

The Moses H. Cone Memorial Hospital and Affiliates

Consolidated Financial Statements as of and for the
Years Ended September 30, 2017 and 2016,
Consolidating Supplemental Schedules as of and for
the Year Ended September 30, 2017

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

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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, 2017 and 2016, 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, 2017 and 2016, 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, 2018

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED BALANCE SHEETS AS OF SEPTEMBER 30, 2017 AND 2016 (In thousands of dollars)

	2017	2016
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	\$ 57,808	\$ 20,337
Short-term investments	26,803	17,826
Patient accounts receivable—net of allowance for uncollectible accounts of \$78,082 in 2017 and \$104,492 in 2016	198,787	229,610
Inventories	31,435	28,873
Assets limited as to use—required for current liabilities	6,674	5,987
Other current assets	<u>82,788</u>	<u>58,521</u>
Total current assets	404,295	361,154
LONG-TERM INVESTMENTS	770,802	700,117
ASSETS LIMITED AS TO USE—Net of portion required for current liabilities	201,041	179,483
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	53,817	52,820
PROPERTY AND EQUIPMENT—Net	1,087,122	1,052,603
GOODWILL	9,729	9,729
OTHER ASSETS	<u>79,495</u>	<u>69,293</u>
TOTAL	<u>\$ 2,606,301</u>	<u>\$ 2,425,199</u>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES:		
Accounts payable	\$ 78,195	\$ 65,005
Accrued expenses	229,215	198,207
Current portion of long-term debt and capital lease obligations	<u>194,591</u>	<u>193,539</u>
Total current liabilities	502,001	456,751
LONG-TERM DEBT—Net of current portion	323,742	287,222
CAPITAL LEASE OBLIGATIONS—Net of current portion	10,526	1,141
OTHER NONCURRENT LIABILITIES	<u>115,493</u>	<u>167,764</u>
Total liabilities	<u>951,762</u>	<u>912,878</u>
NET ASSETS:		
Unrestricted:		
Moses H. Cone Memorial Hospital and Affiliates	1,641,589	1,498,398
Noncontrolling interests	<u>913</u>	<u>2,806</u>
Total unrestricted net assets	1,642,502	1,501,204
Temporarily restricted	<u>12,037</u>	<u>11,117</u>
Total net assets	<u>1,654,539</u>	<u>1,512,321</u>
TOTAL	<u>\$ 2,606,301</u>	<u>\$ 2,425,199</u>

See notes to consolidated financial statements.

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF OPERATIONS FOR THE YEARS ENDED SEPTEMBER 30, 2017 AND 2016 (In thousands of dollars)

	2017	2016
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT:		
Patient service revenue (net of contractual allowances and discounts)	\$ 1,797,134	\$ 1,696,543
Provision for bad debts	<u>145,691</u>	<u>135,933</u>
Net patient service revenue	1,651,443	1,560,610
Other revenue	98,228	75,977
Premium revenue	<u>86,894</u>	<u>41,706</u>
Total revenue	<u>1,836,565</u>	<u>1,678,293</u>
EXPENSES:		
Salaries and wages	697,252	654,568
Fringe benefits	243,423	235,160
Supplies	335,301	318,494
Other direct expenses	379,264	318,405
Interest expense	14,168	11,413
Depreciation and amortization	<u>115,467</u>	<u>107,173</u>
Total expenses	<u>1,784,875</u>	<u>1,645,213</u>
INCOME FROM OPERATIONS	<u>51,690</u>	<u>33,080</u>
OTHER INCOME (EXPENSE):		
Investment income	45,241	46,623
Nonoperating expense—net	<u>(26,080)</u>	<u>(19,718)</u>
Total other income	<u>19,161</u>	<u>26,905</u>
EXCESS OF REVENUES OVER EXPENSES FROM CONSOLIDATED OPERATIONS	70,851	59,985
EXCESS OF REVENUES OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTERESTS	<u>(4,522)</u>	<u>(139)</u>
EXCESS OF REVENUES OVER EXPENSES ATTRIBUTABLE TO MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES	<u>\$ 66,329</u>	<u>\$ 59,846</u>

See notes to consolidated financial statements.

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS FOR THE YEARS ENDED SEPTEMBER 30, 2017 AND 2016 (In thousands of dollars)

	2017	2016
UNRESTRICTED NET ASSETS:		
Excess of revenues over expenses from consolidated operations	\$ 70,851	\$ 59,985
Change in net unrealized gains and losses on investments	57,585	24,715
Pension-related changes other than net periodic benefit cost	16,425	(16,007)
Change in the fair value of the floating-to-fixed swap agreements	18,265	(5,993)
Acquisition of non-controlling interest	(17,600)	
Other changes in net assets	<u>(4,228)</u>	<u>(11,768)</u>
Increase in unrestricted net assets	<u>141,298</u>	<u>50,932</u>
TEMPORARILY RESTRICTED NET ASSETS:		
Contributions	4,915	5,565
Net assets released from restrictions	(4,072)	(5,268)
Other changes in net assets	<u>77</u>	<u>(1,543)</u>
Increase (decrease) in temporarily restricted net assets	<u>920</u>	<u>(1,246)</u>
INCREASE IN NET ASSETS	142,218	49,686
NET ASSETS—Beginning of year	<u>1,512,321</u>	<u>1,462,635</u>
NET ASSETS—End of year	<u>\$1,654,539</u>	<u>\$1,512,321</u>

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, 2017 AND 2016 (In thousands of dollars)

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 142,218	\$ 49,686
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Change in net unrealized gains on investments	(57,585)	(24,715)
Change in fair value of the floating-to-fixed swap agreements	(18,265)	5,993
Net realized gains on sale of investments	(29,037)	(31,340)
Depreciation and amortization	115,467	107,173
Provision for uncollectible accounts	145,691	135,933
Pension-related changes other than net periodic pension cost	(16,425)	16,007
Loss on disposal of property and equipment	2,894	1,301
Earnings of unconsolidated affiliates	(4,364)	(4,541)
Distributions from unconsolidated affiliates	3,399	2,345
Distributions to noncontrolling interests	6,588	
Purchase of noncontrolling interest	17,600	8,270
Contributions to pension plan	(58,750)	
Changes in:		
Patient accounts receivable	(114,869)	(159,964)
Other current assets	(16,539)	(21,454)
Inventories	(2,562)	(1,233)
Accounts payable and accrued expenses	44,905	19,599
Other operating assets and liabilities—net	3,683	(25,491)
Net cash provided by operating activities	<u>164,049</u>	<u>77,569</u>
CASH FLOWS FROM INVESTING ACTIVITIES:		
Additions to property and equipment	(128,675)	(121,960)
Proceeds from sale of property and equipment		(12)
Purchases of investments	(297,869)	(199,848)
Proceeds from sale of investments	292,771	248,498
Restriction of funds in Care N' Care Insurance Company of North Carolina, Inc.	(10,188)	(4,703)
Divestiture of interests in unconsolidated affiliates		1,063
Net cash used in investing activities	<u>(143,961)</u>	<u>(76,962)</u>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from debt issuances and refundable entrance fees	130,397	27,928
Repayments of debt and entrance fees refunded	(92,357)	(25,836)
Purchase of noncontrolling interest	(12,000)	(8,270)
Distributions to noncontrolling interests	(6,588)	
Payments on capital lease obligations	(2,069)	(1,244)
Net cash provided by (used in) financing activities	<u>17,383</u>	<u>(7,422)</u>
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	37,471	(6,815)
CASH AND CASH EQUIVALENTS:		
Beginning of year	<u>20,337</u>	<u>27,152</u>
End of year	<u>\$ 57,808</u>	<u>\$ 20,337</u>
SUPPLEMENTAL INFORMATION:		
Cash paid during the year for interest—net of amounts capitalized	<u>\$ 13,672</u>	<u>\$ 11,206</u>
Purchases of equipment under capital lease	<u>\$ 14,056</u>	<u>\$ 369</u>
Property and equipment purchases in accounts payable	<u>\$ 10,124</u>	<u>\$ 3,902</u>

See notes to consolidated financial statements.

