State of North Carolina

Office of The State Auditor

Beth A. Wood, CPA

University of North Carolina Hospitals at Chapel Hill

Chapel Hill, North Carolina

Financial Statement Audit Report

For the Year Ended June 30, 2017

An Affiliated Enterprise of the University of North Carolina System and a Component Unit of the State of North Carolina

NC OSA

The Taxpayers' Watchdog

STATE OF NORTH CAROLINA
Office of the State Auditor

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State Auditor

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AUDITOR'S TRANSMITTAL

The Honorable Roy Cooper, Governor
The General Assembly of North Carolina
Board of Directors, University of North Carolina Health Care System

We have completed a financial statement audit of the University of North Carolina Hospitals at Chapel Hill for the year ended June 30, 2017, and our audit results are included in this report. You will note from the independent auditor's report that we determined that the financial statements are presented fairly in all material respects.

The results of our tests disclosed no deficiencies in internal control over financial reporting that we consider to be material weaknesses in relation to our audit scope or any instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

North Carolina General Statutes require the State Auditor to make audit reports available to the public. Copies of audit reports issued by the Office of the State Auditor may be obtained through one of the options listed in the back of this report.

Beth A. Wood, CPA
State Auditor

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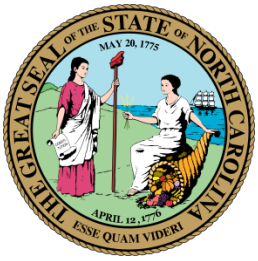
Article V, Chapter 147 of the *North Carolina General Statutes*, gives the Auditor broad powers to examine all books, records, files, papers, documents, and financial affairs of every state agency. The Auditor also has the power to summon people to produce records and to answer questions under oath.



INDEPENDENT AUDITOR'S REPORT

STATE OF NORTH CAROLINA
Office of the State Auditor

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INDEPENDENT AUDITOR'S REPORT

Board of Directors
University of North Carolina Health Care System
Chapel Hill, North Carolina

Report on the Financial Statements

We have audited the accompanying financial statements of the University of North Carolina Hospitals at Chapel Hill (Hospitals), which is a part of the University of North Carolina Health Care System that is an affiliated enterprise of the multi-campus University of North Carolina System, a component unit of the State of North Carolina, as of and for the year ended June 30, 2017, and the related notes to the financial statements, which collectively comprise the Hospitals' basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Hospitals' preparation and fair presentation of the 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 Hospitals' 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 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 financial statements referred to above present fairly, in all material respects, the financial position of the University of North Carolina Hospitals at Chapel Hill, as of June 30, 2017, and the changes in financial position and cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1, the financial statements of the University of North Carolina Hospitals at Chapel Hill are intended to present the financial position, changes in financial position, and cash flows that are only attributable to the transactions of the University of North Carolina Hospitals at Chapel Hill. They do not purport to, and do not, present fairly the financial position of the University of North Carolina Health Care System nor the University of North Carolina System as of June 30, 2017, the changes in its financial position, or its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matters – Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis and other required supplementary information, as listed in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

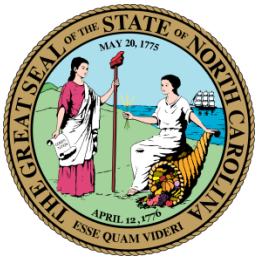
In accordance with *Government Auditing Standards*, we have also issued our report dated October 16, 2017 on our consideration of the Hospitals' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospitals' internal control over financial reporting and compliance.

Beth A. Wood

Beth A. Wood, CPA
State Auditor

Raleigh, North Carolina

October 16, 2017



MANAGEMENT'S DISCUSSION AND ANALYSIS

The Management's Discussion and Analysis section of the University of North Carolina Hospitals at Chapel Hill (Hospitals) annual financial report is provided as an overview of the financial position and operating results as of and for the fiscal years ended June 30, 2017 and 2016. This discussion and analysis should be read in conjunction with the financial statements and related notes which follow this discussion and analysis.

Using this Financial Report

The Hospitals' financial statements report information of the Hospitals using accounting methods similar to those used by private-sector health organizations. These statements offer short and long-term financial information about its activities.

Statement of Net Position

The statement of net position shows the financial position of the Hospitals and includes all of the Hospitals' assets (resources), deferred outflows of resources, liabilities (claims to resources), deferred inflows of resources, and net position (equity). The statement of net position also provides the basis for evaluating the capital structure, liquidity, and financial flexibility of the Hospitals.

Statement of Revenues, Expenses, and Changes in Net Position

Revenues and expenses are accounted for in the statement of revenues, expenses, and changes in net position. This statement measures the success of the Hospitals' operations and can be used to determine whether the Hospitals successfully recovered all of its costs through its revenue, profitability, and credit worthiness.

Statement of Cash Flows

The statement of cash flows reports cash receipts, cash payments, and net changes in cash resulting from operating, investing, capital and related financing activities, and noncapital related financing activities. It also provides answers to such questions as where cash comes from, what cash was used for, and what the change in the cash balance was during the reporting period.

