated group are jointly and severally liable for all obligations issued and outstanding under the Indenture. The Indenture also provides that all obligations issued and outstanding under the Indenture shall be uncollateralized obligations of the Obligated Group. Certain assets of the Health System, including patient accounts receivable, may collateralize future obligations issued under the Indenture.

There are several restrictive covenants contained in the Indenture, including, but not limited to, financial reporting, debt coverage requirements, and the maintenance of insurance coverage. The Health System is also restricted from pledging, mortgaging, or assigning interest in its property. Approximately 78% of the Health System's revenues and 89% of the Health System's assets are part of the Obligated Group under the revenue bonds as of and for the year ended September 30, 2021.

The Series 2017A and 2017B Hospital Revenue Bonds were issued on December 22, 2017, in the aggregate amount of $160 million to provide funding for qualifying Health System's projects. The $100 million carries a ten-year fixed rate of 2.79% and $60 million carries a variable rate of 85% of 1-month LIBOR plus 0.34%. The bonds are payable in annual installments in fiscal year 2021 through fiscal year 2046 for 2017A and fiscal year 2033 through fiscal year 2042 for 2017B.

The Series 2017 Hospital Revenue Bonds were issued on December 26, 2016, with $50 million of proceeds to provide funding for the Health System's pension plan. The bonds are payable in annual installments in fiscal year 2026 through fiscal year 2046 at fixed rates of 4.33%.

On February 29, 2016, the Health System purchased the remaining interest in a medical services building and entered into a $23 million term loan with a commercial bank to fund the acquisition. The term loan carries a fixed interest rate of 2.49% and partially amortizes over 10 years with a final payment March 2, 2026.

The Health System entered into a revolving credit agreement with a financial institution on May 31, 2019, in the amount of $50 million, maturing October 1, 2022. There were no borrowings against the agreement at September 30, 2021. The credit agreement bears interest at an annual rate of BSBY, plus 0.55%. Under terms of the credit agreement, the Health System is required to maintain a specific debt service coverage ratio, a specific day's cash on hand, and minimum debt rating, as those terms are defined.

The Series 2013A, 2013B, and 2013C Revenue Bonds were issued on November 20, 2013, in the aggregate amount of $130.2 million that, along with debt service reserve funds, were used to reimburse construction costs and fund a construction fund in the amount of approximately $59.8 million for construction at ARMC, fund an escrow in the amount of $29.9 million to retire the AEC Series 2007 bonds, reimburse borrowings under a bank line of credit, and pay issuance costs. On January 1, 2014, the above escrow, along with accrued interest, was used to retire the AEC Series 2007 bonds.

The Series 2011C and 2011D Hospital Revenue Bonds were issued on September 21, 2011, with $50 million each of new proceeds to provide funding for qualifying Health System's projects. The bonds are variable-rate bonds issued by a bank with variable-rate commitments through the termination date of September 29, 2020. On that date the bonds were retired and replaced with a bank note at a variable rate through the termination date of September 29, 2023.

The Series 2011B Hospital Revenue Bonds were issued on August 3, 2011, to refund the 2008 Series bonds. The Health System provides self-liquidity in support of the bonds. Bonds that have not been remarketed for a period of 30 days are payable after an additional 180 days. The Series 2011B bonds are classified as current liabilities in the consolidated balance sheets; however, they are reflected in the table of scheduled payments above based on their stated maturities.

The Series 2011A Hospital Revenue Bonds were issued to fully refund the 1993 bonds and are payable in annual installments in fiscal year 2014 through fiscal year 2024 at fixed rates of between 3.2% and 5.0%. On April 7, 2021, the bonds were paid off.

The Series 2004A Hospital Revenue Bonds are puttable variable-rate bonds supported by self-liquidity of the Health System. Additionally, the Health System has entered into a revolving credit agreement through October 1, 2016 with a bank to provide loans to cover 2004A bonds that are not remarketed. The revolving loans convert to a term loan if not repaid within 366 days and the term loan is amortized in six equal semiannual installments. This revolving credit agreement has been extended until October 1, 2022, with the same terms and conditions. The Series 2004A bonds are classified as current liabilities in the consolidated balance sheets; however, they are reflected in the table of scheduled payments above based on their stated maturities.

The Series 2001A and 2001B Hospital Revenue Bonds are puttable variable-rate bonds under which the Health System has entered into two separate standby bond purchase agreements (the "Liquidity Facilities") with a bank to provide credit and liquidity support for the bonds. The Liquidity Facilities were amended during fiscal year 2014 and expire on December 20, 2023. In the event that the bonds are tendered for purchase and cannot be remarketed, the Liquidity Facilities provide the funds to purchase the unremarketed bonds. These agreements will expire if the bonds are converted, or required to be converted, to a fixed interest rate. Principal payments by the Health System under agreement begin 455 days after the day on which the bonds failed to be remarketed and continue in six semiannual installments. The Series 2001A and Series 2001B bonds are classified as current liabilities in the consolidated balance sheets because of subjective acceleration provisions in the amended

Liquidity Facilities. However, they are reflected in the table of scheduled payments above based on their stated maturities.

On November 30, 2012, the Health System purchased a medical services building and entered into a $21.5 million term loan with a commercial bank to partially fund the purchase. The loan carries a fixed interest rate of 2.73% and amortizes over 10 years, with a final payment due in fiscal year 2023.

9. LEASE COMMITMENTS

The Heath System leases certain equipment and facilities under both operating and finance leases expiring on various dates through 2036. The nature of these leases generally include the following categories: real estate, medical equipment (which includes equipment supporting patient services), vehicles, and office and facility equipment. The Health System classifies leases with a term over one year as either a finance or operating leases. The Health System has elected the allowed exception for reporting short-term leases and will not recognize an ROU asset or lease liability for leases with an initial term of twelve months or less.

For finance leases, a ROU asset and lease liability are recognized at the lease commencement date, with the exception of leases with initial terms of twelve months or less. The ROU asset balance is initially measured as the present value of future minimum lease payments adjusted for any initial direct costs incurred and lease incentives received. For operating leases, the liability is initially measured as the present value of the unpaid lease payments. For finance leases, the lease liability is initially measured as the present value of unpaid lease payments, and is subsequently measured at amortized cost using the effective interest method. Certain estimates and judgements are required in the determination of the lease liabilities. A lessee is required to discount unpaid fixed lease payments using the interest rate implicit in the lease or, if that rate cannot be readily determined, the Health System has elected to use the risk-free interest rate for the applicable period. Lease terms include the non-cancellable period of the lease including any additional periods covered by an extension of the lease or an early termination that are reasonably certain to be exercised. Lease payments included in the measurement of the lease liability include fixed payments owed over the lease term, termination penalties if termination options are expected to be exercised, the price to purchase the underlying asset if the Health System is reasonably certain to exercise the purchase option and residual value guarantees, if applicable.

The following table presents the components of the Health System's right-of-use assets and liabilities related to leases and their classification as of September 30, 2021 and 2020 (in thousands of dollars).

Component of Lease Balances		**2021**		**2020**
Assets:				
Operating lease assets	$	75,181	$	70,582
Finance lease assets		9,881		9,523
Total lease assets	$	85,062	$	80,105
Liabilities:				
Operating lease liabilities:				
Current	$	13,952	$	14,210
Long-term		64,693		59,406
Total operating lease liabilities		78,645		73,616
Finance lease liabilities:				
Current		4,139		5,904
Long-term		5,382		3,841
Total finance lease liabilities		9,521		9,745
Total lease liabilities	$	88,166	$	83,361

Real estate leases may include one or more options to renew. The exercise of lease renewal options is at the Health System's sole discretion. In general, renewal options are not considered to be reasonably likely to be exercised, therefore, renewal options are generally not recognized as part of the right-of-use assets and lease liabilities.

The following table presents the components of the Health System's lease costs for the period ended September 30, 2021 and 2020 (in thousands of dollars).

	2021	2020
Lease cost (in thousands of dollars):		
Finance lease cost:		
Amortization of right-of-use assets	$ 7,102	$ 5,813
Interest on lease liabilities	242	437
Operating lease cost	17,617	17,579
Total lease cost	$ 24,961	$ 23,829
The following table presents supplemental cash flow information for the year ended September 30, 2021 and 2020 (in thousands of dollars):		
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from finance leases	$ 242	$ 437
Operating cash flows from operating leases	17,617	17,495
Financing cash flows from finance leases	6,743	5,679
Other information:		
Right of use assets obtained in exchange for new finance lease liabilities	7,521	1,311
Right of use assets obtained in exchange for new operating lease liabilities	17,969	85,373
Weighted average remaining lease term—finance leases (in years)	2.97	2.28
Weighted average remaining lease term—operating leases (in years)	7.72	6.96
Weighted average discount rate—finance leases	2.91 %	3.93 %
Weighted average discount rate—operating leases	2.44 %	2.65 %

Future maturities of lease liabilities at September 30, 2021 are presented in the following table (in thousands of dollars):

Years Ending September 30	**Operating Leases**	**Finance Leases**	**Total Leases**
2022	$ 15,838	$ 3,853	$ 19,691
2023	12,360	2,890	15,250
2024	10,340	1,476	11,816
2025	8,581	1,237	9,818
2026	7,584	499	8,083
Thereafter	35,332	114	35,446
Total lease payments	90,035	10,069	100,104
Less—imputed interest	(11,390)	(548)	(11,938)
Total lease obligations	78,645	9,521	88,166
Less—current obligations	(13,952)	(4,139)	(18,091)
Long-term lease obligations	$ 64,693	$ 5,382	$ 70,075

10. COMMITMENTS UNDER MRS. BERTHA LINDAU CONE GIFT

Under the terms of a gift by Mrs. Bertha Lindau Cone, the Parent Corporation is required to meet certain conditions. The more significant conditions of the gift are that the existing hospital and land will be forever used and maintained for hospital purposes and that the name of The Moses H. Cone Memorial Hospital will never be changed.

A substantial portion of the Parent Corporation's investment in its hospital building has been funded by this gift and is subject to the above conditions. Failure to comply with the conditions of the gift could result in the forfeiture to unrelated parties of all property purchased from the original gift and earnings on the gift.

11. EMPLOYEE RETIREMENT PLANS

The Health System has the right under the terms of the Employees' Retirement Plan of the Moses H. Cone Memorial Hospital (the "Plan"), a pension plan, in certain circumstances, to discontinue its contributions at any time and to terminate the Plan, subject to the provisions set forth in ERISA. On February 6, 2018, the Board of Trustees of the Moses H. Cone Memorial Hospital Board of Trustees approved a resolution to terminate the Plan, effective April 16, 2018. All required regulatory approvals were obtained in November 2018. Letters were mailed to plan participants in February 2019. Lump sum distributions were completed in May 2019. An additional $15 million employer contribution was made on June 5, 2019 to fund the Plan in liquidation. On June 6, 2019 transfer of assets for the purchase of annuities from Principal Financial Services, Inc. ("Principal") was completed. Principal began making payments to the participants beginning on August 1, 2019. As of September 30, 2019, all payments to the participants have been completed.

Certain benefits under the Plan are insured by the Pension Benefit Guaranty Corporation (PBGC) if the Plan terminates. Generally, the PBGC guarantees most vested normal-age retirement benefits, early retirement benefits, and certain disability and survivor's pensions. However, the PBGC does not guarantee all types of benefits under the Plan and the amount of benefit protection is subject to certain limitations. Vested benefits under the Plan are guaranteed at the level in effect on the date of the Plan's termination, subject to a statutory ceiling on the amount of an individual's monthly benefit.

Defined benefit pension plan benefits are based on years of service and employees' compensation during their years of employment. The Health System's pension funding policy is based upon actuarially calculated amounts to fund normal pension cost.

The Health System froze the Plan as of December 31, 2011, at which time benefit accruals under the Plan ceased. Effective October 1, 2003, the Plan was amended to close the Plan to new participants after October 1, 2003, and to offer current participants the right to continue to participate in the Plan or to freeze their accrued benefits and participate in a defined contribution plan sponsored by the Health System. Approximately 93% of participants at October 1, 2003 elected to continue participation in the Plan.

The asset and liability portfolio were $0 as of September 30, 2021 and September 30, 2020.

A reconciliation of the projected benefit obligation and a reconciliation of the Plan's assets, the funded status of the Plan, and amounts recognized in the Health System's consolidated balance sheets at September 30, 2021 and 2020, are as follows (in thousands of dollars):

	2021	2020
Change in benefit obligation:		
Benefit obligation at beginning of year	$ -	$ 842
Interest cost		
Actuarial gain		160
Benefits paid		
Plan amendments		
Settlements		(1,002)
Benefit obligation at end of year	-	-
Change in plan assets:		
Fair value of plan assets at beginning of year		4,785
Actual return on plan assets		(285)
Employer contributions		(3,164)
Benefits paid		
Administrative expenses		(334)
Settlements		(1,002)
Fair value of plan assets at end of year	-	-
Net pension asset (liability)	$ -	$ -

The accumulated benefit obligation was and $0 million as of September 30, 2021 and 2020, respectively. The amounts recognized in the consolidated balance sheets as noncurrent liabilities are $0 million at September 30, 2021 and 2020, respectively.

In addition, Cone Health and ARMC Health Care operate certain voluntary savings and defined contribution retirement plans. Contribution expense related to the plans was $42.4 million in 2021 and $36.8 million in 2020 and is reflected in fringe benefits expense in the accompanying consolidated statements of operations.

Net assets with donor restrictions are available for the following purposes at September 30, 2021 and 2020 (in thousands of dollars):

	2021	2020
Building fund	$ 1,449	$ 1,445
Community outreach	5,187	3,918
Patient support	10,159	7,931
Staff development and education	2,692	2,051
Donor restricted net assets	$ 19,487	$ 15,345

Donor restricted funds are those which have been limited by donors to a specific time period or purpose. As required by US GAAP, donor restricted net assets are classified and reported based on the existence or absence of donor-imposed restrictions. Funds associated with donor restrictions are included in assets limited as to use.

13. CONTINGENCIES

The Health System purchases professional and general liability insurance to cover property and medical malpractice claims in excess of $4 million. There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted arising from services provided to patients. The Health System has estimated and recorded accruals for the self-insurance portion of these arrangements.

The Health System purchases stop loss workers' compensation insurance to cover North Carolina claims in excess of $1 million. The Health System purchases insurance coverage for employees working in states other than North Carolina. The Health System has employed independent actuaries to estimate the ultimate cost for the self-insurance portion, if any, of the settlement of such claims.

The Health System is self-insured for its employee group health insurance and has estimated and recorded accruals for the self-insurance portion of these arrangements. In management's opinion, these accruals provide adequate reserve for loss contingencies.

The Health System is involved in litigation and regulatory investigations arising in the normal course of business. Management believes that these matters will be resolved without material adverse effect on the Health System's financial position, results of operations, or cash flows.

The aggregate amount accrued for these contingencies is approximately $29.7 million and $30.4 million as of September 30, 2021 and 2020, respectively, and are reported in accrued expenses on the accompanying Consolidated Balance Sheets.

12. NET ASSETS

A summary of the changes in net assets without restriction attributable to Moses H. Cone Memorial Hospital and Affiliates and the noncontrolling interests for the year ended September 30, 2021, is as follows (in thousands of dollars):

	Total	Moses H. Cone Memorial Hospital & Affiliates	Noncontrolling Interests
Balance—beginning of year	$ 1,912,281	$ 1,909,647	$ 2,634
Excess of revenues over expenses from consolidated operations	177,982	169,151	8,831
Change in net unrealized gains and losses on investments	(15,770)	(15,770)	
Wellsmith paid in capital	(14)	(134)	120
Close out of joint ventures	5,445	5,445	
Change in the fair value of the floating-to-fixed swap agreements	16,368	16,368	
Distributions to noncontrolling interests	(5,660)		(5,660)
Other changes in net assets	(834)	(834)	
Increase in net assets without restriction	177,517	174,226	3,291
Balance—end of year	$ 2,089,798	$ 2,083,873	$ 5,925

A summary of the changes in net assets without restriction attributable to Moses H. Cone Memorial Hospital and Affiliates and the noncontrolling interests for the year ended September 30, 2020, is as follows (in thousands of dollars):

	Total	Moses H. Cone Memorial Hospital & Affiliates	Noncontrolling Interests
Balance—beginning of year	$ 1,751,997	$ 1,758,283	$ (6,286)
Excess of revenues over expenses from consolidated operations	149,610	139,225	10,385
Adoption of new accounting pronouncement unrealized gain on investments	66,118	66,118	
Change in net unrealized gains and losses on investments	(44,976)	(44,976)	
Wellsmith debt to equity conversion	12,802	12,802	
Wellsmith paid in capital	(12,801)	(14,785)	1,984
Close out of joint ventures	7,539	5,405	2,134
Change in the fair value of the floating-to-fixed swap agreements	(12,289)	(12,289)	
Distributions to noncontrolling interests	(5,583)		(5,583)
Other changes in net assets	(136)	(136)	
Increase in net assets without restriction	160,284	151,364	8,920
Balance—end of year	$ 1,912,281	$ 1,909,647	$ 2,634

CNCNC Liability for Unpaid Health Claims and IBNR

A reconciliation of the changes in CNCNC's unpaid health claims and IBNR recognized in the Health System's consolidated balance sheets at September 30, 2021 and 2020, is as follows (in thousands of dollars):

	2021	2020
Balance of liability for unpaid health claims and IBNR at beginning of year	$ 16,513	$ 17,116
Incurred related to:		
Current year	161,233	135,883
Prior year	824	(92)
Total incurred	162,057	135,791
Paid related to:		
Current year	142,383	119,380
Prior year	17,337	17,014
Total paid	159,720	136,394
Balance of liability for unpaid health claims and IBNR at end of year	$ 18,850	$ 16,513

The above rollforward contains $0.1 million and $7.6 million of CNCNC intercompany expenses paid to THN in relation to their risk-sharing arrangement at September 30, 2021 and 2020, respectively. Management believes that the liability for unpaid claims is adequate to cover the ultimate development of claims. The reserves are continually reviewed to reflect current conditions and claim trends, and any resulting adjustments are reflected in operating results in the year the revisions are made.

14. CONCENTRATIONS OF CREDIT RISK

The Health System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at September 30, 2021 and 2020, was as follows:

	2021	2020
Medicare	8.2 %	11.6 %
Medicare Managed Care	22.4	22.8
Medicaid	15.7	5.3
Commercial	47.8	53.2
Other	3.7	4.8
Self-Pay	2.2	2.3
	100.0 %	100.0 %

15. FUNCTIONAL EXPENSES

Expenses are presented by functional classification in accordance with the overall service mission of Cone Health. Primary program services are health care services and are identified with a specific program at the time they are incurred and are reported accordingly. However, some of these expenses require allocation, which is done on the basis of estimates. General and Administration expenses are allocated based on a percentage of actual costs incurred spent in supporting the operations. We believe our allocations are done on a reasonable and consistent basis.