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS AS OF AND FOR THE YEARS ENDED SEPTEMBER 30, 2017 AND 2016

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 County, Alamance County, 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 Carolinas HealthCare System (CHS). Under the Agreement, the top five executives on the leadership team became employees of CHS, but continue to manage the Health System as a local team in Greensboro, North Carolina. The Health System reimburses CHS for the salary and benefits costs of these executives. The terms of the Agreement also call for the Health System to pay CHS an annual management fee based on a percentage of net revenue. The Health System continues to be governed by its local and independent board of trustees.

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. With the support of CHS under the Agreement, Operating Corporation will provide 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.

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, The Women's Hospital of Greensboro, Wesley Long Hospital, The Cone Behavioral Health Hospital, and Annie Penn Hospital.

Long-term care services are offered through Penn Nursing Center. Patient care services and other major facilities include the Family Practice Center; the Short-Stay Hospital, a presurgery and postsurgery and minor procedure facility attached to Cone Hospital; the Outpatient Surgery Center, an in-house outpatient surgery facility located at Wesley Long Hospital; the Outpatient Rehabilitation Centers; a Nutrition and Diabetes Management Center; a Wound and Hyperbaric Center; a Developmental and Psychological Center; a Center for Pain and Rehabilitative Medicine; Moses Cone MedCenter operations at both Kernersville and High Point; and various medical office buildings. Annie Penn Hospital is supported by 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., a 9-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.

Medical Services, Physician Services, and MCAP—These entities provide nonhospital health care services and other services to support the overall Health System activities.

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, of which \$12.0 million was paid in 2017. The remaining purchase price of \$5.6 million is due on October 31, 2018, and is included in other noncurrent liabilities in the accompanying consolidated balance sheet as of September 30, 2017.

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.

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 is 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 significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates—The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (US 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 and cash equivalents that are expected to be used in current operations.

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

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 cost in the accompanying consolidated balance sheets. Investment income or loss (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 investments are included as changes in unrestricted net assets in the accompanying consolidated statements of changes in net assets.

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 are 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.

Deferred Revenue—Deferred revenue related to AEC includes the reservation deposit and nonrefundable portion of entrance fees paid by the residents. 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. Additionally, some residents paid amounts required to complete changes to the dwelling units as they were built. Net unamortized entrance fees and the amounts paid to make changes to the dwelling units were \$5.4 million and \$6.0 million as of September 30, 2017 and 2016, respectively, and are included in other noncurrent liabilities and accounts payable.

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. Equipment under capital lease obligations is amortized using the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated financial statements. Interest cost incurred on borrowed funds, less any interest earned on temporary investment of those funds, during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

In accordance with Accounting Standards Codification (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. There were no adjustments to the carrying value of long-lived assets in fiscal years 2017 or 2016.

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, 2017 and concluded there was no impairment of goodwill. There were no additions to goodwill during the years ended September 30, 2017 and 2016.

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 income attributable to noncontrolling interests in the consolidated statements of operations.

Temporarily Restricted Net Assets—Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period or purpose.

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.

Allowance for Doubtful Accounts—Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. The Health System estimates the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable by aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. The Health System's allowance for doubtful accounts decreased as a percentage of patient accounts receivable (net of contractals) comparing September 30, 2017 (28.2%), to September 30, 2016 (31.3%). The change in the allowance was the result of various factors including the portion of insured accounts owed by patients as coinsurance and deductibles and expected collection rates on these and other patient balances.

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 Operating Revenue—Other operating revenue consists of cafeteria revenue, child care center revenue, contract and outpatient pharmacy revenue, lease income, grant revenue and other non-patient-related revenues.

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 are entitled to health care services. The Health System recorded premium revenue of \$86.9 million and \$41.7 million for the years ended September 30, 2017 and 2016, respectively.

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 \$81.9 million and \$37.4 million for the years ended September 30, 2017 and 2016, respectively, and is included in other direct expenses in the accompanying consolidated statements of operations.

The liability for unpaid health claims and incurred but not reported claims (IBNR) was \$11.8 million and \$4.7 million as of September 30, 2017 and 2016, respectively, and is 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 Revenue and 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 \$2.1 million and \$1.8 million in fiscal years 2017 and 2016, respectively, is included in nonoperating expense—net in the accompanying consolidated statements of operations.

Revenues on restricted grant funds are recognized only to the extent of expenditures that satisfy the restricted purpose of these grants. Grant revenue of approximately \$5.3 million and \$5.0 million in fiscal years 2017 and 2016, respectively, is included in other revenue 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 other current liabilities.

Excess of Revenues over Expenses—Changes in unrestricted net assets, 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 and its subsidiaries, have been recognized by the Internal Revenue Service as tax exempt under Internal Revenue Code 501(c)(3). As of September 30, 2017 and 2016, the Health System had no uncertain tax positions under Financial Accounting Standards Board (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 2014 through 2016 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 valuation of long-term debt 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. In such instances, the transfer would be reported at the beginning of the reporting period. The Health System evaluates the significance of transfers based on the nature of the financial instrument and the size of the transfer. There were no transfers of investments between levels for the years ended September 30, 2017 and 2016.

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. The fair values of investments in common/commingled/collective trusts, which are recorded at fair value in the consolidated balance sheets, and alternative investments, which are recorded at cost in the consolidated balance sheets and disclosed at fair value in Note 3, 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.

Long-Term Debt—The fair value of the Health System’s variable-rate long-term debt approximates its carrying value. The fair value of the Health System’s remaining long-term debt is estimated based on Level 2 inputs, including discounted cash flow analyses and the Health System’s current incremental borrowing rates for similar types of borrowing arrangements. As of September 30, 2017 and 2016, the fair value of the Health System’s long-term debt, inclusive of the current portion, was \$542.7 million and \$505.5 million, respectively.

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.

Interest Rate Swaps—The Health System is a party to two interest rate swap agreements with a total fair value of \$19.7 million and \$30.3 million as of September 30, 2017 and 2016, respectively, reported in other noncurrent liabilities in the consolidated balance sheets. The interest rates swaps were designated as cash flow hedges and 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 unrestricted net assets and gains or losses related to ineffective portions are recognized in the excess of revenue over expenses.

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 at September 30, 2017 and 2016, and \$7.8 million unrealized gain and \$4.4 million unrealized loss, respectively, was reported in other changes in unrestricted net assets, resulting in a corresponding cumulative liability of \$17.5million and \$25.3 million, respectively.

