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LISA SMITH, COUNTY RECORDER
MADISON COUNTY IOWA

CHEK



DURABLE GENERAL POWER OF ATTORNEY

THE IOWA STATE BAR ASSOCIATION

Official Form No. 120

Recorder's Cover Sheet

Preparer Information: (Name, address and phone number)

Marion E. James, 205 ½ N. Elm Street, Creston, IA 50801, Phone: (641) 782-6000

Taxpayer Information: (Name and complete address)

James W. McFarland, c/o Cinda Long, 1304 N. Cherry St., Creston, Iowa 50801

Return Document To: (Name and complete address)

~~Marion E. James, 205 ½ N. Elm Street, Creston, IA 50801, Phone: (641) 782-6000~~

→ Cinda Long

1304 N Cherry St. Creston, Ia 50801

Grantors:

James Walter McFarland

Grantees:

Cinda Sue Long

Legal description:

Document or instrument number of previously recorded documents:



DURABLE GENERAL POWER OF ATTORNEY

1. Designation of Attorney-in-Fact

I, James Walter McFarland, of
1493 Elmwood Avenue, Earlham, Iowa 50072 appoint
Cinda Sue Long of
1304 N. Cherry Street, Creston, IA 50801,
my Attorney-in-Fact. In the event my Attorney-in-Fact is unable to serve for any reason or if my Attorney-
in-Fact is currently my spouse and we become legally separated or our marriage is dissolved, I name
Jo Ellen Runnells of
404 N. 8th Street, Albia, IA 52531
as successor to my Attorney-in-Fact.

I hereby revoke any and all general powers of attorney that may have been previously executed
by me, but specifically excepting any powers of attorney for health care decisions which I may have
previously executed.

2. Powers of Attorney-in-Fact

My Attorney-in-Fact shall have full power and authority to manage and conduct all of my affairs,
with full power and authority to exercise or perform any act, power, duty, right or obligation I now have or
may hereafter acquire the legal right, power and capacity to exercise or perform. The power and authority
of my Attorney-in-Fact shall include, but not be limited to, the power and authority:

- A. To buy, acquire, obtain, take or hold possession of any property or property rights and to retain such property, whether income producing or non-income producing;
- B. To sell, convey, lease, manage, care for, preserve, protect, insure, improve, control, store, transport, maintain, repair, remodel, rebuild and in every way deal in and with any of my property or property rights, now or hereafter owned by me, and to establish and maintain reserves for improvements, upkeep and obsolescence; to eject or remove tenants or other persons and to recover possession of such property. This includes the right to convey or encumber my homestead;
- C. To pay my debts; to borrow money, mortgage and grant security interests in property; to complete, extend, modify or renew any obligations, either secured, unsecured, negotiable or non-negotiable, at a rate of interest and upon terms satisfactory to my Attorney-in-Fact; to lend money, either with or without collateral; to extend or secure credit; and to guarantee and insure the performance and payment of obligations of another person or entity;
- D. To open, maintain or close accounts, brokerage accounts, savings and checking accounts; to purchase, renew or cash certificates of deposit; to conduct any business with any banking or lending institution in regard to any of my accounts or certificates of deposit; to write checks, make deposits, make withdrawals and obtain bank statements, passbooks, drafts, money orders, warrants, certificates or vouchers payable to me by any person or entity, including the United States of America, and expressly including the right to sell or cash U.S. Treasury Securities and Series E, EE, H, HH, and I Bonds;
- E. To have full access to any safety deposit boxes and their contents;
- F. To pay all city, county, state or federal taxes and to receive appropriate receipts therefore; to prepare, execute, file and obtain from the government income and other tax returns and other governmental reports, applications, requests and documents; to take any appropriate action to minimize, reduce or establish non-liability for taxes; to sue or take appropriate action for refunds of same; to appear for me before the Internal Revenue Service or any other taxing authority in connection with any matter involving federal, state or local taxes in which I may be a party, giving my Attorney-in-Fact full power to do everything necessary to be done and to receive refund checks; to execute waivers of the statute of limitations and to