Notes to the Financial Statements

Notes to the financial statements are designed to give the reader additional information concerning the Hospitals and further supports the statements noted above.

Financial Analysis

The statement of revenues, expenses, and changes in net position reports the net position of the Hospitals and the changes affecting it. The Hospitals' net position, the difference between assets (plus deferred outflows) and liabilities (plus deferred inflows), is a way to measure financial health or financial position. Over time, increases or decreases in the Hospitals' net position are indicators of whether its financial health is improving or deteriorating. However, one will also need to consider other non-financial factors such as changes in economic conditions, population growth, clinical advances, and new or changed governmental legislation.

Condensed Statements of Net Position

The following condensed statements of net position show the Hospitals' financial position at June 30, 2017 and 2016.

STATEMENTS OF NET POSITION

	FY17	FY16	Change	% Change
Current Assets	$ 646,153,789	$ 678,438,778	$ (32,284,989)	(4.8)%
Capital Assets, Net	745,785,947	766,333,435	(20,547,488)	(2.7)%
Other Noncurrent Assets	872,724,510	669,560,761	203,163,749	30.3%
TOTAL ASSETS	2,264,664,246	2,114,332,974	150,331,272	7.1%
DEFERRED OUTFLOWS OF RESOURCES	240,329,370	81,919,932	158,409,438	193.4%
Other Current Liabilities	267,466,265	304,472,231	(37,005,966)	(12.2)%
Other Noncurrent Liabilities	87,912,663	100,512,006	(12,599,343)	(12.5)%
Long-Term Liabilities	722,635,843	444,630,010	278,005,833	62.5%
TOTAL LIABILITIES	1,078,014,771	849,614,247	228,400,524	26.9%
DEFERRED INFLOWS OF RESOURCES	19,929,791	34,922,046	(14,992,255)	(42.9)%
Net Investment in Capital Assets	556,614,501	574,580,319	(17,965,818)	(3.1)%
Restricted for Expendable Uses	294,130,889	254,742,323	39,388,566	15.5%
Unrestricted	556,303,664	482,393,971	73,909,693	15.3%
TOTAL NET POSITION	$ 1,407,049,054	$ 1,311,716,613	$ 95,332,441	7.3%

Total assets increased $150.3 million as of June 30, 2017 primarily from operating performance, which allowed for investment purchases of $180 million. In addition to the investment purchases, the increased market performance resulted in return on investments of $62.8 million compared to investment losses in the prior year.

Deferred outflows of resources increased from $81.9 million to $240.3 million from the required recognition of $166.1 million of deferred outflows in connection with the State of North Carolina Teachers' and State Employees' Retirement System Plan (see Note 11).

Total liabilities increased $228.4 million from June 30, 2016. Current liabilities decreased $37 million primarily due to the payment and resulting reduction in amounts due to the UNC Health Care System. Other changes in current liabilities include accrued salaries and benefits which are the result of the timing of year-end liabilities. The $278 million increase in long-term liabilities is attributable to an overall net increase in bonds payable of $88.8 million, as a result of 2016 bonds issuance for the surgical tower project, and an increase in net pension liability of $192.7 million. See Note 7 and 11 to the audited financial statements for further details related to bonds payable and the pension plan.

Deferred inflows of resources decreased $15 million as a result of the required recognition of differences between actual and expected pension plan experience, including investment performance, related to the pension plan in accordance with GASB Statement No. 68, which became effective June 30, 2015.

Net position improved $95.3 million during the fiscal year ended June 30, 2017 and was driven by operating income of $215.5 million and an investment gain of $62.8 million. This was somewhat offset by UNC Health Care System assessments of $171.9 million. This transfer was predominately utilized to reimburse the System for shared services and clinical, educational, and research investment. For further information on this change, see the following statement of revenues, expenses, and changes in net position.

Capital Assets

The Hospitals expended $20.8 million on the acquisition and construction of buildings, infrastructure, and renovations during the fiscal year. An additional $20.2 million was expended during the year for capital equipment throughout the facilities and $1.1 million on software resulting in a total capital investment of approximately $42.1 million for the year as shown in Note 6. Capital spending is expected to increase in the future as planning is underway for a new surgical tower which will modernize a significant number of operating rooms located on the UNC Chapel Hill campus. Completion is expected within the next four years.

Long-term Debt Activities

At June 30, 2017, the Hospitals had outstanding bond indebtedness in the amount of $330.6 million, of which $12.6 million is due within the next year. Standard & Poor's and Moody's Rating Services classify these bonds at AA and Aa3, respectively. A bond issuance of $100 million occurred during the year to fund upcoming capital projects, primarily the surgical tower. No material new lease commitments are planned in the coming year. The current outstanding indebtedness of the Hospitals is described in Note 7.