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 at September 30, 2017 and 2016, and \$2.7 million unrealized gain and \$1.6 million unrealized loss, respectively, was reported in other changes in unrestricted net assets, resulting in a corresponding cumulative liability of \$2.3 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 a third 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 will pay a fixed rate of 1.336% and receive a variable rate of 70% of the one-month LIBOR index rate. The fair value of the swap of \$7.7 million as of September 30, 2017 is included in other assets in the consolidated balance sheet. At September 30, 2017, the Series 2018A swap was considered effective and \$7.7 million in unrealized gain was reported in other changes in unrestricted net assets.

Subsequent Events—The Health System evaluated events and transactions for potential recognition or disclosure through the date the consolidated financial statements were issued.

On October 1, 2017, WellSmith LLC a North Carolina limited liability company was converted to a Delaware corporation WellSmith, Inc.

On December 22, 2017, the Health System issued debt of \$160 million in the form of direct placement bank loans. The debt will mature between October 2020 and October 2046.

New Accounting Pronouncements—

In May 2014, the FASB issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)* ("ASU 2014-09"). ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets, unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The guidance provided in ASU 2014-09 is effective for fiscal years beginning after December 15, 2017. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In August 2014, FASB issued ASU No. 2014-15, *Presentation of Consolidated Financial Statements—Going Concern (Subtopic 205-40)* ("ASU 2014-15"). ASU 2014-15 requires management to evaluate whether there are conditions or events that raise substantial doubt about an entity's ability to continue as a going concern. If such conditions or events exist, disclosures are required that enable users of the consolidated financial statements to understand the nature of the conditions or events, management's evaluation of the circumstances and management's plans to mitigate the conditions or events that raise substantial doubt about the entity's ability to continue as a going concern. The guidance provided in ASU 2014-15 is effective for annual periods ending after December 15, 2016, including interim reporting periods thereafter. The adoption of this standard had no impact on the Health System's consolidated financial statements for the year ended September 30, 2017.

In April 2015, the FASB issued ASU No. 2015-03, *Interest—Imputation of Interest: Simplifying the Presentation of Debt Issuance Costs* ("ASU 2015-03"), which requires debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct reduction from the carrying amount of that debt liability, consistent with the accounting for debt discounts. This new guidance did not change the measurement or recognition guidance for debt issuance costs. The Health System adopted ASU No. 2015-05

as of October 1, 2016, which resulted in the reclassification of approximately \$2.7 million of debt issuance costs from other assets to a reduction of the related long-term debt in the 2016 consolidated balance sheet.

In April 2015, the FASB issued ASU No. 2015-05, *Customer's Accounting for Fees Paid in a Cloud Computing Arrangement* ("ASU 2015-05"). ASU 2015-05 provides guidance on determining whether a cloud computing arrangement contains a software license that should be accounted for as internal-use software. The new guidance requires fees related to the software license element of the cloud computing arrangement to be accounted for in a consistent manner with the acquisition of other software licenses. The guidance provided in ASU 2015-05 is effective for fiscal years beginning after December 15, 2015. The Health System adopted ASU 2015-05 prospectively as of October 1, 2016. Adoption of this standard did not have a material effect on the Health System's consolidated financial statements.

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* ("ASU 2016-01"). ASU 2016-01 revises an entity's accounting related to (1) the classification and measurement of investments in equity securities and (2) the presentation of certain fair value changes for financial liabilities measured at fair value. It also amends certain disclosure requirements associated with the fair value of financial instruments. ASU 2016-01 is effective for fiscal years beginning after December 15, 2018. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842) Section A—Leases: Amendments to the FASB Accounting Standards Codification* ("ASU 2016-02"), which supersedes existing guidance on accounting for leases in FASB ASC 840, *Leases*, and generally requires all leases to be recognized in the consolidated balance sheets. The liability will be equal to the present value of lease payments and the asset will be based on the liability, subject to adjustment, such as initial direct costs. ASU 2016-02 is effective for fiscal years beginning after December 15, 2018. The amendments are applied using a modified retrospective approach. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In March 2016, the FASB issued ASU 2016-07, *Investments—Equity Method and Joint Ventures (Topic 323) Simplifying the Transition to the Equity Method of Accounting* ("ASU 2016-07"). ASU 2016-07 eliminates the requirement for retroactively accounting for an investment that qualifies for use of the equity method as a result of an increase in the level of ownership interest or degree of influence. The update requires that the equity method investor add the cost of acquiring the additional interest in the investee to the current basis of the investor's previously held interest, and adopt the equity method of accounting as of the date the investment becomes qualified for equity method accounting. The provisions of this ASU are effective for all entities for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2016. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*, which supersedes existing guidance in FASB ASC 958, *Not-for-Profit Entities*, to improve the current net asset classification requirements and the information presented in the consolidated financial statements and related notes about a not-for-profit entity's (NFP's) liquidity, financial

performance, and cash flows. The guidance is effective for NFPs with annual periods beginning after December 15, 2017. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-15, *Statement of Cash Flows—Classification of Certain Cash Receipts and Cash Payments (Topic 230)* (“ASU 2016-15”). ASU 2016-15 clarifies the guidance on the classification of certain cash receipts and payments in the statement of cash flows related to debt extinguishment costs, distributions received from equity method investees, and proceeds from the settlement of insurance claims. ASU 2016-15 is effective for fiscal years beginning after December 15, 2018, and interim periods within fiscal years beginning after December 2019. Early adoption is permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In October 2016, the FASB issued ASU 2016-17, *Consolidation—Interests Held through Related Parties That Are Under Common Control (Topic 810)* (“ASU 2016-17”). ASU 2016-17 clarifies treatment of interests held by a single decision-making entity and other related parties under common control. ASU 2016-17 is effective for fiscal years beginning after December 15, 2016, and interim periods within fiscal years beginning after December 15, 2017. Early adoption is permitted, including adoption in an interim period. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In January 2017, the FASB issued ASU No. 2017-04, *Intangibles—Goodwill and other (Topic 350)* (“ASU 2017-04”). ASU 2017-04 simplifies how an entity is required to test goodwill for impairment by eliminating Step 2 from the goodwill impairment test. Step 2 measures a goodwill impairment loss by comparing the implied fair value of goodwill with the carrying amount of that goodwill, which is currently required if a entity with goodwill fails a Step 1 test comparing the fair value of the entity to its carrying value including goodwill. Under this new guidance, an entity should perform its annual, or interim, goodwill impairment test using only the Step 1 test of comparing the fair value of the entity with its carrying amount. Any goodwill impairment, representing the amount by which the carrying amount exceeds the entity’s fair value, is determined using this Step 1 test. Any goodwill impairment loss recognized would not exceed the total carrying amount of goodwill allocated to that entity. ASU 2017-04 is effective for fiscal years beginning after December 15, 2021, with early adoption permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Compensation—Retirement Benefits (Topic 715)* (“ASU 2017-07”). ASU 2017-07 requires entities to (1) disaggregate the service cost component from the other components of net benefit cost and present it with other current compensation costs for related employees on the statement of operations and (2) present the other components elsewhere on the statement of operations and outside of income from operations. In addition, the ASU requires entities to disclose the statement of operations lines that contain the other components if they are not presented on appropriately described separate lines. ASU 2017-07 is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

In August 2017, the FASB issued ASU 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 Health System is currently evaluating the provisions of this update and their impact on its consolidated financial statements.