A summary of the functional expenses as of September 30, 2021, is as follows (in thousands of dollars):

	Healthcare Services	General and Administration	Other Entities	Total Operating Expenses
Salaries and wages	$ 766,360	$ 163,089	$ 29,615	$ 959,064
Fringe benefits	225,393	47,966	6,922	280,281
Supplies	402,243	85,601	313	488,157
Other direct expenses	304,237	64,745	230,966	599,948
Interest expense	13,201	2,809		16,010
Depreciation/amortization	100,728	21,436	607	122,771
Total	$ 1,812,162	$ 385,646	$ 268,423	$ 2,466,231

A summary of the functional expenses as of September 30, 2020, is as follows (in thousands of dollars):

	Healthcare Services	General and Administration	Other Entities	Total Operating Expenses
Salaries and wages	$ 668,465	$ 150,809	$ 33,844	$ 853,118
Fringe benefits	204,664	46,173	6,180	257,017
Supplies	360,128	81,249	382	441,759
Other direct expenses	272,506	61,479	183,328	517,313
Interest expense	12,932	2,917		15,849
Depreciation/amortization	118,481	26,730	591	145,802
Total	$ 1,637,176	$ 369,357	$ 224,325	$ 2,230,858

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CONSOLIDATING SUPPLEMENTAL SCHEDULES

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATING BALANCE SHEET
AS OF SEPTEMBER 30, 2021
(In thousands of dollars)

	Obligated Group						Nonobligated Group			
ASSETS	Operating Corporation	Parent Corporation	Alamance Regional	Community Foundations	Reclassification and Eliminating Entries	Total Group	Other Entities	Alamance Extended Care	Reclassification and Eliminating Entries	Consolidated
CURRENT ASSETS:										
Cash and cash equivalents	$ 70,359	$ 61,054	$ 5	$ 70,109	$	$ 201,527	$ 11,419	$ 8,819	$	$ 221,765
Short-term investments	147,096					147,096				147,096
Patient accounts receivable	202,288		2,589			204,877	31,707	193		236,777
Inventories	41,300		6,776			48,076	293	23		48,392
Assets limited as to use—required for current liabilities					5,802	5,802				5,802
Other current assets	54,998	2,153	376	35		57,562	59,724	20	(12,622)	104,684
Total current assets	516,041	63,207	9,746	70,144	5,802	664,940	103,143	9,055	(12,622)	764,516
LONG-TERM INVESTMENTS	4,618	946,763		130,354	(135,828)	945,907			(4,618)	941,289
ASSETS LIMITED AS TO USE—Net of portion required for current liabilities	5,827				130,026	135,853	62,269	3,015	4,617	205,754
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	50,207	433	155			50,795	37,333		(35,536)	52,592
PROPERTY AND EQUIPMENT—Net	133,773	761,744	263,656	4,475		1,163,648	24,336	52,317	(999)	1,239,302
RIGHT-OF-USE ASSETS—Operating (net)	16,644		2,946			19,590	55,591			75,181
RIGHT-OF-USE ASSETS—Finance (net)	8,268		1,149			9,417	464			9,881
GOODWILL	3,038	479				3,517	6,315			9,832
OTHER ASSETS	50,007	2,012	695	14		52,728	65,234		(9,732)	108,230
TOTAL	$ 788,423	$ 1,774,638	$ 278,347	$ 204,987	$	$ 3,046,395	$ 354,685	$ 64,387	$ (58,890)	$ 3,406,577

(Continued)

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATING BALANCE SHEET
AS OF SEPTEMBER 30, 2021
(In thousands of dollars)

LIABILITIES AND NET ASSETS	Obligated Group						Nonobligated Group			
	Operating Corporation	Parent Corporation	Alamance Regional	Community Foundations	Reclassification and Eliminating Entries	Total Group	Other Entities	Alamance Extended Care	Reclassification and Eliminating Entries	Consolidated
CURRENT LIABILITIES:										
Accounts payable	$ 50,017	$ 10,195	$ 2,393	$ 279	$	$ 62,884	$ 11,261	$ 127	$	$ 74,272
Accrued expenses	32,513	25,762	46,263	4,381		108,919	164,726	4,408	(22,391)	255,662
Current portion of contract liabilities	120,143					120,143		3,447		123,590
Current portion of operating lease obligations	5,296		1,488			6,784	7,168			13,952
Current portion of finance lease obligations	4,091		183			4,274	139		(274)	4,139
Current portion of long-term debt		173,445				173,445	471			173,916
Total current liabilities	212,060	209,402	50,327	4,660		476,449	183,765	7,982	(22,665)	645,531
LONG-TERM DEBT—Net of current portion		422,606				422,606	49			422,655
OPERATING LEASE OBLIGATIONS—Net of current portion	11,582		1,493			13,075	51,772		(154)	64,693
FINANCE LEASE OBLIGATIONS—Net of current portion	4,501		1,154			5,655	298		(571)	5,382
LONG-TERM CONTRACT LIABILITIES—Net of current portion								14,394		14,394
OTHER NONCURRENT LIABILITIES	78,079		2,699	25		80,803	63,651	183		144,637
Total liabilities	306,222	632,008	55,673	4,685		998,588	299,535	22,559	(23,390)	1,297,292
NET ASSETS (DEFICIT):										
Net assets without donor restrictions:										
Moses H. Cone Memorial Hospital and Affiliates	466,356	1,142,630	222,555	200,302	1,000	2,032,843	50,910	41,545	(41,425)	2,083,873
Noncontrolling interests									5,925	5,925
Total net assets (deficit) without donor restrictions	466,356	1,142,630	222,555	200,302	1,000	2,032,843	50,910	41,545	(35,500)	2,089,798
Net assets (deficit) with donor restrictions	15,845		119		(1,000)	14,964	4,240	283		19,487
Total net assets (deficit)	482,201	1,142,630	222,674	200,302		2,047,807	55,150	41,828	(35,500)	2,109,285
TOTAL	$ 788,423	$ 1,774,638	$ 278,347	$ 204,987	$	$ 3,046,395	$ 354,685	$ 64,387	$ (58,890)	$ 3,406,577

Note: Entities included in the consolidating balance sheet do not reflect their equity interest in the other entities within the consolidating balance sheet

(Concluded)

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATING STATEMENT OF OPERATIONS
FOR THE YEAR ENDED SEPTEMBER 30, 2021
(In thousands of dollars)

	Obligated Group						Nonobligated Group			
	Operating Corporation	Parent Corporation	Alamance Regional	Community Foundations	Eliminating Entries	Total Group	Other Entities	Alamance Extended Care	Eliminating Entries	Consolidated
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT:										
Net patient service revenue	$ 1,502,988	$	$ 344,894	$	$	$ 1,847,882	$ 346,556	$ 10,128	$	$ 2,204,566
Other revenue	88,677	42,297	12,303		(42,064)	101,213	35,434	3,691	(11,106)	129,232
Premium revenue							180,361		(5,486)	174,875
Net assets released from restriction	1,699					1,699	731	20		2,450
Total revenue	1,593,364	42,297	357,197		(42,064)	1,950,794	563,082	13,839	(16,592)	2,511,123
EXPENSES:										
Salaries and wages	588,685	1,160	93,870	1,364		685,079	269,275	5,050	(340)	959,064
Fringe benefits	188,952	246	31,349	336	(27)	220,856	57,797	1,774	(146)	280,281
Supplies	389,100	(206)	68,954	13		457,861	29,409	899	(12)	488,157
Other direct expenses	273,646	10,178	90,375	309	(42,037)	332,471	279,366	4,636	(16,525)	599,948
Interest expense	296	15,731	32			16,059	51		(100)	16,010
Depreciation and amortization	54,626	42,617	17,117	335		114,695	5,153	2,926	(3)	122,771
Total expenses	1,495,305	69,726	301,697	2,357	(42,064)	1,827,021	641,051	15,285	(17,126)	2,466,231
INCOME (LOSS) FROM OPERATIONS	98,059	(27,429)	55,500	(2,357)		123,773	(77,969)	(1,446)	534	44,892
NONOPERATING INCOME (EXPENSE):										
Investment income	1,460	99,213		52,638		153,311	1,878	28	(100)	155,117
Other nonoperating income (expense)—net	(81)	(6,737)	(813)	(7,168)		(14,799)	(15,277)	42	8,007	(22,027)
Total nonoperating (expense) income	1,379	92,476	(813)	45,470		138,512	(13,399)	70	7,907	133,090
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE FROM CONSOLIDATED OPERATIONS	99,438	65,047	54,687	43,113		262,285	(91,368)	(1,376)	8,441	177,982
DEFICIT OF REVENUE OVER EXPENSE ATTRIBUTABLE TO NONCONTROLLING INTERESTS									(8,831)	(8,831)
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE ATTRIBUTABLE TO MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES	$ 99,438	$ 65,047	$ 54,687	$ 43,113	$	$ 262,285	$ (91,368)	$ (1,376)	$ (390)	$ 169,151

Attachment B
Five Year Forecast Statement

ALAMANCE EXTENDED CARE, INC.
D/B/A THE VILLAGE AT BROOKWOOD

COMPILATION OF A FINANCIAL PROJECTION

FOR THE YEARS ENDING
SEPTEMBER 30, 2022 THROUGH SEPTEMBER 30, 2026

WEALTH ADVISORY | OUTSOURCING
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TABLE OF CONTENTS

Independent Accountants' Compilation Report 1

Projected Statements of Operations and Changes in Net Assets
Years Ending September 30, 2022 through 2026 2

Projected Statements of Cash Flows
Years Ending September 30, 2022 through 2026 3

Projected Statements of Financial Position
At September 30, 2022, 2023, 2024, 2025 and 2026 4

Summary of Significant Projection Assumptions and Accounting Policies

Introduction and Background Information 5

Summary of Significant Accounting Policies 9

Summary of Significant Projection Assumptions 14

CliftonLarsonAllen LLP
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INDEPENDENT ACCOUNTANTS' COMPILATION REPORT

Board of Trustees
Alamance Extended Care, Inc.
d/b/a The Village at Brookwood
Burlington, North Carolina

Management is responsible for the accompanying projected financial statements of Alamance Extended Care, Inc. d/b/a The Village at Brookwood (the "Village"), which comprise the projected statements of financial position as of September 30, 2022, 2023, 2024, 2025 and 2026, and the related projected statements of operations and changes in net assets, and cash flows for the years then ending, and the related summary of significant projection assumptions and accounting policies in accordance with the guidelines for presentation of a financial projection established by the American Institute of Certified Public Accountants (AICPA). We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not examine or review the projected financial statements, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these projected financial statements or the assumptions. Furthermore, even if the hypothetical assumptions as noted in Management's Summary of Significant Projection Assumptions and Accounting Policies on page 5 (the "Hypothetical Assumptions") occurs as projected, there will usually be differences between the projected and actual results, because events and circumstances frequently do not occur as expected, and those differences may be material.

The accompanying projection, and this report, are intended solely for the information and use of management, the Board of Trustees, and the North Carolina Department of Insurance (pursuant to the requirements of North Carolina General Statutes, Chapter 58, Article 64 and included in the Village's disclosure statement filing) and is not intended to be and should not be used by anyone other than these specified parties.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Charlotte, North Carolina
February 18, 2022

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ALAMANCE EXTENDED CARE, INC. D/B/A THE VILLAGE AT BROOKWOOD
PROJECTED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
ASSUMING THE HYPOTHETICAL ASSUMPTIONS ON PAGE 5
YEARS ENDING SEPTEMBER 30,
(000s Omitted)

	2022	2023	2024	2025	2026
REVENUES, GAINS, AND OTHER SUPPORT					
Patient Service Revenue	$ 10,424	$ 10,723	$ 11,031	$ 11,347	$ 11,671
Amortization of Entrance Fees	2,530	2,515	2,518	2,532	2,554
Interest Income	28	28	25	29	29
Contribution Revenue - Provider Relief Funds	267	-	-	-	-
Other Revenue	713	729	750	772	794
Total Revenues, Gains, and Other Support	13,962	13,995	14,324	14,680	15,048
OPERATING EXPENSES					
Health Care	2,784	2,868	2,954	3,042	3,133
Resident Services	561	578	596	614	632
Dietary	1,731	1,783	1,837	1,892	1,949
Plant Operations	1,579	1,627	1,675	1,726	1,777
Laundry	23	24	25	26	26
Housekeeping	433	446	459	473	487
General and Administrative	4,585	4,723	4,865	5,011	5,161
Depreciation	3,168	3,182	3,198	3,241	3,309
Total Expenses	14,864	15,231	15,609	16,025	16,474
DEFICIT OF REVENUES UNDER EXPENSES AND DECREASE IN NET ASSETS WITHOUT DONOR RESTRICTIONS	(902)	(1,236)	(1,285)	(1,345)	(1,426)
Change In Net Assets With Donor Restrictions	-	-	-	-	-
Decrease in Net Assets	(902)	(1,236)	(1,285)	(1,345)	(1,426)
Net Assets - Beginning of Year	41,828	40,926	39,690	38,405	37,060
Net Assets - End of Year	$ 40,926	$ 39,690	$ 38,405	$ 37,060	$ 35,634

See Accompanying Summary of Significant Projection Assumptions and Accounting Policies and Independent Accountants' Compilation Report

ALAMANCE EXTENDED CARE, INC. D/B/A THE VILLAGE AT BROOKWOOD

PROJECTED STATEMENTS OF CASH FLOWS
ASSUMING THE HYPOTHETICAL ASSUMPTIONS ON PAGE 5
YEARS ENDING SEPTEMBER 30,
(000s Omitted)

	2022	2023	2024	2025	2026
CASH FLOWS FROM OPERATING ACTIVITIES					
Decrease in Net Assets	$ (902)	$ (1,236)	$ (1,285)	$ (1,345)	$ (1,426)
Adjustments to Reconcile Decrease in Net Assets to Net Cash Used by Operating Activities:					
Depreciation	3,168	3,182	3,198	3,241	3,309
Amortization of Entrance Fees	(2,530)	(2,515)	(2,518)	(2,532)	(2,554)
Changes in Current Assets:					
Accounts Receivable, Net	(32)	(5)	(5)	(6)	(6)
Inventories	(14)	(1)	(1)	(1)	(1)
Other Current Assets	(12)	(1)	(1)	(1)	(1)
Changes in Current Liabilities:					
Accounts Payable	65	6	6	6	6
Accrued Expenses	(301)	145	148	154	156
Refundable Advance	(267)	-	-	-	-
Net Cash Used by Operating Activities	(825)	(425)	(458)	(484)	(517)
CASH FLOWS FROM INVESTING ACTIVITIES					
Net Change in Investments	(182)	-	(16)	33	21
Net Change in Assets Limited as to Use	91	(88)	(91)	(93)	(95)
Acquisition of Property and Equipment	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
Net Cash Used by Investing Activities	(2,091)	(2,088)	(2,107)	(2,060)	(2,074)
CASH FLOWS FROM FINANCING ACTIVITIES					
Entrance Fees Received	2,931	3,019	3,110	3,203	3,299
Entrance Fees Refunded	(503)	(518)	(533)	(549)	(565)
Net Cash Provided by Financing Activities	2,428	2,501	2,577	2,654	2,734
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(488)	(12)	12	110	143
Cash and Cash Equivalents - Beginning of Year	8,819	8,331	8,319	8,331	8,441
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 8,331	$ 8,319	$ 8,331	$ 8,441	$ 8,584

ALAMANCE EXTENDED CARE, INC. D/B/A THE VILLAGE AT BROOKWOOD
PROJECTED STATEMENTS OF FINANCIAL POSITION
ASSUMING THE HYPOTHETICAL ASSUMPTIONS ON PAGE 5
AT SEPTEMBER 30,
(000s Omitted)

	2022	2023	2024	2025	2026
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	$ 8,331	$ 8,319	$ 8,331	$ 8,441	$ 8,584
Patient Accounts Receivable, Net	225	230	235	241	247
Investments	182	182	198	165	144
Inventories	37	38	39	40	41
Other Current Assets	32	33	34	35	36
Total Current Assets	8,807	8,802	8,837	8,922	9,052
ASSETS LIMITED AS TO USE					
Internally Designated for Statutory Operating Reserve	2,924	3,012	3,103	3,196	3,291
PROPERTY AND EQUIPMENT, NET	51,149	49,967	48,769	47,528	46,219
Total Assets	$ 62,880	$ 61,781	$ 60,709	$ 59,646	$ 58,562
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts Payable	$ 192	$ 198	$ 204	$ 210	$ 216
Accrued Expenses	4,807	4,952	5,100	5,254	5,410
Current Portion of Deferred Revenue from Entrance Fees	2,480	2,480	2,480	2,480	2,480
Total Current Liabilities	7,479	7,630	7,784	7,944	8,106
DEFERRED REVENUE AND OTHER LIABILITIES					
Deferred Revenue from Entrance Fees	4,836	4,830	4,853	4,899	4,968
Refundable Entrance Fees	9,456	9,448	9,484	9,560	9,671
Other Non-Current Liabilities	183	183	183	183	183
Total Deferred Revenue and Other Liabilities	14,475	14,461	14,520	14,642	14,822
Total Liabilities	21,954	22,091	22,304	22,586	22,928
NET ASSETS					
Net Assets Without Donor Restrictions	40,643	39,407	38,122	36,777	35,351
Net Assets With Donor Restrictions	283	283	283	283	283
Total Net Assets	40,926	39,690	38,405	37,060	35,634
Total Liabilities and Net Assets	$ 62,880	$ 61,781	$ 60,709	$ 59,646	$ 58,562

Summary of Significant Projection Assumptions and Accounting Policies

Introduction and Background Information

Basis of Presentation

The accompanying financial projection presents, to the best of the knowledge and belief of management ("Management") the expected financial position, results of operations and changes in net assets, and cash flows of Alamance Extended Care, Inc. d/b/a The Village at Brookwood (the "Village" or "AEC") as of and for each of the five years ending September 30, 2026 (the "Projection Period"). The Village is a nonstock, nonprofit organization established to develop and operate a life plan community and provide housing, health care and related services to the elderly. The Village is an affiliate of ARMC Health Care. ARMC Health Care functions as the sole member of the Village, ARMC Foundation, Inc., ARMC Physicians Care, Inc., and Alamance Regional Medical Center, Inc. and all are considered related parties to the Village. The accompanying financial projection only includes the Village and none of the other affiliates.

A projection, although similar to a forecast, is a presentation of prospective financial information that is subject to one or more hypothetical assumptions. Management has included assumptions that are considered to be a "Hypothetical Assumption" as defined by the American Institute of Certified Public Accountants' Guide for Prospective Financial Information. A Hypothetical Assumption is defined as follows: "An assumption used in a financial projection or in a partial presentation of projected information to present a condition or course of action that is not necessarily expected to occur, but is consistent with the purpose of the presentation."

Management's Hypothetical Assumptions are as follows:

- During March 2020, the World Health Organization declared the spread of Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. Specific to the Village, COVID-19 may impact various parts of its 2022 operations and financial results including but not limited to additional costs for emergency preparedness, disease control and containment, potential shortages of healthcare personnel, or loss of revenue due to reductions in certain revenue streams. Management believes the Village is taking appropriate actions to mitigate the negative impact. However, the full impact of COVID-19 is unknown and cannot be reasonably estimated as of the date of this Projection. Management has projected that its projected occupancies and access to labor would not be materially adversely impacted by COVID-19. In addition, Management has projected utilizing $267,000 of provider relief funds in fiscal year 2022 on expenses related to preventing, preparing for, or responding to the COVID-19 pandemic.
- Management is able to achieve the projected operating revenue inflationary rate increases and operating expense inflationary increases, as described hereinafter.

Accordingly, the projection reflects Management's judgment as of February 18, 2022, the date of this projection, of the expected conditions and its expected course of action. The assumptions disclosed herein are the assumptions which Management believes are significant to the financial projection. There will usually be differences between projected and actual results because events and circumstances frequently do not occur as expected, and those differences may be material.