- execute closing agreements on my behalf;
- G. To act as proxy, with full power of substitution, at any corporate meeting and to initiate corporate meetings for my benefit as stockholder, in respect to any stocks, stock rights, shares, bonds, debentures or other investments, rights or interests;
 - H. To invest, re-invest, sell or exchange any assets owned by me and to pay the assessments and charges therefor; to obtain and maintain life insurance upon my life or upon the life of anyone else; to obtain and maintain any other types of insurance policies; to continue any existing plan of insurance or investment;
 - I. To defend, initiate, prosecute, settle, arbitrate, dismiss or dispose of any lawsuits, administrative hearings, claims, actions, attachments, injunctions, arrests or other proceedings, or otherwise participate in litigation which might affect me;
 - J. To carry on my business or businesses; to begin new businesses; to retain, utilize or increase the capital of any business; to incorporate or operate as a general partnership, limited partnership, sole proprietorship, Limited Liability Company or any other legal entities of my businesses;
 - K. To employ professional and business assistants of all kinds, including, but not limited to, attorneys, accountants, real estate agents, appraisers, salesmen and agents;
 - L. To apply for benefits and participate in programs offered by any governmental body, administrative agency, person or entity;
 - M. To transfer, assign, convey, and deliver any real or personal property in which I may have or own an interest to the Trustee of any revocable trust created by me, if such trust is in existence at the time, notwithstanding the fact that my Attorney-in-Fact, or his or her spouse, descendants, heirs or assigns, may be the (a) Trustee or successor Trustee of any such trust, (b) beneficiary of any such trust; or (c) holder of any special or general power of appointment created under such trust. Nothing in this paragraph shall be construed to allow my Attorney-in-Fact to create, amend, restate or revoke any such revocable trust created by me.
 - N. To disclaim any interest in property passing to me from person or entity;
 - O. To make gifts of any of my property or assets to members of my family; and to make gifts to such other persons or religious, educational, scientific, charitable or other nonprofit organizations to whom or to which I have an established pattern of giving; provided, however, that my Attorney-in-Fact may not make gifts of my property to himself or herself. I appoint NA
_____ of _____
_____ as my Attorney-in-Fact solely for the purpose of determining if a gift of my property to the Attorney-in-Fact appointed and acting hereunder is appropriate and to make any such gifts which are appropriate.

3. Construction.

This Power of Attorney is to be construed and interpreted as a general power of attorney. The enumeration of specific items, rights, acts or powers shall not limit or restrict the general and all-inclusive powers that I have granted to my Attorney-in-Fact. All references to property or property rights herein shall include all real, personal, tangible, intangible or mixed property. Words and phrases set forth in this Power of Attorney shall be construed as in the singular or plural number and as masculine, feminine or neuter gender according to the context.

Any authority granted to my Attorney-in-Fact, however, shall be limited so as to prevent this Power of Attorney (a) from causing my Attorney-in-Fact to be taxed on my income; (b) from causing my estate to be subject to a general power of appointment (as that term is defined by Section 2041, Internal Revenue Code of 1986, as amended) by my Attorney-in-Fact; and (c) from causing my Attorney-in-fact to have any incidents of ownership (within the meaning of Section 2042 of the Internal Revenue Code of 1986, as amended) with regard to any life insurance policies on my life.

4. Liability of Attorney-in-Fact.

My Attorney-in-Fact shall not be liable for any loss sustained through an error of judgment made in good faith, but shall be liable for willful misconduct or breach of good faith in the performance of any of the provisions of this power of attorney.

5. Compensation of Attorney-in-Fact.

The Attorney-in-Fact understands that this power of attorney is given without any express or implied

promise of compensation to said Attorney-in-Fact. Any services performed as my Attorney-in-Fact will be done without compensation, either during my lifetime or upon my death, but the Attorney-in-Fact shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions of this power of attorney.

6. Accounting by Attorney-in-Fact.

My Attorney-in-Fact shall maintain complete and accurate records of all acts performed pursuant to this power of attorney, including, without limitation, all receipts and disbursements. Upon my request or the request of any conservator appointed on my behalf or the personal representative of my estate, my Attorney-in-Fact shall allow inspection of these records and shall provide a complete accounting.

7. Effective Date and Durability.

N.B. DELETE INAPPROPRIATE PORTIONS OF THE FOLLOWING PARAGRAPH. IF NO DELETIONS ARE MADE, THE PROVISIONS SET FORTH IN PARAGRAPHS B AND C SHALL BE DEEMED TO HAVE BEEN DELETED.