2. NET PATIENT SERVICE REVENUE

The Health System has agreements with 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 fiscal intermediary through September 30, 2007.

Medicaid—Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services are reimbursed based on 70% of actual costs incurred. The Health System's Medicaid cost reports have been settled through September 30, 2008.

Net revenue from the Medicare and Medicaid programs accounted for 16.5% and 12.8%, respectively, of the Health System's net patient service revenue for the year ended September 30, 2017, and 16.9% and 12.7%, respectively, of the Health System's net patient service revenue for the year ended September 30, 2016. 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 16.9% of net revenue for the year ended September 30, 2017, and 17.1% for the year ended September 30, 2016. 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 \$12.9 million and \$10.5 million from the MRI Plan during the years ended September 30, 2017 and 2016, 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 \$36.1 million and \$31.5 million for the years ended 2017 and 2016, 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 \$79.2 million and \$68.1 million for the years ended 2017 and 2016, 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 \$0.8 million and \$2.1 million for the years ended September 30, 2017 and 2016, 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.

Patient service revenue (net of contractual allowances and discounts) for the years ended September 30, 2017 and 2016, is summarized as follows (in thousands of dollars):

	2017	2016
Medicare and Medicare Advantage	\$ 594,290	\$ 570,403
Medicaid	214,935	202,005
Third-party payors	904,058	843,215
Self-pay	<u>83,851</u>	<u>80,920</u>
Patient service revenue (net of contractual allowances and discounts)	<u>\$ 1,797,134</u>	<u>\$ 1,696,543</u>

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 considered to be 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 \$83.8 million and \$89.6 million for the years ended September 30, 2017 and 2016, 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.

3. 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.

At September 30, 2017, 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	\$ 279,321	\$ 199,114	\$ 80,207	\$ -
Equity securities and funds	<u>126,480</u>	<u>126,480</u>	<u> </u>	<u> </u>
Subtotal	<u>405,801</u>	<u>\$ 325,594</u>	<u>\$ 80,207</u>	<u>\$ -</u>
Investments measured at net asset value	410,241			
Investments measured at cost	<u>243,590</u>			
Total investments and assets limited as to use	<u>\$ 1,059,632</u>			

At September 30, 2016, 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	\$ 212,179	\$ 145,056	\$ 67,123	\$ -
Equity securities and funds	<u>106,170</u>	<u>106,170</u>	<u> </u>	<u> </u>
Subtotal	<u>318,349</u>	<u>\$ 251,226</u>	<u>\$ 67,123</u>	<u>\$ -</u>
Investments measured at net asset value	346,263			
Investments measured at cost	<u>283,583</u>			
Total investments and assets limited as to use	<u>\$ 948,195</u>			

The investments and assets limited as to use are included in the captions in the consolidated balance sheets as of September 30, 2017 and 2016, as follows (in thousands of dollars):

	2017	2016
Short-term investments	<u>\$ 26,803</u>	<u>\$ 17,826</u>
Long-term investments	<u>\$ 770,802</u>	<u>\$700,117</u>
Assets limited as to use:		
Foundation and Impact Alamance	\$ 176,334	\$167,762
AEC	3,885	3,866
Under bond indenture agreements held by trustee	10,978	7,765
CNCNC	14,891	4,703
Other	<u>1,627</u>	<u>1,374</u>
Total assets limited as to use	<u>207,715</u>	<u>185,470</u>
Less assets limited as to use that are required for current liabilities	<u>(6,674)</u>	<u>(5,987)</u>
Assets limited as to use—net of portion required for current liabilities	<u>201,041</u>	<u>179,483</u>
Deferred compensation (within other assets)	<u>\$ 54,312</u>	<u>\$ 44,782</u>
Total investments and assets limited as to use	<u>\$ 1,059,632</u>	<u>\$948,195</u>

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, 2017, 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	\$ 340,358	\$ -	Daily, semimonthly, and monthly	1-30 days
Equity securities and funds	6,650		End of any calendar quarter	65 days
Fixed-income securities and funds	18,340		Daily, semimonthly, and monthly	3-15 days
Commodity securities and funds	34,974		Daily and monthly	None-35 days
Balanced funds	<u>9,919</u>	<u> </u>	Monthly	15 business days
	<u>\$ 410,241</u>	<u>\$ -</u>		
Alternative investment funds carried at cost in the consolidated balance sheets:				
Private equity	\$ 87,878	\$ 53,514	N/A-Illiquid	N/A-Illiquid
Private debt	35,465	29,765	N/A-Illiquid	N/A-Illiquid
Private debt	3,233	6,906	Quarterly	60-90 days
Hedge funds	61,953		Monthly and quarterly	30-90 days
Hedge funds	<u>96,197</u>	<u> </u>	Daily, monthly, and quarterly	1-90 days
	<u>\$ 284,726</u>	<u>\$ 90,185</u>		

A summary of the investments measured at NAV as of September 30, 2016, is as follows (in thousands of dollars):

	Fair Value	Unfunded Commitment	Redemption Frequency	Redemption Notice Period
Investments in common, comingled, and collective trust funds:				
Equity securities and funds	\$ 239,372	\$ -	Daily, semimonthly, and monthly	1-30 days
Equity securities and funds	8,752		End of any calendar quarter	65 days
Fixed-income securities and funds	16,997		Daily, semimonthly, and monthly	3-15 days
Emerging market funds	34,789		Daily and monthly	1-30 days
Commodity securities and funds	34,589		Daily and monthly	None-35 days
Balanced funds	<u>11,764</u>	<u> </u>	Monthly	15 business days
	<u>\$ 346,263</u>	<u>\$ -</u>		
Alternative investment funds carried at cost in the consolidated balance sheets:				
Private equity	\$ 69,370	\$ 61,655	N/A-Illiquid	N/A-Illiquid
Private debt	30,784	36,803	N/A-Illiquid	N/A-Illiquid
Private debt	4,848	4,735	Quarterly	60-90 days
Hedge funds	88,355		Monthly and quarterly	30-90 days
Hedge funds	72,097		Daily, monthly, and quarterly	1-90 days
Risk parity	40,271		Monthly	15 days
Real estate	<u>21,992</u>	<u> </u>	Quarterly	90 days
	<u>\$ 327,717</u>	<u>\$ 103,193</u>		

Alternative investments are less liquid compared to the Health System's other investments. These investments held by the Health System and the Foundation at September 30, 2017 and 2016, are summarized as follows (in thousands of dollars):

	2017		2016	
	Cost	Estimated Fair Value	Cost	Estimated Fair Value
Held by the Health System:				
Private equity	\$ 63,878	\$ 77,908	\$ 49,504	\$ 62,273
Private debt	31,117	33,346	31,534	30,981
Hedge funds	118,422	138,153	126,411	140,817
Risk parity			28,251	33,556
Real estate			12,904	19,194
	<u>\$213,417</u>	<u>\$249,407</u>	<u>\$248,604</u>	<u>\$286,821</u>
Held by the Foundation:				
Private equity	\$ 8,251	\$ 9,971	\$ 5,519	\$ 7,097
Private debt	4,789	5,352	4,588	4,651
Hedge funds	17,133	19,996	17,491	19,634
Risk parity			5,684	6,715
Real estate			1,697	2,799
	<u>30,173</u>	<u>35,319</u>	<u>34,979</u>	<u>40,896</u>
Total	<u>\$243,590</u>	<u>\$284,726</u>	<u>\$283,583</u>	<u>\$327,717</u>

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.