This financial projection is intended solely for the information and use of management, the Board of Trustees, and the North Carolina Department of Insurance (pursuant to the requirements of North Carolina General Statutes, Chapter 58, Article 64 and included in the Village's disclosure statement filing), and is not intended to be and should not be used by anyone other than these specified parties.

Introduction and Background Information (Continued)

Background

Organizational Information

Alamance Extended Care, Inc. d/b/a The Village at Brookwood is a North Carolina not-for-profit corporation which was founded in 1986. The Village has received a determination letter from the Internal Revenue Service stating that the corporation is an organization exempt from federal income tax under Section 501(A) of the Internal Revenue Code of 1986, as amended (the "Code"), as an organization described in Section 50l(c)(3) of the Code.

ARMC Health Care (the "Parent") is a not-for-profit corporation chartered by the State of North Carolina in 1986 and is the sole member of the Village, ARMC Foundation, Inc., ARMC Physicians Care, Inc., and Alamance Regional Medical Center, Inc., a North Carolina not-for-profit hospital system located in Burlington, North Carolina. The Parent is not liable for any activities of the Village.

In December 2011, the Parent announced its intent to integrate with the Moses H. Cone Memorial Hospital ("Cone Health"), a nonstock, not-for-profit, parent holding company, in Greensboro, North Carolina. Cone Health is a regional health care system with four hospitals located in Greensboro, North Carolina and one in Reidsville, North Carolina. A due diligence process was engaged and the required regulatory approvals were obtained. The transaction was effective on May 1, 2013. Effective that date, Cone Health became the sole member of the Parent.

In August 2015, the Village and Well-Spring Services, Inc. ("Services") entered into an agreement that provides the Village an opportunity to collaborate on services such as dining, strategic planning, and marketing. The goals of the agreement were to develop an exceptional dining program utilizing Village management versus contract management, develop a strategic plan sharing consultant resources, and to collaborate on marketing strategies to diversify each community's methods of attracting senior adults. This agreement does not affect governance, management, or financial obligations of the Village.

Effective June 2017, the Village and Well Spring Management and Development, Inc. ("WSMD") entered into a management agreement (the "Management Agreement") for an initial period of two years. In adherence to this agreement, WSMD will provide the following contracted employees to the Village: the Executive Director, a Nursing Home Administrator for the skilled nursing facility, and a Director of Nursing. WSMD will assist the Village in the day to day operations of the facility including all functional areas to ensure that all applicable laws and statutory requirements are met. WSMD will receive reimbursement for positions stated above, plus a monthly fixed fee ("Management Fees"). This Management Agreement does not affect financial obligations of the Village, with the exception of the Management Fees described. Management projects that this Management Agreement will be in effect throughout the Projection Period.

In July 2020, AEC closed its Edgewood Place Public Skilled Nursing Facility and sold 54 of the 81 bed licenses, keeping the remaining 27 beds licenses.

As of the date of this Projection, Management has not determined the future use of the Edgewood Place Public Skilled Nursing Facility property nor the remaining 27 nursing bed licenses, and as such, Management has projected no activity during the Projection Period. Management does not plan to continue to operate Edgewood Place; therefore, depreciation was accelerated in 2020 so that all remaining equipment and real property were fully depreciated, leaving only approximately $517,000 of net book value for land related to Edgewood Place. Management has projected the net book value of the land assets to remain unchanged during the Projection Period. Management does not believe these

Introduction and Background Information (Continued)

assets for Edgewood Place Public Skilled Nursing Facility to be impaired, and as such, has not projected any impairment of these assets during the Projection Period.

The Board of Trustees for Alamance Extended Care, Inc. has been selected, nominated, and approved by the Board of Trustees of ARMC HealthCare, Inc. ARMC HealthCare, Inc. appointed the Chairperson and Vice-Chairperson who will serve until replaced. The power and authority of the Village shall be vested in its Board of Trustees, which shall have a minimum of eight members and a maximum of seventeen members.

Community Information

The Village owns and manages a life plan community ("LPC") situated on approximately 76 acres located in Burlington, North Carolina called The Village at Brookwood (the "Community"). The Community consists of 108 independent living apartment units (two of which are offline as guest and marketing suites) and 45 independent living cottage units (collectively, the "Independent Living Units"); a 24-unit assisted living facility, which contains 12 traditional assisted living units (the "Traditional Assisted Living Units") and 12 memory support units (the "Memory Support Units") (collectively, the Traditional Assisted Living Units and Memory Support Units are referred to as the "Assisted Living Units"); a 24-bed sheltered nursing unit (the "Nursing Facility" or "Nursing Beds"); a community center; and a wellness center. Collectively, the Assisted Living Units and Nursing Beds are referred to as the "Health Care Center" or "Health Care Beds."

The following table summarizes the type, number, and approximate square footage of the units at the Community.

Introduction and Background Information (Continued)

Table 1
Unit Configuration and Square Footage

Independent Living	Type	Number of Units	Approximate Square Feet
Apartments			
Azalea	1 BR / 1 BA	13	826
Birch(1)	1 BR / 1.5 BA	26	1,113
Camellia (2)	2 BR / 2 BA	29	1,206
Dogwood	2 BR / 2 BA	20	1,352
Elm	2 BR / 2 BA / Den	20	1,596
Garden Homes			
Holly	2 BR / 2 BA	16	1,692
Magnolia	2 BR / 2 BA	23	1,892
Oak	2 BR / 2 BA	6	1,965
Total / Weighted Average		153	1,412

Health Care Units	Number of Units	Approximate Square Feet
Assisted Living Units		
Traditional Assisted Living Units	12	289-367
Memory Support Units	12	289-367
Total	24	
Nursing Beds (3)		
Sheltered Nursing Beds	24	205-297
Total	24	

Source: Management
Notes:
(1) One Birch unit is currently being used as a guest suite and is excluded from the table above.
(2) One Camellia unit is currently being used as a marketing unit and is excluded from the table above.
(3) In July 2020, Management closed Edgewood place and sold 54 of the total 81 Edgewood Nursing Beds. The Village still holds license for 27 beds, but Management has projected the beds to remain offline during the Projection Period and have been excluded from the table.

Summary of Significant Accounting Policies

Basis of Accounting

The Village maintains its accounting and financial records according to the accrual basis of accounting.

Use of Estimates

The preparation of projected 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 amounts reported as assets and liabilities and disclosure of contingent assets and liabilities in the projected financial statements and accompanying notes. Estimates also affect the reported amount of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Net Assets

The Village classifies its funds for accounting and reporting purposes as follows:

Net Assets Without Donor Restrictions – Resources of the Village that are not restricted by donors or grantors as to use or purpose. These resources include amounts generated from operations and the investment in property and equipment.

Net Assets With Donor Restrictions – Resources that carry a donor-imposed restriction that permits the Village to use or expend the donated assets as specified, or is satisfied by the passage of time or by actions of the Village. Some of these resources may stipulate that donated assets be maintained in perpetuity, but may permit the Village to use or expend part or all of the income derived from the donated assets.

Cash and Cash Equivalents

The Village considers all highly liquid investments, other than those included in assets limited as to use, with a maturity of three months or less when purchased, to be cash equivalents.

Patient Accounts Receivable

The Village records accounts receivable at the net expected balance. The Village provides an allowance for uncollectible accounts using management's judgement. Accounts past due are individually analyzed for collectability. Accounts receivable that management determines will be uncollectable are written off upon such determination. It is the Village's policy to seek collection on all overdue accounts.

Investments

Investments are measured at fair market value based on quoted market values. Investment income or loss (including realized gains and losses on investments) is included in the excess of revenue, gains and other support over expenses, unless the income is restricted by donor or by law. Management does not project any unrealized gains or losses on investments during the Projection Period.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market. Inventories include medical and surgical supplies and pharmaceuticals.

Summary of Significant Accounting Policies (Continued)

Assets Limited as to Use

Assets limited as to use are assumed to be carried at fair value and include assets set aside for North Carolina statutory operating reserves.

Property and Equipment

Property and equipment are recorded at cost or, if donated, at fair market value on the date of receipt. Property and equipment are capitalized if it has a cost over $5,000 and an estimated useful life of at least 3 years. Depreciation is recorded over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. The following estimated useful lives are used to calculate depreciation:

Land Improvements	10 – 15 years
Building and Fixed Equipment	5 – 40 years
Moveable Equipment	3 – 15 years

The Village periodically reviews its long-lived assets and evaluates such assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable.

Deferred Revenue from Entrance Fees and Refundable Entrance Fees

Entrance fees from the Village's residency and care agreements, excluding the portion that is estimated to be refundable to the resident, are recorded as deferred revenue from entrance fees and are nonrefundable and recognized as income over the estimated life expectancy of each resident. A portion of the entrance fee may be refundable when the residency is terminated. Such refundable amounts are shown as Refundable Entrance Fees in the accompanying projected statements of financial position and are not amortized into income.

Obligation to Provide Future Services

The Village annually calculates the present value of the net cost of future services and use of facilities to be provided to current residents and compares that amount with the balance of deferred revenue from advance fees. If the present value of the net cost of future services and use of facilities exceeds the deferred revenue from advance fees, a liability is recorded (obligation to provide future services and use of facilities) with the corresponding charge to income. Management has not projected any obligation to provide future services during the Projection Period.

Resident and Health Care Service Revenue

Resident service revenue is reported at the amount that reflects the consideration to which the Village expects to be entitled in exchange for providing resident care. These amounts are due from residents, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Village bills the residents and third-party payors several days after the services are performed. Service fees paid by residents for maintenance, meals, and other services are assessed monthly and are recognized as revenue in the period services are rendered. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Village.

Summary of Significant Accounting Policies (Continued)

Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Village 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 residents in the facilities receiving skilled nursing services or housing residents receiving services in the facilities. The Village considers daily services provided to residents of the skilled nursing facilities, and monthly rental for housing services as a separate performance obligation and measures this on a monthly basis, or upon move-out within the month, whichever is shorter. Nonrefundable entrance fees are considered to contain a material right associated with access to future services, which is the related performance obligation. Revenue from nonrefundable entrance fees is recognized ratably in future periods covering a resident's life expectancy using a time-based measurement similar to the output method. Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to residents and customers in a retail setting (for example, gift shop and cafeteria meals) and the Village does not believe it is required to provide additional goods or services related to that sale.

Because all of its performance obligations have a duration of less than one year, the Village has elected to apply the optional exemption provided in FASB 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 Village 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 Village' policy, and/or implicit price concessions provided to residents. The Village determines its estimates of contractual adjustments based on contractual agreements, its policy, and historical experience. The Village determines its estimate of implicit price concessions based on its historical collection experience.

Agreements with third-party payors typically provide for payments at amounts less than the established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare

The Village's licensed nursing facility participates in the Medicare program. This federal program is administered by the Centers for Medicare and Medicaid Services (CMS). The nursing facilities were paid under the Medicare Prospective Payment System (PPS) for residents who are Medicare Part A eligible and met the coverage guidelines for skilled nursing facility services. The PPS was a per diem price-based system. CMS finalized the Patient Driven Payment Model (PDPM) to replace the existing Medicare reimbursement system effective October 1, 2019. Under PDPM, therapy minutes are removed as the primary basis for payment and instead use the underlying complexity and clinical needs of a patient as a basis for reimbursement. In addition, PDPM introduces variance adjustment factors that change reimbursement rates during the resident's length of stay. Annual cost reports are required to be submitted to the designated Medicare Administrative Contractor; however, they do not contain a cost settlement.

Nursing facilities licensed for participation in the Medicare and Medical Assistance programs are subject to annual licensure renewal. If it is determined that a nursing facility is not in substantial compliance with the requirements of participation, CMS may impose sanctions and penalties during the period of noncompliance. Such a payment ban would have a negative impact on the revenues of the licensed nursing facility.

Summary of Significant Accounting Policies (Continued)

Settlements with third-party payors for retroactive adjustments due to 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 Village'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 (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations.

Generally, residents who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Village estimates the transaction price for residents with deductibles and coinsurance 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. Subsequent charges to the estimate of the transaction price are recorded as adjustments to resident services revenue in the period of the change.

Additional revenue recognized due to changes in its estimates of implicit price concessions, discounts, and contractual adjustments are not projected by Management during the Projection Period. Subsequent changes that are determined to be the result of an adverse change in the resident's ability to pay are recorded as bad debt expense.

The Village has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors: payors, service line, method of reimbursement, and timing of when revenue is recognized.

The Village maintains records, and the board has oversight, to identify and monitor the amount of charges foregone for services and supplies furnished under its benevolent assistance policy and to identify and monitor the level of benevolent assistance it provides. These include reduced rates for Medicare, Medicaid, and other governmental programs.

The Village has estimated the costs of providing assistance under its benevolent assistance policy. In order to estimate the cost of providing such assistance, management calculated a ratio by comparing the charges foregone to total operating revenue and applying this ratio to expenses to estimate the costs of providing benevolent assistance.

Contract Costs

The Village has applied the practical expedient provided by FASB ASC 340-40-25-4 and all incremental customer contract acquisition costs are expensed as they are incurred as the amortization period of the asset that the Village otherwise would have recognized is one year or less in duration.

Summary of Significant Accounting Policies (Continued)

Impact of COVID-19 Pandemic on Operations

In March 2020, the World Health Organization declared the outbreak of a novel coronavirus ("COVID-19") as a pandemic which continues to spread throughout the United States and the world. The CARES Act provided funding" to the Department of Health and Human Services ("DHHS") Public Health and Social Services Emergency Fund ("PHSSEF"), which provided funds to qualifying healthcare providers treating COVID-19 patients to replace lost revenues or reimburse for COVID-19 related costs. Qualifying Relief Fund payments are not subject to repayment but there are certain terms and conditions that must be met in order to qualify for the grant funds. Management has projected utilizing $267,000 of provider relief funds in fiscal year 2022 on expenses related to preventing, preparing for, or responding to the COVID-19 pandemic.

Income Tax Status

The Village is organized as a nonprofit, tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code, as amended. Accordingly, no provision for income taxes is included in the accompanying projected statements of operations and changes in net assets.

Summary of Significant Projection Assumptions

Revenues

Independent Living Occupancy

Based on expected marketing efforts and historical occupancy experience, utilization of the Independent Living Units is projected as noted in the following table for the Projection Period.

Table 2
Projected Independent Living Occupancy

Year Ending September 30,	Average Units Available [1]	Average Units Occupied	Average Occupancy
2022	153	144.7	94.6%
2023	153	144.7	94.6%
2024	153	144.7	94.6%
2025	153	144.7	94.6%
2026	153	144.7	94.6%

Source: Management
Note: (1) One Birch unit is currently being used as a guest suite and is excluded from average available units. In addition, one Camellia unit is currently being used as a marketing suite and is excluded from average available units.

Management has assumed that the number of Independent Living Units to have double occupancy will average approximately 36% for each year in the Projection Period.

Health Care Center Occupancy

Based on expected marketing efforts and historical occupancy experience, utilization of the Health Care Beds is projected as noted in the following tables during the Projection Period.

Table 3
Projected Assisted Living Occupancy

Year Ending September 30,	Average Units Available	Average Units Occupied	Average Occupancy
2022	24	22.0	91.7%
2023	24	22.0	91.7%
2024	24	22.0	91.7%
2025	24	22.0	91.7%
2026	24	22.0	91.7%

Source: Management

Table 4
Projected Nursing Beds Occupancy

Year Ending September 30,	Average Units Available	Average Units Occupied	Average Occupancy
2022	24	22.0	91.7%
2023	24	22.0	91.7%
2024	24	22.0	91.7%
2025	24	22.0	91.7%
2026	24	22.0	91.7%

Source: Management

Summary of Significant Projection Assumptions (Continued)

Entrance Fees Receipts and Amortization of Entrance Fees

The Village offers the following four Residence and Services Agreement (the "Residence and Services Agreements") options:

- Fee-for-Service Plans:
  - Fee-for-Service Standard Plan
- Lifecare Plans:
  - Lifecare - Traditional Plan (0% Refundable)
  - Lifecare - 90% Refund Plan
  - Lifecare - 50% Refund Plan

All options require payment of a one-time entrance fee and monthly service fees. Generally, payment of these fees entitles residents to the use and privileges of the facility for life. The Lifecare Plans entitle the resident to full services and amenities as defined in the Residence and Services Agreement. Under the Fee-for-Service Plans, residents who entered into a Residence and Services Agreement after January 1, 2007 pay additional fees for any housekeeping services and meals. Residents who entered into a Residence and Services Agreement prior to January 1, 2007 receive one meal credit per person for each day of the month. The Residence and Services Agreements do not entitle the residents to an interest in the real estate or other property owned by the Village. All residents are fully responsible for payment of the entrance and monthly service fees, associated with their respective plan.

A portion of the entrance fee may be refundable when the residency is terminated. Such refundable amounts are shown as Refundable Entrance Fees in the projected statements of financial position and are not recognized into income. The nonrefundable portion of entrance fees is reduced each month, commencing with the date of occupancy, and recognized as revenue over the estimated life expectancy of residents, and are reflected as Amortization of Entrance Fees on the projected statements of operations and changes in net assets. The unearned portion is classified as Deferred Revenue from Entrance Fees in the projected statement of financial position.

Entrance fees generated and refunded are based on turnover of the Independent Living Units, which has been projected by Management based on historical experience, as shown in the following table.

Table 5
Projected Entrance Fees, Net
Years Ending September 30,
(000s Omitted)

	2022	2023	2024	2025	2026
Independent Living Turnover	15	15	15	15	15
Entrance Fees from Turnover	$ 2,931	$ 3,019	$ 3,110	$ 3,203	$ 3,299
Entrance Fees Refunded	(503)	(518)	(533)	(549)	(565)
Total Entrance Fees, Net	$ 2,428	$ 2,501	$ 2,577	$ 2,654	$ 2,734

Source: Management

Summary of Significant Projection Assumptions (Continued)

Based upon historical experience, Management has projected that approximately 56% of the residents would select the Fee-For-Service Standard Plan and 44% would select the Lifecare – Traditional Plan. Management has not projected any incoming resident would select the Lifecare – 90% Refund Plan or the Lifecare 50% Refund Plan. Entrance fees are projected to increase 3% annually during the Projection Period.

Patient Service Revenue

The monthly and daily service fee revenues are based on the projected utilization and the fee schedules in the tables that follow. It is anticipated that the monthly service fees for independent living will be increased 3.00% annually.