- A. This Power of Attorney shall be effective immediately, shall not be affected by my disability,
~~B. This Power of Attorney shall become effective upon written certification by my physician that I am disabled,~~
~~C. This Power of Attorney shall become effective _____, shall not be affected by my disability,~~

and shall continue effective until my death; provided, however, that this Power of Attorney may be revoked by me as to my Attorney-in-Fact at any time by written notice to such Attorney-in-Fact.

8. Additional Provisions.

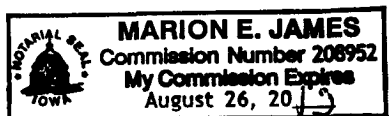
HIPAA and Protected Health Information. If any person's authority under the instrument is dependent upon any determination that I am unable properly to manage my affairs, then any physician attending me or otherwise requested by my Agent to determine my incapacity, and any other person or entity in possession of any of my "protected health information," as contemplated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is hereby authorized and directed to disclose my protected health information to my Agent to the extent necessary, and only to the extent necessary, for my Agent to determine whether an event of incapacity has occurred hereunder. Any limitation on protected health information to be disclosed hereunder shall have no effect upon any rights to such information any Agent may have under any Durable Power of Attorney for Health Care or other instrument granting access to such information.

Dated 5-2-12, at Creston, Iowa

James Walter McFarland
James Walter McFarland

STATE OF IOWA, COUNTY OF UNION

This instrument was acknowledged before me on May 2, 2012, by James Walter McFarland



Marion E. James
Marion E. James, Notary Public

**DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS**
(Medical Power of Attorney)

I, James Walter McFarland, born January 28, 1930, designate
Cinda Sue Long, 1304 N. Cherry Street, Creston, IA 50801, Phone: (641) 782-6563

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number
as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decision.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

Jo Ellen Runnells, 404 N. 8th Street, Albia, IA 52531, Phone: (641) 777-8623

(Type or Print) Name of Alternate, Street Address, City, State, Zip Code and Phone Number

OPTIONAL: ADDITIONAL PROVISIONS - Insert specific instructions or statement of desires (if any):

YES__ NO__ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed this 28 day of May 2012

1493 Elmwood Avenue, Earlham, IA 50072

Your Signature (Declarant/Principal)

Address, Street, City, State and Zip

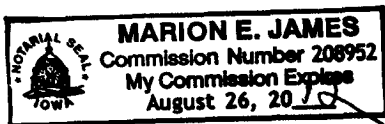
James Walter McFarland

Type or Print Your Name

This Power of Attorney must be witnessed by two persons or notarized.

STATE OF IOWA, COUNTY OF UNION

This instrument was acknowledged before me on May 2, 2013 by
James Walter McFarland



Marion E. James, Notary Public

Durable Power of Attorney for Health Care Decisions Form for James Walter McFarland.

By signing this form, I declare that I signed this form in the presence of the other witness and the Principal and I witnessed the signing by the Principal or other person acting on behalf of and at the Principal's direction.

WITNESS FORM

Signature of First Witness

Signature of Second Witness

Type or Print Name of Witness

Type or Print Name of Witness

Street Address, City, State and Zip Code

Street Address, City, State and Zip Code

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated May 2, 2012 in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark:

☒ sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);

☒ behavioral and mental health; and

☒ alcohol, drug and other substance abuse)

James Walter McFarland
Signature of Principal

May 2, 2012
Date

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated this 2d day of May 2012

James Walter McFarland
James Walter McFarland, Grantor

General Information on Durable Power of Attorney for Health Care

A durable power of attorney for health care is subject to the provisions of Chapter 144B of the Code of Iowa and reference should be made to that chapter. The following is a summary of some of the provisions of Chapter 144B of the Code of Iowa.