The total amount of unrealized losses on alternative investments recorded at cost at September 30, 2017 and 2016, was \$3.0 million and \$3.0 million, respectively.

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 \$1.0 million on investments that were other-than-temporarily impaired at September 30, 2017. The total amount of unrealized losses remaining at September 30, 2017, was \$5.4 million, of which \$4.5 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 \$0.1 million on investments that were other-than-temporarily impaired at September 30, 2016. The total amount of unrealized losses remaining at September 30, 2016, was \$8.0 million, of which \$6.6 million relates to investments that have been in a continuous unrealized loss position for more than 12 months.

At September 30, 2017, the fair value, except for alternative investments which are recorded at cost, and gross unrealized losses of available-for-sale securities, were as follows (in thousands of dollars):

	September 30, 2017					
	Less than 12 Months		12 Months or Longer		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
Fixed income securities and funds	\$ -	\$ -	\$ 57,627	\$(2,322)	\$ 57,627	\$(2,322)

At September 30, 2016, the fair value, except for alternative investments which are recorded at cost, and gross unrealized losses of available-for-sale securities, were as follows (in thousands of dollars):

	September 30, 2016					
	Less than 12 Months		12 Months or Longer		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
Fixed income securities and funds	\$ -	\$ -	\$ 51,769	\$(2,150)	\$ 51,769	\$(2,150)
International equity	-	-	\$ 65,080	\$(2,904)	\$ 65,080	\$(2,904)
Total available-for-sale securities	\$ -	\$ -	\$ 116,849	\$(5,054)	\$ 116,849	\$(5,054)

Investment income and gains and losses for the years ended September 30, 2017 and 2016, consist of the following (in thousands of dollars):

	2017	2016
Dividend and interest income	\$ 16,204	\$ 16,072
Realized gains—net	29,037	31,340
Other	-	(789)
Total	<u>\$ 45,241</u>	<u>\$ 46,623</u>

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, 2017 and 2016, is as follows (in thousands of dollars):

	Percent Ownership		Investment Balance		Health System’s Share of Net Income	
	2017	2016	2017	2016	2017	2016
Investment name:						
Diagnostic Radiology and Imaging, LLC	50.00 %	50.00 %	\$ 1,179	\$ 1,910	\$1,240	\$ 734
Hospice at Greensboro, Inc.	50.00	50.00	15,545	14,466	1,079	191
Advanced Homecare, Inc.	34.49	34.49	25,961	25,883	1,458	2,111
Other			<u>11,132</u>	<u>10,561</u>	<u>587</u>	<u>1,505</u>
Total			<u>\$53,817</u>	<u>\$52,820</u>	<u>\$4,364</u>	<u>\$4,541</u>

Financial information related to investments in unconsolidated affiliated entities at September 30, 2017 and 2016, is summarized as follows (in thousands of dollars):

	2017	2016
Assets	\$ 261,312	\$ 262,482
Liabilities	99,376	102,473
Equity	161,936	160,009
Total revenue	219,629	217,019
Total expenses	205,854	204,842
Net income	13,775	12,176
Health System’s share of net income	4,364	4,541

4. PROPERTY AND EQUIPMENT

A summary of property and equipment at September 30, 2017 and 2016, is as follows (in thousands of dollars):

	Depreciable Lives	2017	2016
Land and land improvements	10-15 years	\$ 89,125	\$ 87,984
Buildings and leasehold improvements	5-40 years	1,253,997	1,219,068
Equipment	3-15 years	<u>487,119</u>	<u>437,525</u>
		1,830,241	1,744,577
Less accumulated depreciation		<u>(822,301)</u>	<u>(735,839)</u>
		1,007,940	1,008,738
Construction in progress		<u>79,182</u>	<u>43,865</u>
Total		<u>\$ 1,087,122</u>	<u>\$ 1,052,603</u>

Depreciation expense for the years ended September 30, 2017 and 2016, amounted to \$115.4 million and \$107.1 million, respectively.

The Health System had unexpended project contractual commitments at September 30, 2017 and 2016, of \$118.4 million and \$30.6 million, respectively.

5. ACCRUED EXPENSES

A summary of accrued expenses at September 30, 2017 and 2016, is as follows (in thousands of dollars):

	2017	2016
Accrued salaries and wages	\$ 67,009	\$ 49,163
Accrued benefits	56,595	57,362
Interest rate swaps	19,723	30,260
Self-insurance and medical insurance liabilities	25,721	17,469
Other current liabilities	<u>60,167</u>	<u>43,953</u>
Total	<u>\$229,215</u>	<u>\$198,207</u>

6. LONG-TERM DEBT

Long-term debt at September 30, 2017 and 2016, consists of the following (in thousands of dollars):

	2017	2016
Series 2001A and 2001B, payable in annual installments increasing in fiscal year 2024 through fiscal year 2035, interest payable monthly at variable rates (0.91% and 0.80% at September 30, 2017 and 2016, 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 (0.95% and 0.83% at September 30, 2017 and 2016, respectively)	46,855	47,500
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%	37,015	42,185
Series 2011B, payable in annual installments in fiscal year 2016 through fiscal year 2036, interest payable monthly at variable rates (1.29% and 1.19% at September 30, 2017 and 2016, respectively)	46,920	47,885
Series 2011C and 2011D, payable in annual installments in fiscal year 2014 through fiscal year 2045, interest payable monthly at variable rates (1.51% and 1.04% at September 30, 2017 and 2016, respectively)	95,750	96,875
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%	15,670	18,400
Series 2013C, payable in annual installments in fiscal year 2014 through fiscal 2023, interest payable monthly at a fixed rate of 2.26%	10,280	12,075
Series 2017A, payable in annual installments in fiscal year 2026 through fiscal 2046, interest payable semiannually at a fixed rate of 4.33%	50,000	
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%	18,060	18,920
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%	21,620	22,540
Note payable, payable in annual installments 2015 through 2018, interest payable monthly at fixed interest 2.85%	<u>2,212</u>	<u>3,065</u>
	518,357	483,420
Less scheduled payments due within one year	15,588	14,563
Less additional portion of Series 2001A and 2001B, 2004A, and 2011B classified as current	176,400	178,975
Less unamortized debt issuance costs	<u>2,627</u>	<u>2,660</u>
Total long-term debt	<u>\$ 323,742</u>	<u>\$ 287,222</u>

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 2.87% and 2.59% in fiscal years 2017 and 2016, respectively.

The Health System has set aside approximately \$11.0 million and \$7.8 million at September 30, 2017 and 2016, respectively, in a debt service interest fund designated to meet scheduled interest payments. These amounts are included in assets limited as to use in the accompanying consolidated balance sheets at September 30, 2017 and 2016.

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, 2017, are as follows (in thousands of dollars):

**Years Ending
September 30**

2018	\$ 15,588
2019	16,014
2020	16,477
2021	15,073
2022	14,980
Thereafter	<u>440,225</u>
 Total	 <u>\$ 518,357</u>

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 80% of the Health System's revenues and 93% 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, 2017.

The Series 2017A 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.

On October 1, 2015, the Health System entered into a revolving credit agreement with a financial institution in the amount of \$50 million to provide liquidity in the event of issues associated with the implementation of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). The line was not used and it expired on September 29, 2016.