Table 6
Independent Living Entrance Fees - 2022

		Lifecare Plans			Fee-for-Service Plan
Independent Living	Number of Units	Traditional	90% Refund	50% Refund	Standard
Apartments					
Azalea	13	$ 186,800	$ 364,200	$ 252,200	$ 104,200
Birch	26	229,500	447,600	309,900	137,300
Camellia	29	243,900	475,600	329,200	153,400
Dogwood	20	272,600	531,500	368,000	176,300
Elm	20	302,200	589,300	408,000	196,400
Garden Homes					
Holly	16	309,000	602,500	417,100	232,500
Magnolia	23	332,300	647,800	448,500	253,600
Oak	6	346,200	675,000	467,300	265,800
Total / Weighted Average	153	$ 272,082	$ 530,523	$ 367,292	$ 182,841
Second Person Fee		$ 33,400	$ 65,130	$ 45,000	$ 20,200

Source: Management

Table 7
Independent Living Monthly Service Fees - 2022

Independent Living	Number of Units	All Lifecare Plans	Fee-for-Service Plan
Apartments			
Azalea	13	$ 2,925	$ 2,456
Birch	26	3,181	2,711
Camellia	29	3,478	3,007
Dogwood	20	3,774	3,332
Elm	20	4,092	3,652
Garden Homes			
Holly	16	4,468	3,684
Magnolia	23	4,675	3,920
Oak	6	4,811	4,057
Total / Weighted Average	153	$ 3,835	$ 3,286
Second Person Fee		$ 1,422	$ 822

Source: Management

Summary of Significant Projection Assumptions (Continued)

Residents under the Lifecare Plans requiring skilled nursing and assisted living services receive 14 free Health Care Center days per calendar year, and are then required to pay a Lifecare rate if the 14 free days are used within each calendar year. The Lifecare rate is equivalent to the current weighted average Lifecare monthly service fee of a single resident of the Community, as well as the charge for two additional daily meals not provided for in the monthly service fee.

Occupancy of the Assisted Living Units is projected to be from internal transfers from Independent Living Units. Nursing Bed occupancy is projected to be from internal transfers from both Independent Living Units and Assisted Living Units. Internal transfers include both temporary and permanent transfers. Temporary transfers reside in a Health Care Center Bed for a short-term stay and pay an added fee, in addition to their monthly service fee, according to their Residence and Services Agreement, as well as the cost of two meals per day. The Independent Living Unit is held while temporary transfers reside in the Health Care Center. Upon permanent transfer to the Health Care Center, the Independent Living Unit is released and the resident pays the specified Health Care Center fee, according to their Residence and Services Agreement.

Residents under the Fee-for-Service contracts requiring skilled nursing and assisted living services pay the current market monthly rate or per diem rate for care.

The monthly and daily service fees for private pay Fee-For-Service residents in the Health Care Center have been projected to increase 3.00% annually during the Projection Period. Lifecare rates are projected to increase 3.00% annually, Medicare rates are projected to increase 2.00% annually.

Table 8
Health Care Center Pricing – 2022

Level of Care	Number of Units	Lifecare Monthly Rates	Fee-for-Service Monthly Rates	Fee-for-Service Per Diem Rates
Traditional Assisted Living Units	12	$4,369	$5,963	$196
Memory Support Units	12	$4,369	$7,716	$254
Sheltered Nursing Beds	24	$4,369	$10,730	$353

Source: Management

Ancillary revenues are projected to average approximately 7.8% of net patient service revenue throughout the Projection Period.

Resident Mix

Management has projected the following Health Care Center resident mix, by contract and payor type, for the Projection Period.

Summary of Significant Projection Assumptions (Continued)

Table 9
Health Care Center Resident Mix by Contract and Payor Type

	Assisted Living		Sheltered Nursing		
Year Ending September 30,	Life Care	Fee-for-Service	Life Care	Medicare	Private Pay
2022	46.1%	53.9%	42.2%	9.4%	48.4%
2023	46.1%	53.9%	42.2%	9.4%	48.4%
2024	46.1%	53.9%	42.2%	9.4%	48.4%
2025	46.1%	53.9%	42.2%	9.4%	48.4%
2026	46.1%	53.9%	42.2%	9.4%	48.4%

Source: Management

Investment Income

Investment income included in the accompanying projected statements of operations and changes in net assets is based on an assumed blended rate of return of 0.25% annually during the Projection Period, based on cash and cash equivalents, investments, and assets limited as to use projected balances.

Other Revenue

Other revenue includes income from additional resident meals and snacks, guest meals, guest apartment rentals, respite care revenue, barber and beauty fees, private duty nursing services, and other miscellaneous revenue. Other revenue based on historical experience and Management has projected at an average of 6.8% of net patient service revenue annually during the Projection Period, according to Management.

Other Revenue Items

As of September 30, 2021, Management had approximately $267,000 remaining in Public Health Social Services Emergency Funds ("PHSSEF") as a result of the CARES Act during the COVID-19 pandemic that were deferred. Management has projected that it will utilize approximately $267,000, as allowed under the CARES Act, and has projected recognizing $267,000 into income during the year ending September 30, 2022. These amounts are included in Contribution Revenue – Provider Relief Funds on the projected statements of operations and changes in net assets. No additional CARES funds have been included in the Projection Period.

Summary of Significant Projection Assumptions (Continued)

Operating Expenses

Management has presented departmental expenses based on their function. Each projected departmental expense includes salaries and benefits as well as other costs.

Salaries and Benefits

Staffing of the Village is based on the Village's existing staffing levels and the experience of Management giving effect to the level of services offered at the Village. The Village is estimated to employ full-time equivalent ("FTE") employees throughout the Projection Period as noted below in Table 10. An FTE is based on 2,080 hours. Average salary and wage rates are based on current rates paid and are projected to increase approximately 3% annually during the Projection Period.

The costs of employees' fringe benefits are assumed to approximate an average of 42% of salaries and wages and primarily include FICA, medical and dental insurance, long-term disability, life insurance, worker's compensation, and retirement benefits.

The below table presents projected FTEs by department during the Projection Period.

Table 10
Projected FTEs
Years Ending September 30,

Department	2022	2023	2024	2025	2026
Health Care	38.1	38.1	38.1	38.1	38.1
Resident Services	7.6	7.6	7.6	7.6	7.6
Dietary	32.0	32.0	32.0	32.0	32.0
Plant Operations	6.8	6.8	6.8	6.8	6.8
Laundry	11.4	11.4	11.4	11.4	11.4
Housekeeping	7.5	7.5	7.5	7.5	7.5
Total	103.4	103.4	103.4	103.4	103.4

Source: Management

Health Care

Non-salary related Health Care Center costs are projected based upon Management's estimate of the costs of health care supplies, purchased services, consultants, and other miscellaneous costs associated with providing health care services. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

Summary of Significant Projection Assumptions (Continued)

Resident Services

Non-salary related resident service costs are projected based upon Management's estimate of providing resident service programs, activities supplies, and other miscellaneous costs associated with resident services. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

Dietary

Non-salary related dietary costs are projected based upon Management's estimate of the costs of providing food services to residents of the Village including raw food, dietary supplies, and other miscellaneous costs associated with providing dietary services. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

Plant Operations

Non-salary related plant operations costs are projected based upon Management's estimate of the costs of utilities, service contracts, repairs, general maintenance, supplies, and other miscellaneous costs associated with providing plant operations services. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

Laundry

Non-salary related laundry costs are projected based upon Management's estimate of the costs of service contracts, laundry supplies, and other miscellaneous costs associated with providing laundry services. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

Housekeeping

Non-salary related housekeeping costs are projected based upon Management's estimate of the costs of service contracts, housekeeping supplies, and other miscellaneous costs associated with providing housekeeping services. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

General and Administrative

Non-salary related general and administrative costs are projected based upon Management's estimate of the costs of professional fees, Management Fees, insurance, supplies, and other miscellaneous costs. These costs are anticipated to increase an average of approximately 3% annually during the Projection Period.

Property and Equipment and Depreciation Expense

Management estimates that the Village will incur routine capital additions during the Projection Period that will be capitalized as property and equipment. Estimated provisions for depreciation during the Projection Period were computed on the straight-line method using an average 7-year life for capital equipment additions.

Summary of Significant Projection Assumptions (Continued)

The following table reflects the major categories of property and equipment throughout the Projection Period.

Table 11
Projected Property and Equipment
Years Ending September 30,
(000s Omitted)

	2022	2023	2024	2025	2026
Land and Land Improvements	$ 9,421	$ 9,421	$ 9,421	$ 9,421	$ 9,421
Building & Fixed Equipment	68,889	70,889	72,889	74,889	76,889
Movable Equipment	2,100	2,100	2,100	2,100	2,100
	80,410	82,410	84,410	86,410	88,410
Less: Accumulated Depreciation	(29,261)	(32,443)	(35,641)	(38,882)	(42,191)
Property and Equipment, Net	$ 51,149	$ 49,967	$ 48,769	$ 47,528	$ 46,219

Source: Management

Long-Term Debt and Interest Expense

In conjunction with the affiliation of ARMC Health Care with Cone Health in 2013, all bond debt on the buildings of the Village was refinanced by Cone Health. As a result of the refinancing of the debt, the Village is no longer part of the obligated group. The Village has no obligation related to its previous debt and reports no interest expense.

Current Assets and Current Liabilities

Cash and Cash Equivalents
Cash and cash equivalents balances for the Projection Period are assumed to reflect net cash flows during the Projection Period.

Patient Accounts Receivable, Net
Patient accounts receivable, net of allowance for uncollectible accounts are projected at historical levels which approximate 6 days of operating revenue (excluding investment income).

Investments
Investments are projected based on the anticipated cash flows of the Projected Statements of Cash Flows.

Inventories
Inventories have been projected based on historical levels which approximate 1 day of operating expense (excluding depreciation).

Other Current Assets
Other current assets have been projected based on historical levels which approximate 1 day of operating expenses (excluding depreciation).

Summary of Significant Projection Assumptions (Continued)

Accounts Payable
Accounts payable have been projected based on historical levels which approximate 6 days of operating expenses (excluding depreciation).

Accrued Expenses
Accrued expenses have been projected based on historical levels which approximate 150 days of operating expenses (excluding depreciation).

Current Portion of Deferred Revenue from Entrance Fees
The current portion of deferred revenue from entrance fees has been projected based on the historical experience of the Village.

Assets Limited as to Use

Under regulations of the North Carolina Department of Insurance, the Village is required to maintain an operating reserve based on projected operating expenses. The operating reserve is based on a certain percentage of operating costs that depends on the independent living and assisted living occupancy. If occupancy is 90 percent or greater, the reserve percentage is 25 percent; otherwise, it is 50 percent of operating costs.

Table 12
Statutory Operating Reserve
As of September 30,
(000s Omitted)

	2022	2023	2024	2025	2026
Total Operating Expenses	$ 14,864	$ 15,231	$ 15,609	$ 16,025	$ 16,474
Exclude:					
Depreciation	(3,168)	(3,182)	(3,198)	(3,241)	(3,309)
Total Operating Costs	$ 11,696	$ 12,049	$ 12,411	$ 12,784	$ 13,165
Operating Reserve Percentage [1]	25%	25%	25%	25%	25%
Operating Reserve at 9/30	$ 2,924	$ 3,012	$ 3,103	$ 3,196	$ 3,291

Source: Management
Notes:
(1) Management's projected year-end occupancy percentages:

	2022	2023	2024	2025	2026
Available Units:					
Independent Living	153	153	153	153	153
Assisted Living	24	24	24	24	24
Total Available Units	177	177	177	177	177
Occupied Units:					
Independent Living	144.7	144.7	144.7	144.7	144.7
Assisted Living	22.0	22.0	22.0	22.0	22.0
Total Occupied Units	166.7	166.7	166.7	166.7	166.7
Occupancy at Year-end	94.2%	94.2%	94.2%	94.2%	94.2%

Source: Management

Summary of Significant Projection Assumptions (Continued)

Risks and Uncertainties

During March 2020, the World Health Organization declared the spread of Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. Specific to the Village, COVID-19 may impact various parts of its 2022 operations and financial results including but not limited to additional costs for emergency preparedness, disease control and containment, potential shortages of healthcare personnel, or loss of revenue due to reductions in certain revenue streams. Management believes the Village is taking appropriate actions to mitigate the negative impact. However, the full impact of COVID-19 is unknown and cannot be reasonably estimated as of the date of this Projection. Management has projected that its projected occupancies and access to labor would not be materially adversely impacted by COVID-19. In addition, Management has projected utilizing $267,000 of provider relief funds in fiscal year 2022 on expenses related to preventing, preparing for, or responding to the COVID-19 pandemic.

Future Event

Well-Spring Services, Inc. has entered into an agreement to acquire the Village from Cone Health. Well Spring has managed the Village since 2015. The transaction is expected to be completed no later than June 2022, pending regulatory approval. Management does not expect the merger to have any material impact on the projected operations of the Village.

Attachment C
Un-audited Financial Statement

Alamance Extended Care
Consolidated Statements of Operations
December 31, 2021

	ACTUAL 12/31/2021	ACTUAL Prior R3 Avg	ACTUAL Prior R12 Avg	ACTUAL 12/31/2020	$ Var Prior R3 Avg	$ Var Prior R12 Avg	$ Var 12/31/2020
REVENUE							
Gross Patient Revenue	$ 919,435	$ 880,412	$ 883,439	$ 913,859	$ 39,023	$ 35,996	$ 5,576
Revenue Deductions	47,599	32,403	42,909	(16)	(15,196)	(4,690)	(47,615)
Net Patient Service Revenue (Note 1)	871,836	848,009	840,530	913,875	23,827	31,306	(42,039)
Other Operating Revenue	258,058	348,792	336,725	263,841	(90,734)	(78,667)	(5,783)
TOTAL OPERATING REVENUES	**1,129,894**	**1,196,801**	**1,177,255**	**1,177,716**	**(66,907)**	**(47,361)**	**(47,822)**
EXPENSE							
Salaries and Wages	376,217	376,166	364,077	396,079	(51)	(12,140)	19,862
Fringe Benefits	158,092	154,842	150,138	155,752	(3,250)	(7,954)	(2,340)
Purchased Personnel	56,279	56,427	58,118	64,234	148	1,839	7,955
Supplies	89,410	75,055	75,782	66,268	(14,355)	(13,628)	(23,142)
Other Operating Expense	384,018	342,746	382,002	449,645	(41,272)	(2,016)	65,627
Depreciation/Amortization	265,291	268,534	247,681	367,330	3,243	(17,610)	102,039
TOTAL OPERATING EXPENSE	**1,329,307**	**1,273,770**	**1,277,798**	**1,499,308**	**(55,537)**	**(51,509)**	**170,001**
INCOME FROM OPERATIONS	**(199,413)**	**(76,969)**	**(100,543)**	**(321,592)**	**(55,537)**	**(51,509)**	**170,001**
OTHER INCOME							
Other Expense (Note 3)	(1)	-	3,494	1	1	3,495	2
Total Other Income (Expense)	**494**	**620**	**5,251**	**1,423**	**126**	**4,757**	**929**
EXCESS OF REVENUES OVER EXPENSE	**(198,919)**	**(76,349)**	**(95,292)**	**(320,169)**	**(122,570)**	**(103,627)**	**121,250**
INCREASE IN UNRESTRICTED NET ASSETS	**$ (198,919)**	**$ (76,349)**	**$ (95,292)**	**$ (320,169)**	**$ (122,570)**	**$ (103,627)**	**$ 121,250**
Operating Margin %	-17.65%	-6.43%	-8.54%	-27.31%	-11.22%	-9.11%	9.66%
Operating EBIDA Margin %	5.83%	16.01%	12.50%	3.88%	-10.18%	-6.67%	1.95%
Excess Revenue over Expense Margin %	-17.60%	-6.38%	-8.06%	-27.15%	-11.22%	-9.54%	9.56%

Alamcne Extended Care, Inc
BALANCE SHEET
December 31, 2021

ASSETS:

CURRENT ASSETS:	
Cash	9,885,765
Patient Accounts Receivable	167,257
Allowance for Uncollectibles	(1,192)
Net Patient Accounts Receivable	166,065
Other Receivables	572
Inventories	22,542
Prepaid Expenses	80,000
TOTAL CURRENT ASSETS	10,154,945
PROPERTY, PLANT & EQUIPMENT:	
Land & Land Improvements	9,593,599
Buildings & Fixed Equipment	65,947,281
Movable Equipment	2,053,716
Accumuated Depreciation	(26,884,924)
Construction In Progress/Equipment In Progress	1,401,553
Property, Plant & Equipment (Net)	52,111,224
Investments	3,075,872
Other Assets	-
TOTAL ASSETS	65,342,042

LIABILITIES AND NET ASSETS:

CURRENT LIABILITIES	
Accrued Payroll	1,935,408
Accounts Payable	895,174
Pal & Retirement	242,132
Other Current Liabilities	5,674,214
TOTAL CURRENT LIABILITIES	8,746,928
OTHER NON-CURRENT LIABILITIES	14,838,639
TOTAL LIABILITIES	23,585,567
UNRESTRICTED FUNDS	41,484,357
TEMPORARILY RESTRICTED FUNDS	272,118
	41,756,475
LIABILITIES AND NET ASSETS	65,342,042

AEC Cash Flow Summary at 12-31-21

Increase (Decrease) in net assets	951,039
Adjustments to reconcile revnue and gains in excess of expenses and losses to new cash provided by operating activities	
Change in net unrealized gains and losses on investments	-
Net realized (gains) on sale of investments	-
Depreciation and amortization	(1,920,432)
Provision for uncollectible accounts	168,270
Changes to medical claims IBNR in Care-n-Care of NC	
(Increase) Decrease in patient accounts receivable	(264,364)
(Increase) Decrease in prepaids and other receivables	(701,591)
(Increase) Decrease in inventory	-
Increase (Decrease) in accounts payable and accrued expenses	(766,619)
Contribution to pension liability	-
Change in other operating assets and liabilities (net)	1,144,983
Net cash provided by oerpating activities and gains and losses	(1,388,714)
CASH FLOWS FROM INVESTING ACTIVITIES	
(Additions) to Property, Plant and Equipment	3,132,398
Loss on write off of property and equipment	-
Purchases of investments	-
Proceeds from sale of investments	-
Net cash used in investing activities	3,132,398
CASH FLOWS FROM FINANCING ACTIVITIES	
Payments on capital lease obligations	-
Net cash used in financing activities	-
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	1,743,684
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	8,818,955
CASH AND CASH EQUIVALENTS, END OF PERIOD	10,562,639

Attachment D
Residence and Service Agreement
Life Care

LIFE CARE
RESIDENCE AND SERVICES AGREEMENT
The Village at Brookwood

This Life Care Residence and Services Agreement ("Agreement") is made this day of ____________________, _________, by and between Alamance Extended Care, Inc., d.b.a. THE VILLAGE AT BROOKWOOD, ("The Village" or "Provider") and ____ ("Resident", if more than one person enters into the agreement, the word "Resident" shall apply to them collectively unless otherwise stated).

Whereas, the Provider is a non-profit 501(c)(3) corporation and a wholly owned subsidiary of ARMC Health Care, chartered by the State of North Carolina, and is organized to establish and operate a retirement community; and

Whereas, the Provider operates The Village at Brookwood, a continuing care retirement community located on Brookwood Avenue in Burlington, North Carolina, consisting of apartment residences, garden home residences, a community center with common areas and amenities, wellness center and a licensed health care center providing assisted living, skilled nursing care, and memory care; and

Whereas, the Resident desires to enter into this Agreement with The Village, and has made the following choices regarding residence and accompanying fees:

Residence Number: ____

Residence Type: ____
(hereinafter referred to as "Residence")

Resident Entrance Fee: ____

Co-Resident Entrance Fee: ____

Entrance Fee Option: ____

Resident Monthly Fee: ____

Co-Resident Monthly Fee: ____

Now, therefore, the Resident and the Provider agree as follows:

I. RESIDENCE, COMMON AREAS, AMENITIES, PROGRAMS AND SERVICES

A. **Residence**. Except as set forth in this Agreement, the Resident has the right to occupy, use, and enjoy the Residence and services of The Village during the term of this Agreement.