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Health care" does not include the provision of nutrition or hydration except when they are required to be provided parenterally or through intubation.
2. The following individuals shall not be witnesses for a durable power of attorney for health care
 - a. A health care provider attending the principal on the date of execution.
 - b. An employee of a health care provider attending the principal on the date of execution.
 - c. The individual designated in the durable power of attorney for health care as the attorney in fact
 - d. An individual who is less than eighteen years of age.
3. One of the witnesses shall be an individual who is not a relative of the principal by blood, marriage, or adoption within the third degree of consanguinity.
4. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
 - a. A health care provider attending the principal on the date of execution.
 - b. An employee of a health care provider attending the principal on the date of execution unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.
5. Revocation.
 - a. A durable power of attorney for health care may be revoked at any time and in any manner by which the principal is able to communicate the intent to revoke, without regard to mental or physical condition.
 - b. Revocation may be made by notifying the attorney in fact orally or in writing.
 - c. Revocation can also be made by notifying a health care provider orally or in writing while that provider is engaged in providing health care to the principal.
 - d. A revocation is only effective as to a health care provider upon its communication to the provider by the principal or by another to whom the principal has communicated revocation.
 - e. The health care provider is required to document the revocation in the treatment records of the principal.
 - f. The principal is presumed to have the capacity to revoke a durable power of attorney for health care.
 - g. Unless it provides otherwise, a valid durable power of attorney for health care revokes any prior durable power of attorney for health care.
6. Prohibited Practices.
 - a. A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not condition admission to a facility, or the providing of treatment, or insurance, on the requirement that an individual execute a durable power of attorney for health care.
 - b. A policy of life insurance shall not be legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of an attorney in fact appointed pursuant to this Chapter.
7. It is the responsibility of the principal to notify the health care provider (doctor) of the terms of the Durable Power of Attorney for Health Care.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a true copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to designated attorney in fact (agent) and to alternate designated attorney(s) in fact (if any).



DECLARATION OF DESIGNEE FOR FINAL DISPOSITION

I hereby designate Cinda Sue Long, 1304 N. Cherry Street, Creston, IA 50801, Phone:
(641) 782-6563

as my designee. My designee shall have the sole responsibility for making decisions concerning the final disposition of my remains and the ceremonies to be performed after my death. This declaration hereby revokes all prior declarations. This designation becomes effective upon my death.

My designee shall act in a manner that is reasonable under the circumstances.

I may revoke this declaration at any time. I agree that a third party (such as a funeral or cremation establishment, funeral director, or cemetery) who receives a copy of this declaration may act in reliance upon it. Revocation of this declaration is not effective as to a third party until the third party receives notice of the revocation. My estate shall indemnify my designee and any third party for costs incurred by them or claims arising against them as a result of their good faith reliance on this declaration.

Note: (The Declarant may designate one or more alternatives as designee but does not have to.) If the person designated above is unable or unwilling to serve, I designate Jo Ellen Runnells, 404 N. 8th Street, Albia, IA 52531, Phone: (641) 777-8623

_____, to serve as my designee.

[Option 1: I have entered into a contract for prearranged funeral services or funeral merchandise as defined in and accepted under Iowa Code Chapter 523A. The contract may be found at _____.]

[Option 2: I own or have reserved a cemetery lot at Penn Center Cemetery _____.]

[Option 3: (You may include any special instructions concerning organ donation consistent with Iowa Code Chapter 142C.) _____.]

[Option 4: YES__ NO__ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.]

I executed this declaration as my free and voluntary act.

Signed this 5-2-12

1493 Elmwood Avenue, Earlham, IA
50072

Address, Street, City, State and Zip


Signature of Declarant

James Walter McFarland

Type or Print Your Name

This Declaration must be witnessed by two persons or notarized.

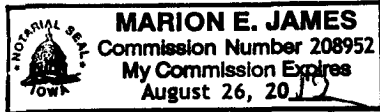
This form must be attached to an existing durable power of attorney for health care under Iowa Code Chapter 144B.

State of IOWA

County of UNION

} ss.

This instrument was acknowledged before me on May 2, 2012, by
James Walter McFarland



A handwritten signature in cursive script that reads "Marion E. James".

Marion E. James, Notary Public

By signing this form, I declare that I signed this form in the presence of the other witness and the Declarant and I witnessed the signing by the Declarant or other person acting on the Declarant's behalf at the direction of and in the presence of the Declarant.

Signature of 1st Witness

Signature of 2nd Witness

Type or Print Name of Witness

Type or Print Name of Witness

Street Address, City, State, Zip

Street Address, City, State, Zip