The Health System entered into a revolving credit agreement with a financial institution on January 28, 2015, in the amount of \$50 million, maturing January 28, 2018. There were no borrowings against the agreement at September 30, 2017. The credit agreement bears interest at an annual rate of LIBOR, plus 0.40%. 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 October 1, 2020.

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%.

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, 2019, 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, 2018. 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.

7. LEASE COMMITMENTS

The Health System leases various equipment and buildings used in its operations. Future minimum lease payments on capital leases and operating leases that have initial or remaining non-cancellable lease terms in excess of one year as of September 30, 2017, are as follows:

Years Ending September 30

	Operating Leases	Capital Leases
2018	\$11,729	\$ 2,901
2019	10,051	3,158
2020	7,533	3,113
2021	5,873	3,068
2022	4,743	1,080
Thereafter	<u>25,224</u>	<u>554</u>
Total	<u>\$65,153</u>	<u>\$13,874</u>
Less finance charges on capital leases		1,042
Less current portion of capital lease obligations		<u>2,306</u>
Capital lease obligation, net of current portion		<u>\$10,526</u>

Rent expense for the years ended September 30, 2017 and 2016, was approximately \$16.3 million and \$14.2 million, respectively.

8. 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.

9. EMPLOYEE RETIREMENT PLANS

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 pension plan (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 Health System’s pension costs are calculated using various actuarial assumptions and methodologies as prescribed by ASC 715, Compensation—Retirement Benefits. These assumptions include discount rates, expected return on the Plan’s assets, inflation, mortality rates, and other factors and are reviewed on an annual basis.

A discount rate is used to determine the present value of the Health System’s future pension benefit obligations. The discount rate is determined by matching the expected cash flows to a yield curve based on long-term, high-quality fixed-income debt instruments available as of the measurement date and is updated on an annual basis.

An assumption for return on the Plan’s assets is used to determine the expected return on asset component of net periodic benefit cost for the Health System’s pension plan. The expected long-term target rate of return on the Plan’s assets is based upon the Health System’s projected investment mix of the Plan’s assets, the assumption that future returns will be close to the historical long-term rate of return experienced for equity and fixed-income securities, actuarial surveys performed in association with the Health System’s investment policies, and a 10- to 15-year investment horizon. This assumption is consistent with the assumption used for funding purposes and target asset allocations.

Actuarial Assumptions—The weighted-average actuarial assumptions used to determine the net periodic benefit cost of the Health System’s pension plan are as follows:

	Pension Plan	
	2017	2016
Discount rate	3.55 %	4.37 %
Expected return on plan assets	5.20	5.35

The weighted-average actuarial assumptions used to determine the benefit obligations of the Health System's pension plan are as follows:

	Pension Plan	
	2017	2016
Discount rate	3.80 %	3.55 %
Expected return on plan assets	5.30	5.20

Assets of the Plan are invested in marketable equity and fixed-income securities, hedge funds, and private investment vehicles.

Plan Asset Investment Policy—The Health System's Investment Committee establishes investment policies and strategies that support the objectives of the Plan. The primary objective of the Plan is to provide a source of retirement income for its participants and beneficiaries. The primary financial objective of the Plan is to maintain full funding of the plans, as well as minimize cash contributions over the long term. The desired investment objective is a long-term real rate of return on assets that is approximately 4.5% greater than the assumed rate of inflation, as measured by the Consumer Price Index. The target rate of return for the Plan has been based upon an analysis of historical returns supplemented with an economic and structural review for each asset class. The Plan currently has target allocations of 60% growth assets, 30% income assets, and 10% diversified strategy assets.

In fiscal year 2015, the Health System modified the pension investment policy to incorporate a separate liability hedging allocation outside of the allocation noted above. The amount of assets transferred to the liability hedging portfolio is based on the funded status of the Plan and the liability hedging portion of the total assets will grow as the Plan's funded status increases. At September 30, 2015, 20% of the total pension investment assets were allocated to the liability hedging portfolio.

The Health System's defined benefit plan asset allocations at September 30, 2017 and 2016, are as follows:

Asset Category	Percentage of Plan Assets at September 30,	
	2017	2016
Equity securities	31 %	33 %
Fixed-income securities	55	43
Alternative investments	13	22
Commodities and other	1	1
Cash	<u> </u>	<u> </u>
Total	<u>100 %</u>	<u>100 %</u>

The liability hedging portfolio was allocated 100% to long-dated US Treasuries. The following table summarizes the basis used to measure the fair value of the Health System's pension plan assets as of September 30, 2017 (in thousands of dollars):

Fair Value Measurement at September 30, 2017				
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets:				
Cash and cash equivalents	\$ 854	\$ -	\$ -	\$ 854
US equity securities and funds	5			5
Fixed-income securities and funds	<u>112,607</u>	<u>1</u>		<u>112,608</u>
Subtotal	<u>\$ 113,466</u>	<u>\$ 1</u>	<u>\$ -</u>	<u>113,467</u>
Investments measured at net asset value:				
US equity funds				15,631
International equity funds				46,252
Commodity securities funds				<u>1,549</u>
Subtotal				<u>63,432</u>
Alternative investments				<u>26,297</u>
Total				<u>\$ 203,196</u>

The following table summarizes the basis used to measure the fair value of the Health System's pension plan assets as of September 30, 2016 (in thousands of dollars).

Fair Value Measurement at September 30, 2016				
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets:				
Cash and cash equivalents	\$ 1,890	\$ -	\$ -	\$ 1,890
US equity securities and funds	9,403			9,403
Fixed-income securities and funds	<u>52,169</u>	<u>12,284</u>		<u>64,453</u>
Subtotal	<u>\$63,462</u>	<u>\$12,284</u>	<u>\$ -</u>	<u>75,746</u>
Investments measured at net asset value:				
US equity funds				6,779
International equity funds				30,508
Emerging market funds				3,104
Commodity securities funds				<u>2,014</u>
Subtotal				<u>42,405</u>
Alternative investments				<u>33,416</u>
Total				<u>\$151,567</u>

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, 2017 and 2016, are as follows (in thousands of dollars):

	2017	2016
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 225,807	\$ 205,472
Interest cost	6,665	7,408
Actuarial (gain) loss	(2,292)	28,118
Benefits paid	(3,123)	(3,049)
Settlements	<u>(14,643)</u>	<u>(12,142)</u>
Benefit obligation at end of year	<u>212,414</u>	<u>225,807</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	151,567	142,916
Actual return on plan assets	10,646	8,842
Employer contributions	58,750	15,000
Benefits paid	(3,124)	(3,049)
Settlements	<u>(14,643)</u>	<u>(12,142)</u>
Fair value of plan assets at end of year	<u>203,196</u>	<u>151,567</u>
Net pension liability	<u>\$ (9,218)</u>	<u>\$ (74,240)</u>

The accumulated benefit obligation was \$212.4 million and \$225.8 million as of September 30, 2017 and 2016, respectively. The amounts recognized in the consolidated balance sheets as noncurrent liabilities are \$9.2 million and \$74.2 million at September 30, 2017 and 2016, respectively. Amounts recorded as changes in unrestricted net assets arising from the defined benefit plan, but not yet included in net periodic benefit cost are \$86.8 million and \$103.0 million at September 30, 2017 and 2016, respectively. The estimated net actuarial loss to be amortized into net periodic pension costs over the next fiscal year is approximately \$6.0 million. The Health System does not expect to amortize any prior-service costs into net period pension cost over the next fiscal year.