B. **Furnishings in the Residence**. The Village provides flooring, appliances and other furnishings per current standards as described in The Village's current literature. The Resident will be responsible for furnishing the Residence. All furniture and electrical and other appliances provided by the Resident shall be subject to The Village's approval in order to keep the Residence safe and sanitary.

C. **Options and Custom Features in the Residence**. The Resident may select certain options and custom features for the Residence as described in The Village's literature for an additional charge. Any such options and custom features selected and paid for by the Resident will become the property of The Village. The value of any such improvements will be considered in computing refunds if such options or custom features involve structural changes to the Residence or substantially increase livable square footage in the Residence.

D. **Common Areas and Amenities**. The Village maintains common areas and amenities for the use and benefit of all residents.

E. **Parking**. The Village provides parking areas for the Resident's personal vehicle and limited parking for guests.

F. **Storage**. Limited storage space of one (1) unit per apartment is provided by The Village for apartment residents and shall be in addition to the space in each apartment. Garden homes have storage rooms adjacent to the carport and/or garage.

G. **Services and Programs**.

1. **Utilities**. The Village furnishes heating, air conditioning, electricity, water, sewer service, trash removal, telephone including long distance, basic cable TV and secure WIFI access. The Resident is responsible for the charges for expanded cable television service. The Village shall not be responsible for any periods of disruption regarding these utilities.

2. **Dining Services**. The Village will provide nutritionally balanced meals per published dining hours. The Resident's monthly service fee will include a meal plan, which the Resident may choose in accordance with The Village dining services procedures. The cost of additional meals taken by the Resident will be billed on a monthly basis.

3. **Special Diets**. When authorized by the Village's medical and dietary personnel, meals accommodating special diets may be provided. The Provider may make additional charges for special diets.

4. **Tray Service**. When authorized by The Village, meal delivery may be provided to you in your Residence. The Village may make additional charges for meals delivered to the Residence per current scheduled fees.

5. **Housekeeping Services**. The Village provides weekly housekeeping services. Additional housekeeping may be scheduled at the request and expense of the Resident.

6. **Laundry**. The Village provides washers and dryers in the Residence.

7. **Grounds-keeping**. The Village furnishes basic grounds-keeping services including lawn, tree, and shrubbery care. The Resident may plant and maintain certain areas designated for such purpose by The Village.

8. **Maintenance and Repairs**. The Village maintains and repairs its own improvements, furnishings, appliances, and equipment. The Resident will be responsible for the cost of repairing damage to property of The Village caused by the Resident or any guests of the Resident, ordinary wear and tear excepted.

9. **Transportation**. The Village provides local transportation for medical appointments for residents on a regularly scheduled basis. An additional charge may be made for transportation for special, personal, or group trips.

10. **Security**. The Village provides twenty-four (24) hour staffing to include evening and nighttime security patrol. Emergency call devices are provided, and smoke detectors will be located in each Residence. Security cameras may be located in parking areas and at building entrances or other common areas.

11. **Life Enrichment**. The Village provides planned and scheduled social, recreational, spiritual, educational and cultural activities; arts and crafts classes; and other special activities. Some activities may require an additional charge.

12. **Wellness Programs**. The Village provides a variety of exercise programs, including aquatic classes, exercise equipment and aerobics as a part of an overall Wellness Program.

13. **Health Care Services**:

    a. **Health Care Center**. The Health Care Center consists of licensed Assisted Living, Memory Care, and Skilled Nursing accommodations.

        (1) **Assisted Living Services**. The Assisted Living section of the Provider is licensed by North Carolina as an Adult Care Home, where assistance with daily living activities may include: bathing, dressing, administration of

medication, bed making, three (3) meals per day, housekeeping, transportation, activities, and personal laundry service.

(2) **Memory Care**. The Village provides, in a separate Assisted Living section of the facility licensed by North Carolina as an Adult Care Home, specialized services for memory support. Assistance with daily living activities tailored to the different needs of the residents may include: bathing, dressing, administration of medication, bed making, three (3) meals per day, housekeeping, transportation, specialized activities, and personal laundry service.

(3) **Skilled Nursing Services**. The Village provides nursing care in its licensed nursing center as may be deemed necessary by the Medical Director and/or their staff. The Resident agrees that nursing care provided by The Village shall be limited to care in keeping with licensure requirements. Services may include three (3) meals per day, housekeeping, assistance with daily living activities, and nursing services as ordered by the appropriate physician.

(4) **Staffing**. The Health Care Center is staffed by licensed and certified nursing staff twenty-four (24) hours per day and meets all North Carolina licensing requirements.

b. **Clinic Services**:

(1) A health clinic, staffed with a licensed nurse, is available on site during scheduled hours for resident use.

(2) Additional periodic services may be provided through the Clinic as deemed necessary by The Village. The cost of such services shall be the responsibility of the Resident.

c. **Medical Director**. The overall coordination and supervision of health care services by The Village is provided by a Medical Director who is a physician licensed by the State of North Carolina and selected by Provider.

d. **Physician Services**. The Resident is responsible for the cost of all physician services. Residents are free to choose their personal physicians; however, The Village recommends that the Resident have at least one physician on record that has been approved for admitting privileges by the Alamance Regional Medical Center Medical Staff.

II. FINANCIAL ARRANGEMENTS

A. **Entrance Fee Refund Options**. The Resident agrees to pay to The Village an Entrance Fee as a condition of becoming a Resident. Refunds will be handled as described in Section VI below. The Resident shall choose one of the following Entrance Fee Refund Options:

Entrance Fee Refund Option	Amortization Schedule
Standard	The Entrance Fee (less an initial 6% nonrefundable fee) will be amortized at 2% per month for 47 months after which time the Entrance Fee is fully amortized. Any refund due to the Resident will be paid (as described in Section VI below).
50% Refund	The Entrance Fee (less an initial 6% nonrefundable fee) will be amortized at 2% per month for 22 months. Any refund due to the Resident will be paid (as described in Section VI below).
90% Refund	The Entrance Fee (less an initial 6% nonrefundable fee) will be amortized at 2% per month for 2 months. Any refund due to the Resident will be paid (as described in Section VI below).

The Resident must notify The Village in writing of the selection of the Standard, 50% Refund or 90% Refund Entrance Fee Option on or before the date that the balance of the Entrance Fee is paid as provided in Section II.B. below. The Resident may not change the refund option selected after the date that the balance of the Entrance Fee is paid.

B. **Terms of Payment of the Balance of the Entrance Fee**. The balance of the total Entrance Fee for the Entrance Fee Option selected by the Resident will be due and payable by the mutually agreed upon date of occupancy.

C. **Monthly Fee**. In addition to the Entrance Fee, the Resident agrees to pay a Monthly Fee during occupancy which shall be payable upon receipt of invoice each month. The first month's Monthly Fee is due and payable by the date of occupancy and will be prorated based on the day of the month.

D. **Adjustments in the Monthly Fee**. The Monthly Fee provides for the facilities, programs, and services described in this Agreement and is intended to meet the cost of the expenses associated with the operation and management of The Village. The Village shall have the authority and discretion to adjust the Monthly Fee during the term of this Agreement to reflect increases and changes in costs of providing the facilities, programs, and services described herein consistent with operating on a sound

financial basis and maintaining the quality of services provided to residents. At least a thirty (30) day notice will be given to the Resident before any adjustment in fees or charges.

E. **Away Allowance**. Residents away from The Village for fourteen (14) consecutive days or more, and who make arrangements in advance with The Village (excluding hospitalizations), will be credited with a current published dining services credit.

F. **Monthly Statements**. The Village will furnish the Resident with a monthly statement showing the total amount of fees and other charges owed by the Resident which shall be due and payable upon receipt of invoice each month. The Village may charge interest at a rate of one and one-half Percent (1½%) per month on any unpaid balance owed by the Resident Thirty (30) Days after the monthly statement is furnished.

G. **Fees and Charges for Health Care Services**.

1. **Life Care Benefit**. Should the Resident qualify for services in the Health Care Center, it is understood that at the time of transfer the Resident will be charged a monthly fee known as the Life Care Benefit. The Life Care Benefit will apply to Assisted Living, Assisted Living Memory Care and Skilled Nursing accommodations.

2. **Additional Charges for Ancillary Services**. Charges in addition to the monthly fee may be made for ancillary services provided at The Village. Examples of such additional ancillary charges include, but are not limited to: the cost of prescription and non-prescription medications; surgical, podiatric, dental, optical services; physical examinations; physician services; laboratory tests; physical therapy, occupational therapy, rehabilitative treatments; wheelchairs; other medical equipment and supplies; and any other medical services beyond those available in The Village. Such services are contracted and may not be regularly available. Also, any professional services (medical or otherwise) contracted by the Resident or on behalf of the Resident shall be billed directly to the Resident or their assigned third party.

3. **Illness Away From the Village**. The Resident agrees to assume all financial responsibility for hospital, medical and nursing care during any illness or accident occurring while away from The Village and to see that, upon return, full medical information is supplied to The Village for the Resident's medical records file.

4. **Life Care Respite Benefit**. Fourteen (14) days of qualified respite care are available to Life Care Residents on an annual basis. This benefit applies to skilled nursing only.

III. ADMISSION REQUIREMENTS AND PROCEDURES

The admission requirements for residence at The Village are non-discriminatory; The Village is open to individuals of all races, color, gender, religious beliefs, sexual orientation

and national origin. A prospective resident will become qualified for admission to The Village upon satisfaction of the following provisions:

A. **Age**. Generally, admission is restricted to persons 62 years of age or older. If one member of the residential party is 62, the co-resident may be 55 years of age or older.

B. **Residence and Services Agreement**. Upon notification of acceptance by Provider, the Resident shall enter into this Agreement.

C. **Representations**. The Resident affirms that the representations made in the required Application for Residency as well as the Reservation Agreement that was previously executed by the parties (which representations include a confidential personal and health history and a financial disclosure), are true and correct and may be relied upon by the Provider as a basis for entering into this Agreement.

D. **Direct Admission to Health Care Center**. Upon admission, if it is determined by Provider that Resident is unable to live independently in the residence, such resident may be offered direct admission to the Health Care Center. Such Resident shall pay monthly fees equal to the current Fee for Service per diem rate (as described in The Village's current literature) in the Health Care Center (for the required level of care, Assisted Living, Skilled Care or Memory Care). Residents directly admitted to the Health Care Center shall complete the Amendment to Residence and Services Agreement for Direct Admission to Health Care and documents as required by the Provider and North Carolina licensure statutes. In the event a Resident that qualifies for direct admission into the Health Care Center has a Co-Resident that does not qualify for such direct admission, the Co-Resident shall continue to be governed by the terms of this Agreement as a single occupant of the Residence.

IV. TERMS OF OCCUPANCY

A. **Rights of Resident**. The Resident has the right to occupy, use, and enjoy the Residence, common areas, amenities, programs, and services of The Village during the term of this Agreement. It is understood that this Agreement does not transfer or grant any interest in the real or personal property owned by the Provider other than the rights and privileges as described in this Agreement.

Occupancy (and the obligations of the Provider for care of the Resident) shall be defined as beginning when the Resident has paid the Entrance Fee in full and has paid the first month's Monthly Fee.

B. **Policies and Procedures**. The Resident will abide by The Village's policies and procedures and such amendments, modifications, and changes of the policies and procedures as may hereafter be adopted by the Provider.

C. **Changes in the Residence, Services, or Fees**. Provider has the right to change the Residence, the services offered, or the fees charged to meet requirements of, or changes to any applicable statute, law, or regulation. The Residence may not be used in any manner in violation of any zoning ordinances or other governmental law or regulation.

D. <u>Visitors</u>. The Resident shall be free to invite guests to the Residence for daily and overnight visits. Guest rooms may be available from time to time at a reasonable rate for overnight stays by your guests. The Village reserves the right to make rules regarding visits and guest behavior and may limit or terminate a visit at any time for reasons it deems appropriate. Two (2) weeks is the maximum continuous stay for guests unless prior approval from the Executive Director is obtained. Except for short-term guests, no person other than the Resident or a Co-Resident, if any, may reside in the Residence without prior approval of The Village.

E. <u>Occupancy by Two Residents</u>. In the event that two Residents occupy a Residence under the terms of this Agreement, upon the permanent transfer to the Health Care Center or the death of one Resident, or in the event of the termination of this Agreement with respect to one of the Residents, the Agreement shall continue in effect as to the remaining or surviving Resident who shall have the option to retain the same Residence. Should the remaining or surviving Resident wish to move to another residence, the policies of The Village governing said residence transfer will prevail.

F. <u>Addition of a Co-Resident or Marriage</u>. If a Resident marries a person who is also a Resident, the two Residents may occupy the Residence of either Resident and shall surrender the Residence not to be occupied by them. Such married Residents will pay the Monthly Fee for double occupancy associated with the Residence occupied by them. In the event that a Resident shall marry a person who is not a Resident of The Village, the spouse may become a Resident if such spouse meets all the current requirements for admission to The Village, enters into a current version of the Life Care Residence and Services Agreement with Provider, and pays the current single person Entrance Fee for the smallest one bedroom apartment at The Village. The Resident and spouse shall pay the Monthly Fee for double occupancy associated with the Residence occupied by them. If the Resident's spouse does not meet the requirements of The Village for admission as a resident, the Resident may terminate this Agreement in the same manner as provided in Section VI.B. hereof with respect to a voluntary termination.

G. <u>Loss or Damage of Property</u>. Provider shall not be responsible for the loss or damage of any property belonging to the Resident due to theft, mysterious disappearance, fire or any other cause. Resident shall provide any desired insurance protection covering any such personal loss. Provider shall insure all property (except personal property) within all residences and common areas belonging to The Village.

H. <u>Health Insurance and Assignments</u>. If not already enrolled, the Resident shall apply for and secure, before taking occupancy, coverage under Medicare Parts A and B and any other hospital or medical insurance benefit program which supplements Medicare or other comparable insurance accepted by Provider. The Resident shall provide Provider with evidence of such coverage or of an acceptable substitute insurance plan and shall pay all premiums.

The Resident shall authorize, as necessary, any provider of hospital, medical, and health services to receive reimbursement under the programs designated in this Section IV. H.

If the Resident is or becomes entitled to medical care and/or reimbursement from governmental agencies or insurance policies, application shall be made for such care and benefits, and the Resident shall assign all insurance proceeds receivable to Provider to the extent necessary to reimburse Provider for all health care expenditures made by Provider on behalf of the Resident.

I. Right of Entry. Resident hereby authorizes employees or agents of Provider to enter the Residence for reasonable purposes, including without limitation the following: housekeeping, repairs, maintenance, inspection, fire drills, and in the event of emergency. Provider shall when feasible use reasonable efforts to enter at scheduled times or upon prior notice to Resident. Resident shall afford Provider's employees or agents access to all areas of the Residence when requested to ensure that the Residence is maintained in good repair in accordance with this Agreement and to ensure the health and safety of Resident and other Residents.

J. Residents' Association. Residents of The Village are encouraged to participate in the Residents' Association Committees. The organization elects representatives, officers, and other positions to engage in concerted activities set forth by the Residents' Association.

K. Tobacco Free Campus. The Village at Brookwood is a Tobacco Free Campus. Smoking and tobacco use is prohibited for residents, staff and visitors.

V. TRANSFERS OR CHANGES IN LEVELS OF CARE

A. Voluntary Transfer between Independent Residences. The Resident may transfer from one independent Residence to another. The Resident shall comply with The Village's current Resident Transfer Advantage Program for selection of such Residence. There may be a refurbishment fee (for the Residence being vacated) charged for such a transfer.

1. **Transfer of Resident to a Larger Residence**. If the Resident elects to transfer to a larger Residence, an additional Entrance Fee (according to the Entrance Fee Refund Option selected at the original Date of Occupancy) equal to the difference between the Entrance Fee for the smaller Residence and the Entrance Fee for the larger Residence will be due to The Village. The Resident will also pay the Monthly Service Fee associated with the larger Residence.

2. **Transfer of Resident to a Smaller Residence**. The Resident may elect to transfer to a smaller Residence and pay the current monthly service fee for that Residence. The transfer to a smaller Residence shall not result in any entrance fee refund.

B. Transfer to the Health Care Center. The Resident agrees that Provider shall have authority to determine that the Resident be transferred from one level of care to another

level of care within The Village. Such determination shall be based on the professional opinion of the Medical Director and shall be made after reasonable efforts to consult with the Resident or the Resident's chosen and legal representative.

C. **Transfer to Hospital or Other Facility**. If it is determined by Provider that the Resident needs care beyond that which can be provided by The Village; the Resident may be transferred to a hospital, center, or institution equipped to give such care and such care will be at the expense of the Resident. Such transfer of the Resident will be made only after consultation to the extent possible with the Resident or the Resident's chosen and legal representative.

D. **Surrender of Residence**. If a determination is made by Provider that any transfer described in Section V.B. or V.C. is likely to be permanent in nature, the Resident agrees to surrender the Residence upon such transfer. The Provider shall continue charging the monthly fees until such time that the Residence is vacated. If Provider subsequently determines that the Resident can resume occupancy in a Residence or accommodation comparable to that occupied by the Resident prior to such transfer, the Resident shall have priority to such residence as soon as it becomes available.

VI. TERMINATION AND REFUND PROVISIONS

A. **Termination by Resident Prior to Occupancy**. This Agreement may be terminated by the Resident for any reason prior to occupancy by giving written notice to Provider. In the event of such termination, the Resident shall receive a refund of the 10% Deposit paid by the Resident, less any expenses incurred by The Village and less a nonrefundable fee equal to 2% of the total amount of the selected Entrance Fee option.

If the Resident dies before occupying the Residence, or if, on account of illness, injury, or incapacity, the Resident would be precluded from occupying the Residence under the terms of this Agreement, this Agreement is automatically canceled. The nonrefundable fee (equal to 2% of the total amount of the selected Entrance Fee option) will not be charged, however, if such termination is because of death of a Resident, or because the Resident's physical, mental or financial condition makes the Resident ineligible for entrance to The Village.

Any such refund shall be paid by The Village within sixty (60) days following receipt of notification of such termination. Provider requires that such notification be in writing.

B. **Voluntary Termination after Occupancy**. At any time after occupancy, the Resident may terminate this Agreement by giving Provider thirty (30) days written notice of such termination. Such notice effectively releases the Residence to The Village. Any refunds of the Entrance Fee due to the Resident shall be calculated based upon the Entrance Fee option chosen by the Resident and as described in Section II.A. Any refund due the Resident under this paragraph will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one

(1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

C. Termination upon Death. In the event of death of the Resident at any time after occupancy, this Agreement shall terminate and the refund of the Entrance Fee paid by the Resident shall be calculated based upon the Entrance Fee option chosen by the Resident and as described in Section II.A. Any refund due to the Resident's estate will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

D. Termination by Provider. Provider may terminate this Agreement at any time if there has been a material misrepresentation or omission made by the Resident in the Resident's Application for Admission, Personal Health History, or Confidential Financial Statement; if the Resident fails to make payment to Provider of any fees and charges due The Village within sixty (60) days of the date when due; or if the Resident does not abide by the rules and regulations adopted by Provider or breaches any of the terms and conditions of this Agreement. Any refunds of the Entrance Fee due to the Resident shall be calculated based upon the Entrance Fee option chosen by the Resident and as described in Section II.A. Any refund due the Resident under this paragraph will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

E. Condition of Residence. At termination of this Agreement, the Resident shall vacate the Residence and shall be liable to The Village for any cost incurred in restoring the Residence to good condition except for normal wear and tear. The Provider shall continue charging the monthly fees until such time that the Residence is vacated. Any refunds due the Resident upon termination may be credited against the cost of returning the Residence to its original condition.

VII. RIGHT OF RESCISSION

Notwithstanding anything herein to the contrary, this Agreement may be rescinded by the Resident giving written notice of such rescission to The Village within thirty (30) days following the later of the execution of this Agreement or the receipt of the Disclosure Statement that meets the requirements of Section 58-64-25, et.seq. of the North Carolina General Statutes. In the event of such rescission, the Resident shall receive a refund of the Entrance Fee paid by the Resident, less 2%. The Resident shall not be required to move into The Village before the expiration of such thirty (30) day period. Any such refund shall be paid by The Village within sixty (60) days following receipt of written notice of rescission pursuant to this paragraph.

VIII. FINANCIAL ASSISTANCE

Provider declares that it is the intent of The Village to permit a Resident to continue to reside at The Village if the Resident is no longer capable of paying the prevailing fees and charges of The Village as a result of financial reversals occurring after occupancy, provided such reversals, in Provider's judgment, are not the result of willful or unreasonable dissipation of the Resident's assets. In the event of such circumstances, Provider will give careful consideration to subsidizing the fees and charges payable by the Resident so long as such subsidy can be made without impairing the ability of Provider to operate on a sound financial basis. Any determination by Provider with regard to the granting of financial assistance shall be within the sole discretion of Provider.

IX. GENERAL

A. **Relationships between Residents and Staff Members**. Employees of The Village are supervised solely by The Village's management staff, and not by residents. Employees and their families may not accept gratuities, bequests, or payment of any kind from residents. Any complaints about employees or requests for special assistance must be made to the appropriate supervisor or to the Executive Director or his/her designee. The Resident acknowledges and agrees that the Resident or the Resident's family will not hire The Village's employees or solicit such employees to resign their employment at The Village in order to work for the Resident or the Resident's family. The Resident also acknowledges and agrees that, unless consented to by The Village, the Resident will not hire any former Village employee until three (3) months has elapsed from the date of termination of the person's employment at The Village.

B. **Assignment**. The rights and privileges of the Resident under this Agreement to the Residence, common areas, and amenities, and services, and programs of The Village are personal to the Resident and may not be transferred or assigned by the Resident or otherwise.

C. **Management of The Village at Brookwood**. The absolute rights of management are reserved by Provider, its Board of Directors, and its administration as delegated by said Board of Directors. The Village retains all authority regarding acceptance of Residents, adjustment of fees, financial assistance, and all other aspects of the management of The Village. Residents do not have the right to determine admission or terms of admission of any other Resident.

D. **Entire Agreement**. This Agreement constitutes the entire agreement between Provider and the Resident. Provider shall not be liable or bound in any manner by any statements, representations, or promises made by any person representing or assuming to represent Provider, unless such statements, representations, or promises are set forth in this Agreement.

E. **Successors and Assigns**. Except as set forth herein, this Agreement shall bind and inure to the benefit of the successors and assigns of The Village and the heirs, executors, administrators, and assigns of the Resident.

F. **Power of Attorney, Will, Living Will, and Health Care Power of Attorney**. The Resident agrees to execute a power of attorney designating some competent person as attorney-in-fact. The Resident is also encouraged to execute a will, Living Will and Health Care Power of Attorney. The Resident shall provide The Village with copies of Power of Attorney, Living Will, and Health Care Power of Attorney, as well as the location of the Will, prior to occupancy.

G. **Transfer of Property**. The Resident agrees not to make any gift or other transfer of property for less than adequate consideration for the purpose of evading the Resident's obligations under this Agreement or if such gift or transfer would render such Resident unable to meet such obligations.

H. **Governing Law**. This Agreement shall be governed by the laws of the State of North Carolina.

I. **Disclosure Statement**. The Resident acknowledges that a current copy of the Disclosure Statement for The Village at Brookwood has been received.

J. **Third Party Injuries and Claims**. Provider is not required to provide any medical, surgical, nursing or other care for the Resident when the Resident is injured as a result of the fault or negligence of a third party or parties. The Resident shall promptly notify Provider of any such injury. In the event that Provider provides such care as can be furnished by its employees and facilities, the Resident hereby assigns to Provider any compensation that the Resident may recover from such third party or parties to the extent necessary to reimburse Provider for the cost of such care furnished by Provider. The Resident or his legal representative shall have the duty to pursue diligently any and all proper claims for compensation due from a third party or parties for injury to the Resident and to cooperate with Provider in collecting such compensation and reimbursing Provider for the cost of all such care provided the Resident.

K. **Affiliations of the Provider**. The Village at Brookwood is not affiliated with any religious or charitable provider other than its owner, ARMC Health Care. All financial and contractual obligations of The Village at Brookwood will be the sole responsibility of The Village; the owner will not be responsible for any of these obligations.

L. **Notice Provisions**. Any notices, consents, or other communications to The Village hereunder (collectively "notices") shall be in writing and addressed as follows:

Executive Director
The Village at Brookwood
1860 Brookwood Avenue
Burlington, North Carolina 27215

The address of the Resident for the purpose of giving notice is the address appearing after the signature of the Resident below.

IN WITNESS WHEREOF, The Provider has executed this Agreement and Resident has read and understands this Agreement and has executed this Agreement as of the day and year above written.

______________________ Witness	______________________ Resident
______________________ Witness	______________________ Co-Resident
	______________________ Date
	______________________ Address (Prior to Occupancy)
	______________________ City, State, Zip Code
	______________________ Telephone
	THE VILLAGE AT BROOKWOOD
	______________________ Signature (Executive Director)
	______________________ Date

EXHIBIT A

TARGET OCCUPANCY DATE: ______________________________

FEE SCHEDULE: Entrance Fees and Monthly Fees are based on the type of Residence you occupy and the number of persons residing in the Residence. The Residence you have selected, and the applicable fees are stated below:

RESIDENCE NUMBER: ______________________________

RESIDENCE TYPE: ______________________________

ENTRANCE FEE FOR:

( ) Resident ______________________________

( ) Co-Resident ______________________________

TOTAL ENTRANCE FEE: ______________________________

CREDIT FOR FRIENDS ADVANTAGE PROGRAM (FAP) OR WAIT LIST: (______________________________)

CREDIT FOR PARTIAL PAYMENTS OF THE ENTRANCE FEE RECEIVED: (______________________________)

ENTRANCE FEE BALANCE DUE AND PAYABLE: ______________________________

MONTHLY FEE FOR:

( ) Resident ______________________________

( ) Co-Resident ______________________________

TOTAL MONTHLY FEE: ______________________________

REFUND OPTION SELECTED:

( ) Life Care – Standard, Declining Refund

( ) Life Care – Fifty Percent (50%) Refund

( ) Life Care – Ninety Percent (90%) Refund

ADDRESSES FOR REQUIRED NOTICE:

To The Village:

The Village at Brookwood
Attention: Executive Director
1860 Brookwood Avenue
Burlington, NC 27215

To You Prior to Occupancy:

Name: ____

Address: ____

City, State, Zip Code: ____

To You Following Occupancy:

Name: ____

Address: ____

City, State, Zip Code: ____

Your signature below certifies that you have read, understand and accept this Exhibit A.

Applicant: ____

Co-Applicant: ____

Date: ____

Attachment E
Residence and Services Agreement
Fee for Service

FEE FOR SERVICE
RESIDENCE AND SERVICES AGREEMENT
The Village at Brookwood

This Fee for Service Residence and Services Agreement ("Agreement") is made this ______ day of ____________________, _________, by and between Alamance Extended Care, Inc., d.b.a. THE VILLAGE AT BROOKWOOD, ("The Village" or "Provider") and ____ ("Resident", if more than one person enters into the agreement, the word "Resident" shall apply to them collectively unless otherwise stated).

Whereas, the Provider is a non-profit 501(c)(3) corporation and a wholly-owned subsidiary of ARMC Health Care, chartered by the State of North Carolina, and is organized to establish and operate a retirement community; and

Whereas, the Provider operates The Village at Brookwood, a continuing care retirement community located on Brookwood Avenue in Burlington, North Carolina, consisting of apartment residences, garden home residences, a community center with common areas and amenities, wellness center and a licensed health care center providing assisted living, skilled nursing care, and memory care; and

Whereas, the Resident desires to enter into this Agreement with The Village, and has made the following choices regarding residence and accompanying fees:

Residence Number: ____

Residence Type: ____
(hereinafter referred to as "Residence")

Resident Entrance Fee: ____

Co-Resident Entrance Fee: ____

Resident Monthly Fee: ____

Co-Resident Monthly Fee: ____

Now, therefore, the Resident and the Provider agree as follows:

I. RESIDENCE, COMMON AREAS, AMENITIES, PROGRAMS AND SERVICES

A. Residence. Except as set forth in this Agreement, the Resident has the right to occupy, use, and enjoy the Residence and services of The Village during the term of this Agreement.

B. Furnishings in the Residence. The Village provides flooring, appliances and other furnishings per current standards as described in The Village's current literature. The Resident will be responsible for furnishing the Residence. All furniture and electrical and other appliances provided by the Resident shall be subject to The Village's approval in order to keep the Residence safe and sanitary.

C. Options and Custom Features in the Residence. The Resident may select certain options and custom features for the Residence as described in The Village's literature for an additional charge. Any such options and custom features selected and paid for by the Resident will become the property of The Village. The value of any such improvements will be considered in computing refunds if such options or custom features involve structural changes to the Residence or substantially increase livable square footage in the Residence.

D. Common Areas and Amenities. The Village maintains common areas and amenities for the use and benefit of all residents.

E. Parking. The Village provides parking areas for the Resident's personal vehicle and limited parking for guests.

F. Storage. Limited storage space of one (1) unit per apartment is provided by The Village for apartment residents and shall be in addition to the space in each apartment. Garden homes have storage rooms adjacent to the carport and/or garage.

G. Services and Programs.

1. **Utilities.** The Village furnishes heating, air conditioning, electricity, water, sewer service, trash removal, telephone including long distance, basic cable TV and secure WIFI access. The Resident is responsible for the charges for expanded cable television service. The Village shall not be responsible for any periods of disruption regarding these utilities.

2. **Dining Services.** The Village will provide nutritionally balanced meals per published dining hours. The Resident's monthly service fee will include a meal plan, which the Resident may choose in accordance with The Village dining services procedures. The cost of additional meals taken by the Resident will be billed on a monthly basis.

3. **Special Diets.** When authorized by the Provider's medical and dietary personnel, meals accommodating special diets may be provided. The Provider may make additional charges for special diets.

4. **Tray Service.** When authorized by The Village, meal delivery may be provided to you in your Residence. The Village may make additional charges for meals delivered to the Residence per current scheduled fees.

5. **Housekeeping Services.** The Village provides housekeeping services every other week. Additional housekeeping may be scheduled at the request and expense of the Resident.

6. **Laundry.** The Village provides washers and dryers in the Residence.

7. **Grounds-keeping.** The Village furnishes basic grounds-keeping services including lawn, tree, and shrubbery care. The Resident may plant and maintain certain areas designated for such purpose by The Village.

8. **Maintenance and Repairs.** The Village maintains and repairs its own improvements, furnishings, appliances, and equipment. The Resident will be responsible for the cost of repairing damage to property of The Village caused by the Resident or any guests of the Resident, ordinary wear and tear excepted.

9. **Transportation.** The Village may provide transportation services for residents. An additional charge may be made for transportation for special, personal, or group trips.

10. **Security.** The Village provides twenty-four (24) hour staffing to include evening and nighttime security patrol. Emergency call devices are provided and smoke detectors will be located in each Residence. Security cameras may be located in parking areas and at building entrances or other common areas.

11. **Life Enrichment.** The Village provides planned and scheduled social, recreational, spiritual, educational and cultural activities; arts and crafts classes; and other special activities. Some activities may require an additional charge.

12. **Wellness Programs.** The Village provides a variety of exercise programs, including aquatic classes, exercise equipment and aerobics as a part of an overall Wellness Program.

13. **Health Care Services:**

    a. **Health Care Center**. The Health Care Center consists of licensed Assisted Living, Memory Care, and Skilled Nursing accommodations.

        (1) **Assisted Living Services**. The Assisted Living section of the Provider is licensed by North Carolina as an Adult Care Home, where assistance with daily living activities may include: bathing, dressing, administration of

medication, bed making, three (3) meals per day, housekeeping, transportation, activities, and personal laundry service.

(2) **Memory Care**. The Village provides, in a separate Assisted Living section of the facility licensed by North Carolina as an Adult Care Home, specialized services for memory support. Assistance with daily living activities tailored to the different needs of the residents may include: bathing, dressing, administration of medication, bed making, three (3) meals per day, housekeeping, transportation, specialized activities, and personal laundry service.

(3) **Skilled Nursing Services**. The Village provides nursing care in its licensed nursing center as may be deemed necessary by the Medical Director and/or their staff. The Resident agrees that nursing care provided by The Village shall be limited to care in keeping with licensure requirements. Services may include three (3) meals per day, housekeeping, assistance with daily living activities, and nursing services as ordered by the appropriate physician.

(4) **Staffing**. The Health Care Center is staffed by licensed and certified nursing staff twenty-four (24) hours per day and meets all North Carolina licensing requirements.

b. **Clinic Services**:

(1) A health clinic, staffed with a licensed nurse, is available on site during scheduled hours for resident use.

(2) Additional periodic services may be provided through the health clinic as deemed necessary by The Village. The cost of such services shall be the responsibility of the Resident.

c. **Medical Director**. The overall coordination and supervision of health care services by The Village is provided by a Medical Director who is a physician licensed by the State of North Carolina and selected by Provider.

d. **Physician Services**. The Resident is responsible for the cost of all physician services. Residents are free to choose their personal physicians; however, The Village recommends that the Resident have at least one physician on record that has been approved for admitting privileges by the Alamance Regional Medical Center Medical Staff.

II. FINANCIAL ARRANGEMENTS

A. Entrance Fee Refund. The Resident agrees to pay to The Village an Entrance Fee as a condition of becoming a Resident. Refunds will be handled as described in Section VI below.

Entrance Fee Refund	Amortization Schedule
Standard	The Entrance Fee (less an initial 6% nonrefundable fee) will be amortized at 2% per month for 47 months after which time the Entrance Fee is fully amortized. Any refund due to the Resident will be paid (as described in Section VI below).

B. Terms of Payment of the Balance of the Entrance Fee. The balance of the total Entrance Fee will be due and payable by the mutually agreed upon date of occupancy.

C. Monthly Fee. In addition to the Entrance Fee, the Resident agrees to pay a Monthly Fee during occupancy which shall be payable upon receipt of invoice each month. The first month's Monthly Fee is due and payable by the date of occupancy and will be prorated based on the day of the month.

D. Adjustments in the Monthly Fee. The Monthly Fee provides for the facilities, programs, and services described in this Agreement and is intended to meet the cost of the expenses associated with the operation and management of The Village. The Village shall have the authority and discretion to adjust the Monthly Fee during the term of this Agreement to reflect increases and changes in costs of providing the facilities, programs, and services described herein consistent with operating on a sound financial basis and maintaining the quality of services provided to residents. At least a thirty (30) day notice will be given to the Resident before any adjustment in fees or charges.

E. Monthly Statements. The Village will furnish the Resident with a monthly statement showing the total amount of fees and other charges owed by the Resident which shall be due and payable upon receipt of invoice each month. The Village may charge interest at a rate of one and one-half Percent (1½%) per month on any unpaid balance owed by the Resident Thirty (30) Days after the monthly statement is furnished.

F. Fees and Charges for Health Care Services.

Should the Resident need and qualify for the services of the Health Care Center, it is understood that the Resident will be charged the published "per diem rate" for those services. The Village will file Medicare and third party insurance when deemed to be a covered benefit.

1. **Additional Charges for Ancillary Services**. Charges in addition to the monthly fee may be made for ancillary services provided at The Village. Examples of such

additional ancillary charges include, but are not limited to: the cost of prescription and non-prescription medications; surgical, podiatric, dental, optical services; physical examinations; physician services; laboratory tests; physical therapy, occupational therapy, rehabilitative treatments; wheelchairs; other medical equipment and supplies; and any other medical services beyond those available in The Village. Such services are contracted and may not be regularly available. Also, any professional services (medical or otherwise) contracted by the Resident or on behalf of the Resident shall be billed directly to the Resident or their assigned third party.

2. **Illness Away From the Village**. The Resident agrees to assume all financial responsibility for hospital, medical and nursing care during any illness or accident occurring while away from The Village and to see that, upon return, full medical information is supplied to The Village for the Resident's medical records file.

III. ADMISSION REQUIREMENTS AND PROCEDURES

The admission requirements for residence at The Village are non-discriminatory; The Village is open to individuals of all races, color, gender, religious beliefs, sexual orientation and national origin. A prospective resident will become qualified for admission to The Village upon satisfaction of the following provisions:

A. **Age**. Generally, admission is restricted to persons 62 years of age or older. If one member of the residential party is 62, the co-resident may be 55 years of age or older.

B. **Residence and Services Agreement**. Upon notification of acceptance by Provider, the Resident shall enter into this Agreement.

C. **Representations**. The Resident affirms that the representations made in the required Application for Residency as well as the Reservation Agreement that was previously executed by the parties (which representations include a confidential personal and health history and a financial disclosure), are true and correct and may be relied upon by the Provider as a basis for entering into this Agreement.

D. **Direct Admission to Health Care Center**. Upon admission, if it is determined by Provider that Resident is unable to live independently in the Residence, the Resident may be offered direct admission to the Health Care Center. Such Resident shall pay monthly fees equal to the current Fee for Service per diem rate (as described in The Village's current literature) in the Health Care Center (for the required level of care, Assisted Living, Skilled Care or Memory Care). Residents directly admitted to the Health Care Center shall complete the Amendment to Residence and Services Agreement for Direct Admission to Health Care and documents as required by the Provider and North Carolina licensure statutes. In the event a Resident that qualifies for direct admission into the Health Care Center has a Co-Resident that does not qualify for such direct admission, the Co-Resident shall continue to be governed by the terms of this Agreement as a single occupant of the Residence.

IV. TERMS OF OCCUPANCY

A. <u>Rights of Resident</u>. The Resident has the right to occupy, use, and enjoy the Residence, common areas, amenities, programs, and services of The Village during the term of this Agreement. It is understood that this Agreement does not transfer or grant any interest in the real or personal property owned by the Provider other than the rights and privileges as described in this Agreement.

Occupancy (and the obligations of the Provider for care of the Resident) shall be defined as beginning when the Resident has paid the Entrance Fee in full and has paid the first month's Monthly Fee.

B. <u>Policies and Procedures</u>. The Resident will abide by The Village's policies and procedures and such amendments, modifications, and changes of the policies and procedures as may hereafter be adopted by the Provider.

C. <u>Changes in the Residence, Services, or Fees</u>. Provider has the right to change the Residence, the services offered, or the fees charged to meet requirements of, or changes to any applicable statute, law, or regulation. The Residence may not be used in any manner in violation of any zoning ordinances or other governmental law or regulation.

D. <u>Visitors</u>. The Resident shall be free to invite guests to the Residence for daily and overnight visits. Guest rooms may be available from time to time at a reasonable rate for overnight stays by your guests. The Village reserves the right to make rules regarding visits and guest behavior and may limit or terminate a visit at any time for reasons it deems appropriate. Two (2) weeks is the maximum continuous stay for guests unless prior approval from the Executive Director is obtained. Except for short-term guests, no person other than the Resident or a Co-Resident, if any, may reside in the Residence without prior approval of The Village.