On October 26, 2017 the Finance Committee of the Health System's board of directors approved a motion and recommended to the board of directors approval to terminate the Employees' Retirement Plan of the Moses H. Cone Memorial Hospital. If approved by the board of directors, the termination process will take approximately 18 to 24 months.

The components of net periodic pension costs and other pension-related changes in net assets for fiscal years 2017 and 2016, are as follows (in thousands of dollars):

	2017	2016
Interest cost on projected benefit obligation	\$ 6,665	\$ 7,408
Expected return on plan assets	(9,703)	(7,538)
Net amortization	7,052	5,267
Settlements	<u>5,982</u>	<u>5,541</u>
Net periodic pension cost	<u>9,996</u>	<u>10,678</u>
Current-year actuarial net (gain) loss	(3,391)	26,815
Amortization of net actuarial loss	(7,052)	(5,267)
Settlements	<u>(5,982)</u>	<u>(5,541)</u>
Total recognized in unrestricted net assets	<u>(16,425)</u>	<u>16,007</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ (6,429)</u>	<u>\$ 26,685</u>

The Health System made contributions totaling \$58.8 million and \$15.0 million to the pension plan in fiscal year 2017 and 2016, respectively. The following benefit payments are expected to be paid in the following fiscal years (in thousands of dollars):

**Years Ending
September 30**

2018	\$ 19,547
2019	20,678
2020	19,204
2021	17,928
2022	17,680
2023–2027	75,379

In addition, Cone Health and ARMC Health Care operate certain voluntary savings and defined contribution retirement plans. Contribution expense related to the plans was \$33.8 million in 2017 and \$29.6 million in 2016 and is reflected in fringe benefits expense in the accompanying consolidated statements of operations.

10. NET ASSETS

A summary of the changes in consolidated unrestricted net assets attributable to Moses H. Cone Memorial Hospital and Affiliates and the noncontrolling interests for the year ended September 30, 2017, is as follows (in thousands of dollars):

	Total	Moses H. Cone Memorial Hospital & Affiliates	Noncontrolling Interests
Balance—beginning of year	<u>\$ 1,501,204</u>	<u>\$ 1,498,398</u>	<u>\$ 2,806</u>
Excess of revenues over expenses from consolidated operations	70,851	66,329	4,522
Change in net unrealized gains and losses on investments	57,585	57,585	
Pension-related changes other than periodic benefit cost	16,425	16,425	
Change in the fair value of the floating-to-fixed swap agreements	18,265	18,265	
Acquisition of HTA noncontrolling interest	(17,600)	(14,162)	(3,438)
Distributions to noncontrolling interests	(6,588)		(6,588)
Other changes in net assets	<u>2,360</u>	<u>(1,251)</u>	<u>3,611</u>
Increase (decrease) in unrestricted net assets	<u>141,298</u>	<u>143,191</u>	<u>(1,893)</u>
Balance—end of year	<u>\$ 1,642,502</u>	<u>\$ 1,641,589</u>	<u>\$ 913</u>

A summary of the changes in consolidated unrestricted net assets attributable to Moses H. Cone Memorial Hospital and Affiliates and the noncontrolling interests for the year ended September 30, 2016, is as follows (in thousands of dollars):

	Total	Moses H. Cone Memorial Hospital & Affiliates	Noncontrolling Interests
Balance—beginning of year	<u>\$ 1,450,272</u>	<u>\$ 1,442,445</u>	<u>\$ 7,827</u>
Excess of revenues over expenses from consolidated operations	59,985	59,846	139
Change in net unrealized gains and losses on investments	24,715	24,715	
Pension-related changes other than periodic benefit cost	(16,007)	(16,007)	
Change in the fair value of the floating-to-fixed swap agreements	(5,993)	(5,993)	
Other changes in net assets	<u>(11,768)</u>	<u>(6,608)</u>	<u>(5,160)</u>
Increase (decrease) in unrestricted net assets	<u>50,932</u>	<u>55,953</u>	<u>(5,021)</u>
Balance—end of year	<u>\$ 1,501,204</u>	<u>\$ 1,498,398</u>	<u>\$ 2,806</u>

Temporarily restricted net assets are available for the following purposes at September 30, 2017 and 2016 (in thousands of dollars):

	2017	2016
Building fund	\$ 3,078	\$ 3,039
Community outreach	2,980	2,486
Patient support	4,657	3,575
Staff development and education	<u>1,322</u>	<u>2,017</u>
Temporarily restricted net assets	<u>\$12,037</u>	<u>\$11,117</u>

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

11. CONTINGENCIES

The Health System purchases professional and general liability insurance to cover 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 workers' compensation insurance to cover claims. 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 \$33.7 million and \$30.6 million as of September 30, 2017 and 2016, respectively.

12. 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 net receivables from patients and third-party payors at September 30, 2017 and 2016, was as follows:

	2017	2016
Medicare	12.1 %	10.5 %
Medicare Managed Care	17.6	17.2
Medicaid	6.5	5.5
Commercial	55.3	58.9
Other	6.8	6.9
Self-Pay	<u>1.7</u>	<u>1.0</u>
	<u>100.0 %</u>	<u>100.0 %</u>

13. FUNCTIONAL EXPENSES

The Health System provides general health care services to residents within its geographic location. Expenses related to providing these services, as determined by the Medicare Home Office Cost Reporting methodology, as of September 30, 2017 and 2016, are as follows (in thousands of dollars):

	2017	2016
Health care services	\$ 1,506,561	\$ 1,405,720
General and administrative	<u>278,314</u>	<u>239,493</u>
	<u>\$ 1,784,875</u>	<u>\$ 1,645,213</u>

* * * * *

CONSOLIDATING SUPPLEMENTAL SCHEDULES

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATING BALANCE SHEET

AS OF SEPTEMBER 30, 2017

(In thousands of dollars)

	Obligated Group					Total Group	Nonobligated Group			Consolidated
	Operating Corporation	Parent Corporation	Alamance Regional	Community Foundations	Reclassification and Eliminating Entries		Other Entities	Alamance Extended Care	Reclassification and Eliminating Entries	
ASSETS										
CURRENT ASSETS:										
Cash and cash equivalents	\$ 2,101	\$ 14,703	\$ 4	\$ 1,768	\$ -	\$ 18,576	\$ 30,740	\$ 8,492	\$ -	\$ 57,808
Short-term investments	26,789			14		26,803				26,803
Patient accounts receivable—net of allowance for uncollectible accounts of \$78,082 in 2017 and \$104,492 in 2016	177,138		(4,786)			172,352	25,704	731		198,787
Inventories	24,868		6,190			31,058	350	27		31,435
Assets limited as to use—required for current liabilities					6,674	6,674				-
Other current assets	<u>35,981</u>	<u>17,476</u>	<u>869</u>			<u>54,326</u>	<u>36,496</u>	<u>227</u>	<u>(8,261)</u>	<u>82,788</u>
Total current assets	266,877	32,179	2,277	1,782	6,674	309,789	93,290	9,477	(8,261)	404,295
LONG-TERM INVESTMENTS	3,261	781,854		168,914	(179,966)	774,063			(3,261)	770,802
ASSETS LIMITED AS TO USE—Net of portion required for current liabilities	1,553				173,292	174,845	19,050	3,885	3,261	201,041
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	46,499	433	1,621			48,553	22,849		(17,585)	53,817
PROPERTY AND EQUIPMENT—Net	194,203	562,893	248,182	2,206		1,007,484	21,435	58,203		1,087,122
GOODWILL	2,636	779				3,415	6,314			9,729
OTHER ASSETS	31,417	537	945	4		32,903	57,225	44	(10,677)	79,495
INTERCOMPANY RECEIVABLES (PAYABLES)	<u>206,607</u>	<u>(361,016)</u>	<u>232,729</u>	<u>(1,963)</u>		<u>76,357</u>	<u>(78,615)</u>	<u>2,258</u>		<u>-</u>
TOTAL	<u>\$ 753,053</u>	<u>\$ 1,017,659</u>	<u>\$ 485,754</u>	<u>\$ 170,943</u>	<u>\$ -</u>	<u>\$ 2,427,409</u>	<u>\$ 141,548</u>	<u>\$ 73,867</u>	<u>\$ (36,523)</u>	<u>\$ 2,606,301</u>