E. <u>Occupancy by Two Residents</u>. In the event that two Residents occupy a Residence under the terms of this Agreement, upon the permanent transfer to the Health Care Center or the death of one Resident, or in the event of the termination of this Agreement with respect to one of the Residents, the Agreement shall continue in effect as to the remaining or surviving Resident who shall have the option to retain the same Residence. Should the remaining or surviving Resident wish to move to another residence, the policies of The Village governing said residence transfer will prevail.

F. <u>Addition of a Co-Resident or Marriage</u>. If a Resident marries a person who is also a Resident, the two Residents may occupy the Residence of either Resident and shall surrender the Residence not to be occupied by them. Such married Residents will pay the Monthly Fee for double occupancy associated with the Residence occupied by them. In the event that a Resident shall marry a person who is not a Resident of The Village, the spouse may become a Resident if such spouse meets all the current requirements for admission to The Village, enters into a current version of the Fee for Service Residence and Services Agreement with Provider, and pays the current single person Entrance Fee for the smallest one bedroom apartment at The Village. The

Resident and spouse shall pay the Monthly Fee for double occupancy associated with the Residence occupied by them. If the Resident's spouse does not meet the requirements of The Village for admission as a resident, the Resident may terminate this Agreement in the same manner as provided in Section VI.B. hereof with respect to a voluntary termination.

G. Loss or Damage of Property. Provider shall not be responsible for the loss or damage of any property belonging to the Resident due to theft, mysterious disappearance, fire or any other cause. Resident shall provide any desired insurance protection covering any such personal loss. Provider shall insure all property (except personal property) within all residences and common areas belonging to The Village.

H. Health Insurance and Assignments. If not already enrolled, the Resident shall apply for and secure, before taking occupancy, coverage under Medicare Parts A and B and any other hospital or medical insurance benefit program which supplements Medicare or other comparable insurance accepted by Provider. The Resident shall provide Provider with evidence of such coverage or of an acceptable substitute insurance plan, and shall pay all premiums.

The Resident shall authorize, as necessary, any provider of hospital, medical, and health services to receive reimbursement under the programs designated in this Section IV.H.

If the Resident is or becomes entitled to medical care and/or reimbursement from governmental agencies or insurance policies, application shall be made for such care and benefits, and the Resident shall assign all insurance proceeds receivable to Provider to the extent necessary to reimburse Provider for all health care expenditures made by Provider on behalf of the Resident.

I. Right of Entry. Resident hereby authorizes employees or agents of Provider to enter the Residence for reasonable purposes, including without limitation the following: housekeeping, repairs, maintenance, inspection, fire drills, and in the event of emergency. Provider shall when feasible use reasonable efforts to enter at scheduled times or upon prior notice to Resident. Resident shall afford Provider’s employees or agents access to all areas of the Residence when requested to ensure that the Residence is maintained in good repair in accordance with this Agreement and to ensure the health and safety of Resident and other Residents.

J. Residents’ Association. Residents of The Village are encouraged to participate in the Residents’ Association Committees. The organization elects representatives, officers, and other positions to engage in concerted activities set forth by the Residents’ Association.

K. Tobacco Free Campus. The Village at Brookwood is a Tobacco Free Campus. Smoking and tobacco use is prohibited for residents, staff and visitors.

V. TRANSFERS OR CHANGES IN LEVELS OF CARE

A. Voluntary Transfer between Independent Residences. The Resident may transfer from one independent Residence to another. The Resident shall comply with The Village's current Resident Transfer Advantage Program for selection of such Residence. There may be a refurbishment fee (for the Residence being vacated) charged for such a transfer.

1. **Transfer of Resident to a Larger Residence**. If the Resident elects to transfer to a larger Residence, an additional Entrance Fee (according to the Entrance Fee at the original Date of Occupancy) equal to the difference between the Entrance Fee for the smaller Residence and the Entrance Fee for the larger Residence will be due to The Village. The Resident will also pay the Monthly Service Fee associated with the larger Residence.

2. **Transfer of Resident to a Smaller Residence**. The Resident may elect to transfer to a smaller Residence, and pay the current monthly service fee for that Residence. The transfer to a smaller Residence shall not result in any entrance fee refund.

B. Transfer to the Health Care Center. The Resident agrees that Provider shall have authority to determine that the Resident be transferred from one level of care to another level of care within The Village. Such determination shall be based on the professional opinion of the Medical Director, and shall be made after reasonable efforts to consult with the Resident or the Resident's chosen and legal representative.

C. Transfer to Hospital or Other Facility. If it is determined by Provider that the Resident needs care beyond that which can be provided by The Village, the Resident may be transferred to a hospital, center, or institution equipped to give such care and such care will be at the expense of the Resident. Such transfer of the Resident will be made only after consultation to the extent possible with the Resident or the Resident's chosen and legal representative.

D. Surrender of Residence. If a determination is made by Provider that any transfer described in Section V.B. or V.C. is likely to be permanent in nature, the Resident agrees to surrender the Residence upon such transfer. The Provider shall continue charging the monthly fees until such time that the Residence is vacated. If Provider subsequently determines that the Resident can resume occupancy in a Residence or accommodation comparable to that occupied by the Resident prior to such transfer, the Resident shall have priority to such residence as soon as it becomes available.

VI. TERMINATION AND REFUND PROVISIONS

A. Termination by Resident Prior to Occupancy. This Agreement may be terminated by the Resident for any reason prior to occupancy by giving written notice to Provider. In the event of such termination, the Resident shall receive a refund of the 10% Deposit paid by the Resident, less any expenses incurred by The Village and less a nonrefundable fee equal to 2% of the total amount of the Entrance Fee.

If the Resident dies before occupying the Residence, or if, on account of illness, injury, or incapacity, the Resident would be precluded from occupying the Residence under the terms of this Agreement, this Agreement is automatically canceled. The nonrefundable fee (equal to 2% of the total amount of the Entrance Fee) will not be charged, however, if such termination is because of death of a Resident, or because the Resident's physical, mental or financial condition makes the Resident ineligible for entrance to The Village.

Any such refund shall be paid by The Village within sixty (60) days following receipt of notification of such termination. Provider requires that such notification be in writing.

B. **<u>Voluntary Termination after Occupancy</u>**. At any time after occupancy, the Resident may terminate this Agreement by giving Provider thirty (30) days written notice of such termination. Such notice effectively releases the Residence to The Village. Any refunds of the Entrance Fee due to the Resident shall be calculated as described in Section II.A. Any refund due the Resident under this paragraph will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

C. **<u>Termination upon Death</u>**. In the event of death of the Resident at any time after occupancy, this Agreement shall terminate and the refund of the Entrance Fee paid by the Resident shall be calculated as described in Section II.A. Any refund due to the Resident's estate will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

D. **<u>Termination by Provider</u>**. Provider may terminate this Agreement at any time if there has been a material misrepresentation or omission made by the Resident in the Resident's Application for Admission, Personal Health History, or Confidential Financial Statement; if the Resident fails to make payment to Provider of any fees and charges due The Village within sixty (60) days of the date when due; or if the Resident does not abide by the rules and regulations adopted by Provider or breaches any of the terms and conditions of this Agreement. Any refunds of the Entrance Fee due to the Resident shall be calculated as described in Section II.A. Any refund due the Resident under this paragraph will be made at such time as such Resident's Residence shall have been reserved by a prospective resident and such prospective resident shall have paid to The Village the full Entrance Fee, or within one (1) year from the date of termination, whichever first occurs. All refunds may be reduced by the cost of returning the Residence to its original condition and by any outstanding charges due from Resident.

E. **<u>Condition of Residence</u>**. At termination of this Agreement, the Resident shall vacate the Residence and shall be liable to The Village for any cost incurred in restoring the Residence to good condition except for normal wear and tear. The Provider shall continue charging the monthly fees until such time that the Residence is vacated. Any refunds due the Resident upon termination may be credited against the cost of returning the Residence to its original condition.

VII. RIGHT OF RESCISSION

Notwithstanding anything herein to the contrary, this Agreement may be rescinded by the Resident giving written notice of such rescission to The Village within thirty (30) days following the later of the execution of this Agreement or the receipt of the Disclosure Statement that meets the requirements of Section 58-64-25, et.seq. of the North Carolina General Statutes. In the event of such rescission, the Resident shall receive a refund of the Entrance Fee paid by the Resident, less 2%. The Resident shall not be required to move into The Village before the expiration of such thirty (30) day period. Any such refund shall be paid by The Village within sixty (60) days following receipt of written notice of rescission pursuant to this paragraph.

VIII. FINANCIAL ASSISTANCE

Provider declares that it is the intent of The Village to permit a Resident to continue to reside at The Village if the Resident is no longer capable of paying the prevailing fees and charges of The Village as a result of financial reversals occurring after occupancy, provided such reversals, in Provider's judgment, are not the result of willful or unreasonable dissipation of the Resident's assets. In the event of such circumstances, Provider will give careful consideration to subsidizing the fees and charges payable by the Resident so long as such subsidy can be made without impairing the ability of Provider to operate on a sound financial basis. Any determination by Provider with regard to the granting of financial assistance shall be within the sole discretion of Provider.

IX. GENERAL

A. **<u>Relationships between Residents and Staff Members</u>**. Employees of The Village are supervised solely by The Village's management staff, and not by residents. Employees and their families may not accept gratuities, bequests, or payment of any kind from residents. Any complaints about employees or requests for special assistance must be made to the appropriate supervisor or to the Executive Director or his/her designee. The Resident acknowledges and agrees that the Resident or the Resident's family will not hire The Village's employees or solicit such employees to resign their employment at The Village in order to work for the Resident or the Resident's family. The Resident also acknowledges and agrees that, unless consented to by The Village, the Resident will not hire any former Village employee until three (3) months has elapsed from the date of termination of the person's employment at The Village.

B. **<u>Assignment</u>**. The rights and privileges of the Resident under this Agreement to the Residence, common areas, and amenities, and services, and programs of The Village

are personal to the Resident and may not be transferred or assigned by the Resident or otherwise.

C. **Management of The Village at Brookwood**. The absolute rights of management are reserved by Provider, its Board of Directors, and its administration as delegated by said Board of Directors. The Village retains all authority regarding acceptance of Residents, adjustment of fees, financial assistance, and all other aspects of the management of The Village. Residents do not have the right to determine admission or terms of admission of any other Resident.

D. **Entire Agreement**. This Agreement constitutes the entire agreement between Provider and the Resident. Provider shall not be liable or bound in any manner by any statements, representations, or promises made by any person representing or assuming to represent Provider, unless such statements, representations, or promises are set forth in this Agreement.

E. **Successors and Assigns**. Except as set forth herein, this Agreement shall bind and inure to the benefit of the successors and assigns of The Village and the heirs, executors, administrators, and assigns of the Resident.

F. **Power of Attorney, Will, Living Will, and Health Care Power of Attorney**. The Resident agrees to execute a power of attorney designating some competent person as attorney-in-fact. The Resident is also encouraged to execute a will, Living Will and Health Care Power of Attorney. The Resident shall provide The Village with copies of Power of Attorney, Living Will, and Health Care Power of Attorney, as well as the location of the Will, prior to occupancy.

G. **Transfer of Property**. The Resident agrees not to make any gift or other transfer of property for less than adequate consideration for the purpose of evading the Resident's obligations under this Agreement or if such gift or transfer would render such Resident unable to meet such obligations.

H. **Governing Law**. This Agreement shall be governed by the laws of the State of North Carolina.

I. **Disclosure Statement**. The Resident acknowledges that a current copy of the Disclosure Statement for The Village at Brookwood has been received.

J. **Third Party Injuries and Claims**. Provider is not required to provide any medical, surgical, nursing or other care for the Resident when the Resident is injured as a result of the fault or negligence of a third party or parties. The Resident shall promptly notify Provider of any such injury. In the event that Provider provides such care as can be furnished by its employees and facilities, the Resident hereby assigns to Provider any compensation that the Resident may recover from such third party or parties to the extent necessary to reimburse Provider for the cost of such care furnished by Provider. The Resident or his legal representative shall have the duty to pursue diligently any and all proper claims for compensation due from a third party or parties for injury to the

Resident and to cooperate with Provider in collecting such compensation and reimbursing Provider for the cost of all such care provided the Resident.

K. <u>Affiliations of the Provider</u>. The Village at Brookwood is not affiliated with any religious or charitable provider other than its owner, ARMC Health Care. All financial and contractual obligations of The Village at Brookwood will be the sole responsibility of The Village; the owner will not be responsible for any of these obligations.

L. <u>Notice Provisions</u>. Any notices, consents, or other communications to The Village hereunder (collectively "notices") shall be in writing and addressed as follows:

Executive Director
The Village at Brookwood
1860 Brookwood Avenue
Burlington, North Carolina 27215

The address of the Resident for the purpose of giving notice is the address appearing after the signature of the Resident below.

IN WITNESS WHEREOF, The Provider has executed this Agreement and Resident has read and understands this Agreement and has executed this Agreement and the Ten Percent (10%) Deposit has been paid as of the day and year above written.

______________________________	______________________________
Witness	Resident
______________________________	______________________________
Witness	Co-Resident
	______________________________
	Date
	______________________________
	Address (Prior to Occupancy)
	______________________________
	City, State, Zip Code
	______________________________
	Telephone
	THE VILLAGE AT BROOKWOOD
	______________________________
	Signature (Executive Director)
	______________________________
	Date

EXHIBIT A

TARGET OCCUPANCY DATE:	______________________________
FEE SCHEDULE:	Entrance Fees and Monthly Fees are based on the type of Residence you occupy and the number of persons residing in the Residence. The Residence you have selected and the applicable fees are stated below:
RESIDENCE NUMBER:	______________________________
RESIDENCE TYPE:	______________________________
ENTRANCE FEE FOR:	
( ) Resident	______________________________
( ) Co-Resident	______________________________
TOTAL ENTRANCE FEE:	______________________________
CREDIT FOR FRIENDS ADVANTAGE PROGRAM (FAP) OR WAIT LIST:	(______________________________)
CREDIT FOR PARTIAL PAYMENTS OF THE ENTRANCE FEE RECEIVED:	(______________________________)
ENTRANCE FEE BALANCE DUE AND PAYABLE:	______________________________
MONTHLY FEE FOR:	
( ) Resident	______________________________
( ) Co-Resident	______________________________
TOTAL MONTHLY FEE:	______________________________

ADDRESSES FOR REQUIRED NOTICE:

To The Village:

The Village at Brookwood
Attention: Executive Director
1860 Brookwood Avenue
Burlington, NC 27215

To You Prior to Occupancy:

Name: ________________________________

Address: ________________________________

City, State, Zip Code: ________________________________

To You Following Occupancy:

Name: ________________________________

Address: ________________________________

City, State, Zip Code: ________________________________

Your signature below certifies that you have read, understand and accept this Exhibit A.

Applicant: ________________________________

Co-Applicant: ________________________________

Date: ________________________________

Attachment F

Reservation Agreement

RESERVATION AGREEMENT
The Village at Brookwood

The undersigned applicant(s) ("you") hereby tender(s) this Reservation Agreement (“Agreement”), together with payment of Reservation Fee (described below) to The Village at Brookwood, ("The Village") for the purpose of reserving an Independent Living Residence at The Village at Brookwood, in Burlington, North Carolina ("The Village").

The terms of this Agreement between you and The Village are as follows:

<u>TERM</u>

This Agreement becomes effective when signed by both you and The Village, and The Village receives your Reservation Fee. This Agreement terminates when you sign a Residence and Services Agreement with The Village, unless it is terminated earlier by you or by The Village in accordance with the terms of this Agreement.

<u>THE RESERVED RESIDENCE</u>

You have reserved the Independent Living Residence identified on the attached Exhibit A (the "Reserved Residence"). A site plan showing the location of the Reserved Residence together with a floor plan of the Reserved Residence are attached. This Reservation Agreement gives you first priority to enter into a Residence and Services Agreement for the Reserved Residence before the Residence is made available to other applicants for independent living residences in The Village.

The Village has made every effort to accurately describe its plans for the Reserved Residence and The Village in the informational materials and Disclosure Statement furnished to you. The Reserved Residence and The Village may vary somewhat from the information furnished to you. The Village will furnish you with a Disclosure Statement as required by North Carolina law.

<u>FEES</u>

The Reservation Fee and Entrance Fee for the Reserved Residence shall be payable as follows:

- The Reservation Fee shall equal ten percent (10%) of the Entrance Fee (less the One Thousand Dollar ($1,000.00) FAP fee, if applicable) as set forth in Exhibit A. It shall be paid upon execution of this Reservation Agreement and will be credited to the total Entrance Fee. The Entrance Fee for your Reserved Residence for the Refund Option selected shall not be increased above the Entrance Fee set forth on Exhibit A.

- The balance of the Entrance Fee and first month’s Monthly Fee shall be due and payable at or before your Target Occupancy Date (as described on Exhibit A).

- Checks for all fees should be made payable to The Village at Brookwood.

ACCEPTANCE TO THE VILLAGE

To begin the process of obtaining residency at The Village, you must select an available Residence and submit an Application for Residency, provided by The Village, which includes a confidential personal and health history and a financial disclosure, this signed Reservation Agreement, and the Reservation Fee (which shall equal ten percent (10%) of the selected Entrance Fee option set forth on Exhibit A). All confidential documents will be kept on file at The Village. You agree to provide The Village with true and complete responses to all information requested by The Village.

Your Application for Residency will be reviewed by The Village. The Village requires an onsite health assessment to be conducted by our healthcare team within thirty (30) days of this Agreement. You shall also submit a report of a physical examination, completed on a medical form provided by The Village, by a physician of your choice and returned to The Village no more than sixty (60) days prior to occupancy. The form shall include a statement by the physician that the you are in good health and are capable of independent living (able to provide self-care in activities of daily living). You shall be responsible for the cost of such physical examinations. If your health as disclosed by such physical examination differs materially from that disclosed in your Application for Residency, The Village shall have the right to decline your admission to the Residence and may offer occupancy in the Health Care Center. If additional information is required, you or your physician will be contacted, and The Village may contact and request information from other physicians and health care providers who have provided you with treatment.

Once The Village has received the additional information from your physician, The Village will evaluate your eligibility for residency at The Village in accordance with its residency criteria. For residency at The Village, applicants must be at least sixty-two (62) years of age, in the case of Co-applicants, the Co-applicant must be at least fifty-five (55) years of age, able to live independently, and possess adequate resources to meet present and future financial obligations to The Village for the Reserved Residence selected.

Your race, color, gender, religious beliefs, sexual orientation, or national origin will not have any bearing upon whether you are accepted into The Village.

If you are approved for residency at The Village, an acceptance letter will be sent welcoming you. You agree to execute the then current version of the Residence and Services Agreement within seven (7) calendar days after The Village notifies you that you have been accepted for residency at The Village.

You agree that if you are accepted for residency by The Village and decide to sign a Residence and Services Agreement, you will commence occupancy on a mutually agreed upon date. This date shall not be more than ninety (90) calendar days after you sign the Residence and Services Agreement. The Village will use its best efforts to establish an occupancy date that is acceptable to you. The balance of the Entrance Fee and first month’s Monthly Fee shall be due and payable at or before your Target Occupancy Date.

TERMINATION AND REFUNDS

This Agreement will terminate upon any of the following occurrences:

(a) you fail to pay the Reservation Fee;
(b) you die, or if your Co-applicant dies, before the Residence and Services Agreement becomes effective;
(c) you submit to The Village written notice of termination of Agreement for any reason;
(d) you are not accepted by The Village;
(e) you fail to sign a Residence and Services Agreement in accordance with the terms of this Agreement;
(f) you experience changes in your financial status prior to occupancy at The Village that causes you to fail to meet The Village's financial qualifications for admission;
(g) you experience changes in your health status that prevent you from being able to live in independent living.

The Reservation Fee, less any fees charged by The Village, will be credited to the balance of the Entrance Fee when payment of that balance is due.

If you or The Village terminate this Agreement for a reason other than your signing a Residence and Services Agreement, The Village shall have the right to reassign the Reserved Residence, and you will have no further rights to that Reserved Residence except that a surviving Co-applicant shall be given the opportunity to enter into a new Reservation Agreement for the Reserved Residence based on single occupancy or on joint occupancy with another Co-applicant before the Reserved Residence is offered to others. In case of termination of this Agreement for reasons set forth in a., b., d., f., and g. above, The Village will return all Reservation Fees, less any fees charged by The Village, to you or your legal representative. Should this Agreement be terminated for the reasons set forth in c. or e. above, in addition to any fees charged by The Village, The Village reserves the right to withhold an administrative charge of two percent (2%) of your total Entrance Fee amount, from any refunds owed to you to the extent permitted by law.

Any refund due to you will be made within sixty (60) days after the termination of this Agreement (unless this Agreement is terminated as a result of you and The Village entering into a residence and Services Agreement in which no refund is due hereunder).

MISCELLANEOUS

Your rights under this Agreement may not be transferred to any other person. When a reservation is made by Co-applicants, the word "you" shall be deemed to include both of you.

This Agreement will be governed by the laws of the State of North Carolina, and specifically by the North Carolina law governing continuing care facilities, Chapter 58, Article 64 of the General Statutes of North Carolina.

Notices shall be given in writing and shall be given to The Village or to you at the addresses set forth in Exhibit A, or at such address as The Village and you shall specify in writing to each other.

By signing this Agreement, you certify that you understand and agree to its terms.

By signing this Agreement, you acknowledge that you received a current copy of The Village Disclosure Statement dated ____________________, 20____.

____________________________________ ________________
Applicant's Signature Date

____________________________________ ________________
Co-Applicant's Signature Date

THE VILLAGE AT BROOKWOOD

____________________________________ ________________
Authorized Representative Date

EXHIBIT A

TARGET OCCUPANCY DATE: ______________________________

FEE SCHEDULE: Entrance Fees and Monthly Fees are based on the type of Residence you occupy and the number of persons residing in the Residence. The Residence you have selected and the applicable fees are stated below:

RESIDENCE NUMBER: ______________________________

RESIDENCE TYPE: ______________________________

ENTRANCE FEE FOR:
- ( ) Resident ______________________________
- ( ) Co-Resident ______________________________

TOTAL ENTRANCE FEE: ______________________________

CREDIT FOR FRIENDS ADVANTAGE PROGRAM (FAP) OR WAIT LIST: (______________________________)

CREDIT FOR PARTIAL PAYMENTS OF THE ENTRANCE FEE RECEIVED: (______________________________)

ENTRANCE FEE BALANCE DUE AND PAYABLE: ______________________________

MONTHLY FEE FOR:
- ( ) Resident ______________________________
- ( ) Co-Resident ______________________________

TOTAL MONTHLY FEE: ______________________________

REFUND OPTION SELECTED:
- ( ) Life Care – Standard, Declining Refund
- ( ) Life Care – Fifty Percent (50%) Refund
- ( ) Life Care – Ninety Percent (90%) Refund
- ( ) Fee For Service – Standard, Declining Refund

ADDRESSES FOR REQUIRED NOTICE:

To The Village:

The Village at Brookwood
Attention: Executive Director
1860 Brookwood Avenue
Burlington, NC 27215

To You Prior to Occupancy:

Name: ____

Address: ____

City, State, Zip Code: ____

To You Following Occupancy:

Name: ____

Address: ____

City, State, Zip Code: ____

Your signature below certifies that you have read, understand and accept this Exhibit A.

Applicant: ____

Co-Applicant: ____

Date: ____

Attachment G

Summary of Most Recent

Actuarial Report

ACTUARIAL COMPILATION REPORT
FOR
THE VILLAGE AT BROOKWOOD
AS OF SEPTEMBER 30, 2020

prepared
March 6, 2021

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MANAGING CONSULTANTS
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March 6, 2021

Mr. Steve Fleming
President/CEO
The Well Spring Group
4100 Well Spring Drive
Greensboro, NC 27410

Dear Mr. Fleming:

We have prepared a compilation of actuarial tables and projections for The Village at Brookwood based on census data as of September 30, 2020, internal unaudited financial statements as of September 30, 2020, and the fiscal year 2021 operating budget and capital budgets, all of which were provided by you. Enclosed are several tables that show the results of this compilation. It is our opinion that the financial condition of The Village at Brookwood is in satisfactory actuarial balance as defined by Actuarial Standards of Practice No. 3 and The Village at Brookwood has earned the AVP exemplary recognition seal.

A.V. Powell & Associates' actuarial compilation report includes the following items:

- A projection of future population flows and independent living turnover
- An actuarial valuation of reserves held on behalf of current residents
- An actuarial pricing analysis of fees charged to new entrants
- A cash flow projection of future cash sources and uses

These projections, evaluated together, provide a reasonable basis for determining whether the CCRC contracts are priced adequately. Due to the long-term nature of CCRC contracts, and uncertainties regarding health care and refund guarantees, sound financial management requires integration of actuarial methods into CCRC financial projections.

By applying actuarial techniques, management can quantify a policy to minimize intergenerational subsidies. This means that the fee structure is expected to be self-supporting for each generation of residents. Contracts are priced, and evaluated, with a goal of matching the annual increase in monthly and entry fees to the rate of increase in the CCRC's expenses. The internal inflation rate includes increasing costs related to adding programs and services as well as normal expense inflation. An

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adequately priced fee structure will automatically result in the accumulation of funds to cover the future shortfall between fees and deferred liabilities.

Population Projection

The population projection (refer to Table 2.1) shows expected independent living turnover and health center utilization by contractholders for the next 20 years.

The population projection indicates that independent living turnover is expected to average about 15 units per year. The actuarial projection indicates that turnover is likely to range from about 9 units per year to 21 units per year due to random fluctuation in experience.

The population projection shows that The Village at Brookwood has sufficient health center (assisted living and nursing care) capacity to meet expected contractholder needs. This projection does not include any direct admits to assisted living or nursing care in the starting census, nor does it assume any future direct admits into these care levels. The health care utilization only reflects residents who originated in independent living. Assisted living utilization is projected to remain level at 17 to 20 beds per year throughout the 20-year projection period. Nursing care utilization is projected to increase to 23 beds per year by the end of the 20-year projection period.

These projections are based on the September 30, 2020, census (refer to Table 0.1.1) and increasing occupancy from 146 independent living units as of September 30, 2020, to 149 units as of September 30, 2021, and level thereafter. The average age of the current census is 85 years (refer to Table 0.1.2) and the assumed weighted average entry age is 80 years (refer to Table 1.4). The life expectancy for the typical female entrant is 10.1 years (refer to Table 1.3); this value is based on actuarial decrement assumptions that were developed from an analysis of The Village at Brookwood experience.

Our health care utilization projections are consistent with the historical practices at The Village at Brookwood and other similar CCRCs around the country. Health care utilization can be influenced by several factors, including management's philosophy regarding aging-in-place, the number and mix of health care beds, and the availability of home care services and private duty nurses. Therefore, if transfer policies change in the future, actual utilization could be different than projected.

Actuarial Valuation

The purpose of the actuarial valuation is to determine whether The Village at Brookwood has adequate reserves to fund its contractual obligation to residents as of the valuation date (refer to Table 4.1). The actuarial valuation provides an early warning of deficiencies in pricing policies, far in advance of a financial crisis.

The funded status of The Village at Brookwood is 136.3%. The funded status as of September 30, 2019, was 140.8%. The funded status decreased due to operating expenses increasing at a much higher percentage (16%) over 2019 operating budget and monthly fees increasing as only 3%. The funded status represents the portion of liabilities (future expenses) covered by assets (future monthly fees and reserves). A funded status of 100% means the liability is fully funded. A funded status of 105% to 110% is desirable to assure an appropriate surplus. For CCRCs reviewed by A.V. Powell & Associates the median funded status is 106.0%. The funded status for The Village at Brookwood places it in the top quartile (above the 75th percentile) of CCRCs in our database.

The funded status is based on the original cost of fixed assets and may be revalued if new entrant fees generate a surplus. If an alternative fixed asset value and corresponding liabilities are used, then the funded status may be higher. The revaluation is discussed in the "Evaluation of ASOP#3 Conditions".

Actuarial reserves should be sufficient to offset the difference between future revenues and future expenses. Actuarial reserves consist of liquid assets, such as cash and investments, and non-liquid assets, such as land and physical plant minus specific liabilities and the actuarial present value of long-term debt. Reserves total $70.1 million as of September 30, 2020 (refer to Table 4.4).

Another statistic related to the actuarial valuation is the liquid reserve ratio (LRR). The LRR measures the degree by which actuarial liabilities are covered by liquid assets. It is neither necessary nor desirable that a CCRC show a 100% LRR. Often, the LRR will be lower in the earlier operating years of a CCRC. It is expected to increase over time as the physical plant ages. The median LRR for CCRCs reviewed by AVP is 51.7%. The LRR for The Village at Brookwood is 28.1%, which places it in the bottom quartile (below the 25th percentile) of CCRCs in our database.

New Entrant Pricing

The new entrant pricing analysis (refer to Table 5.1 – 5.4) indicates whether the entrance fee and monthly fees charged to new entrants are expected to cover the cost of care associated with the contract. This analysis provides information about whether fees for specific contract options cover the expected contractual obligations.

The pricing analysis results in deficits for all contract types that are currently offered by The Village at Brookwood, as shown in the following table.

Contract	Surplus	New Contract Distribution
Standard Lifecare	(1.3%)	25%
Fee-for-Service 2017	(5.8%)	70%
50% Refundable Lifecare	(1.2%)	0%
90% Refundable Lifecare	(0.8%)	5%

The median surplus for CCRCs reviewed by AVP is 11.7%. The weighted average deficit of (4.7%) for contract offered by The Village at Brookwood is in the bottom quartile (below the 25th percentile) of CCRCs in our database.

The actuarial surplus for singles and couples for all contracts (both nonrefundable and refundable) shows that couples generate lower surpluses than singles within each unit type, which indicates that second person fees do not cover the additional costs associated with another person in the unit. The actuarial analysis also shows that larger units subsidize smaller units since their actuarial surplus is higher. This result is common within the CCRC industry.

We recommend that future monthly fee increases be no less than budgeted expense increases to ensure that the combination of monthly fees and entry fees are sufficient to cover future costs. Moreover, this condition is necessary to validate the implicit assumption underlying the actuarial valuation that fees for new entrants are adequate to cover their share of costs. If fees are not increased to match internal expense inflation, it is likely that the funded status of The Village at Brookwood will decline in future actuarial valuations.

Cash Flow Projection

The 20-year cash flow projection (refer to Tables 6.1 and 4.5) indicates whether positive cash and investment balances will be maintained and debt covenants will be met. Reserves must increase at an average annual rate at least equal to the inflation rate in order to maintain the balance between increasing liabilities and revenues.

The cash flow projection for The Village at Brookwood shows increasing cash and investment balances for all years. The median 10-year reserve accumulation factor for CCRCs reviewed by AVP is 2.20. The 10-year reserve accumulation factor for The Village at Brookwood is 3.19, placing it in the third quartile (between the 5oth and 75th percentiles) of CCRCs in our database.

This analysis integrates the population projection with financial information. Each projection year includes the projected independent living turnover and new entrance fees, projected population movements and likely health care utilization by contractholders, and the appropriate revenues associated with the projected living status.

The cash flow projection is based on the assumption that 25% of new entrants will select the standard lifecare contract, and 70% will select the fee-for-service 2017 contract, and 5% will select the 90% refund lifecare contract.

Evaluation of ASOP#3 Conditions

In the Actuarial Standards of Practice No. 3 ("ASOP#3"), the American Academy of Actuaries defines three conditions to determine whether or not a CCRC is in satisfactory actuarial balance ("SAB"). Condition 1 is adequate reserves for current residents and requires an actuarial calculation that determines whether or not the CCRC will be able to meet its long-term contractual obligations to residents. Condition 2 is adequate fee structure for a cohort of new entrants and requires an actuarial calculation to determine whether or not the combination of the entry fee plus future monthly fees will cover the operating and capital costs of care and pay refunds, if any, to a typical group of entrants. Condition 3 is positive projected cash and investment balances and uses an actuarially-based resident census projection by level of care to determine whether or not future cash balances will be increasing and if bond covenants will be met, if applicable.

In addition to testing for these three conditions, the actuary should review the assumptions used in their calculations in regard to reasonableness, both individually and in aggregate, with consideration given to the level of surplus available for adverse fluctuations in experience and explicit or implicit contingency margins for uncertainty in the actuarial assumptions.

Our experience during the past 30 years shows that approximately 50-to-60% of our actuarial studies generated results where clients pass Conditions 1 and 2 using actuarial book values for fixed assets whereas other investment assets are reflected at current, or averaged, market values. For the other 40-to-50% of clients, most fail Condition 1 adequate reserves but pass Condition 2 adequate fees and a few (less than 5% of total) pass Condition 1 adequate reserves but fail Condition 2. In these latter two cases, if the results show that a positive actuarial surplus exists for either the new entrant cohort fee structure or reserves for current residents, then it is appropriate and necessary for the actuary to combine the individual results of Conditions 1 and 2 to make an evaluation that determines if this surplus associated with the passed condition is sufficient to fund the deficit associated with the failed condition and therefore support the finding/opinion that the CCRC is in satisfactory actuarial balance. We refer to the resulting value as the "unified funded status" and it is calculated by replacing the actuarial book value of fixed assets with the actuarial appraisal value of fixed assets and the corresponding actuarial depreciation.

For those cases where either Condition 1 or 2 are not met based on actuarial book values of fixed assets and their corresponding actuarial depreciation expenses, the unified funded status is used as an alternative solution to determine whether or not a community is in satisfactory actuarial balance. If the unified funded status exceeds 100% by a sufficient amount that the actuary deems is appropriate for adequate surplus, then the community meets Condition 1. It should be noted that the unified funded status implicitly confirms that the new entrant cohort pricing is 0% so that Condition 2 is satisfied. In cases where Condition 1 and 2 are met based on actuarial book value of fixed assets, the unified funded status will also show the community to be in satisfactory actuarial balance. However, unified funded status has explanatory value for all communities. Use of this metric allows the actuary to provide consistent opinions regarding satisfactory actuarial balance among various CCRCs as well as for the same CCRCs over time.

Using ASOP#3 and techniques previously described, AV Powell & Associates has established four categories of findings for our clients' comprehensive actuarial study results:

(1) "Not in satisfactory actuarial balance" for CCRCs who fail one or more of the three ASOP#3 conditions since their unified funded status is less than 100% or their cash balances are projected to be negative;

(2) "In satisfactory actuarial balance with qualifications about surplus and contingency margins" for CCRCs who pass all three ASOP#3 conditions since their unified funded status is greater than or equal to 100%, but their unified funded status does not generate sufficient margins for surplus and contingencies in accordance with AVP internal guidelines;

(3) "In satisfactory actuarial balance" for CCRCs who pass all three ASOP#3 conditions since their unified funded status is greater than or equal to 100%, and their unified funded status does generate sufficient margins for surplus and contingencies; and

(4) "In satisfactory actuarial balance with AVP seal" for a limited number of CCRCs, typically less than 50% annually, who pass all three ASOP#3 conditions since their unified funded status is greater than or equal to 100%, and their unified funded status does generate sufficient margins for surplus and contingencies and exceeds the AVP benchmarks for the current year. Designation of this status is documented by the inclusion of the AVP exemplary recognition seal in the actuarial report opinion statement.

CCRCs must have positive and increasing cash balances to be categorized in satisfactory actuarial balance (categories two through four).

Table 4.3 shows a unified funded status of 130.9% based on an actuarial appraisal value for fixed assets plus deferred costs of $48.8 million versus the actuarial book value for fixed assets plus deferred costs of $59.2 million (the corresponding GAAP book value for fixed assets plus deferred costs is $51.1 million). This places The Village at Brookwood in the AVP actuarial opinion Category 4. The median unified funded status for CCRCs reviewed by AVP is 114.3%. The unified funded status for The Village at Brookwood places it in the top quartile (above the 75th percentile) of CCRCs in our database.

Actuarial Opinion

It is our opinion that the financial condition of The Village at Brookwood is in satisfactory actuarial balance as defined by ASOP#3 and The Village at Brookwood has earned the AVP exemplary recognition seal, provided that future experience

substantially follows the underlying assumptions that are contained in this actuarial report. However, it should be noted that the new entrant pricing reflects and overall negative and as new residents move into the community the funded status and cash flows will decline over time.

The key assumptions are:

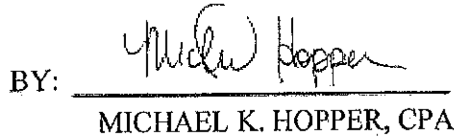
a) increases in monthly fees will match assumed increases in operating expenses;
b) all residents are able to pay the fees charged without significant subsidies for financial aid;
c) the difference between interest earnings/discount rate and revenue/expense inflation ("real rate-of-return") is 2.0%;
d) average occupancy in independent living will increase from 146 units occupied (95.4%) as of September 30, 2020, to 149 units occupied (97.4%) as of September 30, 2021, and level thereafter. Assisted living and nursing care are assumed to remain constant at current rates;
e) capital expenditures are adequate to maintain the market position of the community; and
f) projected accumulated cash balances are all available for the exclusive benefit of contractholders and all cash outflows have been reflected in the report to the best of our knowledge.

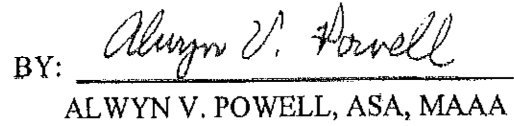
AVP believes that the assumptions and projections in this report form a reasonable basis for evaluating the long-term financial condition of The Village at Brookwood. We also believe that the methods employed in developing these calculations are consistent with sound actuarial principles and practices. Provision has been made for all actuarial liabilities and related statement items that ought to be recognized, except no assessment has been made of potential liabilities for residents' inability to pay their fees.

In order to monitor the appropriate level of fees required to maintain the long-term financial solvency of The Village at Brookwood, we recommend that actuarial studies be conducted regularly. It should be noted that any number of variations from the underlying assumptions may occur and such variations could have a material impact on the projections and observations contained herein.

This report is submitted only for use by the management of The Village at Brookwood. **Any other distribution or reference to the report is expressly prohibited.**

The undersigned credentialed actuary is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

BY: 
MICHAEL K. HOPPER, CPA
FOR: A.V. POWELL & ASSOCIATES LLC

BY: 
ALWYN V. POWELL, ASA, MAAA