(Continued)

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATING BALANCE SHEET AS OF SEPTEMBER 30, 2017 (In thousands of dollars)

	Obligated Group					Total Group	Nonobligated Group			Consolidated
	Operating Corporation	Parent Corporation	Alamance Regional	Community Foundations	Reclassification and Eliminating Entries		Other Entities	Alamance Extended Care	Reclassification and Eliminating Entries	
LIABILITIES AND NET ASSETS										
CURRENT LIABILITIES:										
Accounts payable	\$ 56,706	\$ 9,769	\$ 2,849	\$ 343	\$ -	\$ 69,667	\$ 9,002	\$ 426	\$ (900)	\$ 78,195
Accrued expenses	36,672	21,831	28,991	4,885	-	92,379	133,824	4,948	(1,936)	229,215
Current portion of long-term debt and capital lease obligations	2,565	191,500	-	-	-	194,065	526	-	-	194,591
Total current liabilities	95,943	223,100	31,840	5,228	-	356,111	143,352	5,374	(2,836)	502,001
LONG-TERM DEBT—Net of current portion	-	322,018	-	-	-	322,018	17,826	-	(16,102)	323,742
CAPITAL LEASE OBLIGATION—Net of current portion	10,391	-	35	-	-	10,426	100	-	-	10,526
OTHER NONCURRENT LIABILITIES	57,086	82	1,150	404	-	58,722	42,290	14,481	-	115,493
Total liabilities	163,420	545,200	33,025	5,632	-	747,277	203,568	19,855	(18,938)	951,762
NET ASSETS (DEFICIT):										
Unrestricted:										
Moses H. Cone Memorial Hospital and Affiliates	580,868	472,459	452,521	165,311	1,000	1,672,159	(65,874)	53,802	(18,498)	1,641,589
Noncontrolling interests	-	-	-	-	-	-	-	-	913	913
Total unrestricted net assets (deficit)	580,868	472,459	452,521	165,311	1,000	1,672,159	(65,874)	53,802	(17,585)	1,642,502
Temporarily restricted	8,765	-	208	-	(1,000)	7,973	3,854	210	-	12,037
Total net assets (deficit)	589,633	472,459	452,729	165,311	-	1,680,132	(62,020)	54,012	(17,585)	1,654,539
TOTAL	\$ 753,053	\$ 1,017,659	\$ 485,754	\$ 170,943	\$ -	\$ 2,427,409	\$ 141,548	\$ 73,867	\$ (36,523)	\$ 2,606,301

(1) The members of the Obligated Group are jointly and severally liable for the entire amount of long-term debt issued under the Master Trust Indenture.

(Concluded)

THE MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2017

(In thousands of dollars)

	Obligated Group					Total Group	Nonobligated Group			Consolidated
	Operating Corporation	Parent Corporation	Alamance Regional	Community Foundations	Eliminating Entries		Other Entities	Alamance Extended Care	Eliminating Entries	
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT:										
Net patient service revenue	\$ 1,138,546	\$ -	\$ 268,632	\$ -	\$ -	\$ 1,407,178	\$ 229,564	\$ 14,701	\$ -	\$ 1,651,443
Other revenue	52,526	36,583	7,910	22	(34,974)	62,067	39,121	3,032	(5,992)	98,228
Premium revenue							86,894			86,894
Total revenue	<u>1,191,072</u>	<u>36,583</u>	<u>276,542</u>	<u>22</u>	<u>(34,974)</u>	<u>1,469,245</u>	<u>355,579</u>	<u>17,733</u>	<u>(5,992)</u>	<u>1,836,565</u>
EXPENSES:										
Salaries and wages	419,935	887	77,599	1,011		499,432	191,618	7,248	(1,046)	697,252
Fringe benefits	171,266	235	27,483	270		199,254	41,680	2,725	(236)	243,423
Supplies	266,057	17	48,330	46		314,450	19,129	1,852	(130)	335,301
Other direct expenses	210,021	15,855	67,821	369	(48,873)	245,193	136,591	4,212	(6,732)	379,264
Interest expense	375	13,691				14,066	719		(617)	14,168
Depreciation and amortization	59,468	35,730	14,010	91		109,299	3,848	2,320		115,467
Total expenses	<u>1,127,122</u>	<u>66,415</u>	<u>235,243</u>	<u>1,787</u>	<u>(48,873)</u>	<u>1,381,694</u>	<u>393,585</u>	<u>18,357</u>	<u>(8,761)</u>	<u>1,784,875</u>
INCOME (LOSS) FROM OPERATIONS	<u>63,950</u>	<u>(29,832)</u>	<u>41,299</u>	<u>(1,765)</u>	<u>13,899</u>	<u>87,551</u>	<u>(38,006)</u>	<u>(624)</u>	<u>2,769</u>	<u>51,690</u>
OTHER INCOME (EXPENSE):										
Investment income	2,424	35,645		6,809		44,878	579	19	(235)	45,241
Nonoperating income (expense)	5,544	(7,785)	(1,015)	(3,292)	(13,899)	(20,447)	(3,500)	(82)	(2,051)	(26,080)
Total other income (expense)	<u>7,968</u>	<u>27,860</u>	<u>(1,015)</u>	<u>3,517</u>	<u>(13,899)</u>	<u>24,431</u>	<u>(2,921)</u>	<u>(63)</u>	<u>(2,286)</u>	<u>19,161</u>
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSE FROM CONSOLIDATED OPERATIONS	71,918	(1,972)	40,284	1,752	-	111,982	(40,927)	(687)	483	70,851
EXCESS OF REVENUE OVER EXPENSE ATTRIBUTABLE TO NONCONTROLLING INTERESTS									(4,522)	(4,522)
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSE ATTRIBUTABLE TO MOSES H. CONE MEMORIAL HOSPITAL AND AFFILIATES	<u>\$ 71,918</u>	<u>\$ (1,972)</u>	<u>\$ 40,284</u>	<u>\$ 1,752</u>	<u>\$ -</u>	<u>\$ 111,982</u>	<u>\$ (40,927)</u>	<u>\$ (687)</u>	<u>\$ (4,039)</u>	<u>\$ 66,329</u>