Statements of Revenues, Expenses, and Changes in Net Position

While the condensed statements of net position show the financial position of the Hospitals, the following condensed statements of revenues, expenses, and changes in net position provide answers to the nature and source of changes in net position for the years ended June 30, 2017 and 2016:

STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

	FY17	FY16	Change	% Change
Net Patient Service Revenue	$ 1,728,597,641	$ 1,551,326,267	$ 177,271,374	11.4%
Other Operating Revenues	45,047,813	39,079,109	5,968,704	15.3%
TOTAL OPERATING REVENUES	1,773,645,454	1,590,405,376	183,240,078	11.5%
Salaries and Benefits	670,735,215	581,746,106	88,989,109	15.3%
Medical and Surgical Supplies	410,805,171	344,883,927	65,921,244	19.1%
Contracted Services	321,946,285	275,804,098	46,142,187	16.7%
Other Supplies and Services	70,618,861	64,389,701	6,229,160	9.7%
Medical Malpractice Cost	3,059,619	4,348,331	(1,288,712)	(29.6)%
Communications, Utilities, and Travel	21,291,055	22,165,190	(874,135)	(3.9)%
Depreciation and Amortization	59,651,888	66,806,623	(7,154,735)	(10.7)%
TOTAL OPERATING EXPENSES	1,558,108,094	1,360,143,976	197,964,118	14.6%
OPERATING INCOME	215,537,360	230,261,400	(14,724,040)	(6.4)%
Investment Income (Loss)	62,823,790	(6,175,873)	68,999,663	1117.2%
Other Nonoperating Revenues	2,210,291	1,822,743	387,548	21.3%
Nonoperating Expenses	(13,376,777)	(8,611,895)	(4,764,882)	55.3%
NET NONOPERATING REVENUES (EXPENSES)	51,657,304	(12,965,025)	64,622,329	498.4%
Health Care System Assessments	(171,862,223)	(129,713,445)	(42,148,778)	32.5%
INCREASE IN NET POSITION	95,332,441	87,582,930	7,749,511	8.8%
NET POSITION - BEGINNING OF YEAR	1,311,716,613	1,224,133,683	87,582,930	7.2%
NET POSITION - END OF YEAR	$ 1,407,049,054	$ 1,311,716,613	$ 95,332,441	7.3%
TOTAL REVENUES	$ 1,838,679,535	$ 1,592,228,119	$ 246,451,416	15.5%
TOTAL EXPENSES	1,743,347,094	1,504,645,189	238,701,905	15.9%
INCREASE IN NET POSITION	$ 95,332,441	$ 87,582,930	$ 7,749,511	8.8%

Net patient revenue increased $177.3 million and reflects a 2.1% increase in total discharges, a 5.1% increase in total surgeries and a 4.5% increase in Emergency Department visits. Volume and gross revenue have continued to increase from the opening of the Hillsborough Hospital Campus while net revenue has benefitted from continued pricing and collection improvements.

Operating expenses increased $198 million over the prior year. Note that the increase in salaries and benefits of $89 million is net of an unfavorable $11.6 million adjustment to pension expense as required by GASB Statement No. 68. This adjustment inflates the impact of increased salary and benefit expense that has occurred due to the expansion of hospital operations and market increases in pay. Medical supply expenses increased $65.9 million from last year and reflect a significant increase in pharmaceutical supplies expense as a result of increases in outpatient pharmacy volume and inpatient patient acuity. Contracted services increased $46.1 million from last year due to continued growth and consolidation of hospitals and accounting systems within the UNC Health Care System.

Net nonoperating revenues increased $64.6 million over last year due to higher investment returns. Cash required for day to day operations is deposited with the State Treasurer in the Short Term Investment Fund (STIF). Funds set aside to fund specific capital projects and the future growth of the Hospitals, have been primarily invested with UNC Investment Fund, LLC as described in Note 2.

Health Care System assessments reflect the funding of initiatives that the Chief Executive Officer of UNC Health Care System deems appropriate. These initiatives are selected and applicable assessments are quantified based on recommendations made from Senior Leadership. These assessments increased by $42.1 million from 2016 to 2017 due to an increase in support provided to UNC Health Care to fund UNC Faculty Practice and the UNC School of Medicine programs. These assessments are described in more detail in Note 15.

Discussion of Conditions that may have a Significant Effect on Net Position or Revenues, Expenses, and Changes in Net Position

The Hospitals derives the vast majority of its revenue from patient care services. Ongoing strong operating performance has enabled the Hospitals to continue to make investments in support of clinical education and research programs of UNC Faculty Practice, the UNC School of Medicine, and other network entities. These investments continue to yield positive results as measured by growth in needed services, expansions of the medical school class, and increased research funding.

The Hospitals has sought to remain a leader by evolving to meet the changing healthcare environment. We are making infrastructure investments to modernize our patient care. The inpatient census at the Hospitals is regularly near maximum capacity. To address this need, we constructed and opened a 25-bed observation unit and continue to leverage opportunities to increase Hillsborough campus utilization to decompress the main campus. We are also in the process of developing a replacement perioperative tower on the Chapel Hill campus. These facilities are designed to optimize efficiency and the patient experience and allow for an appropriate and safe care environment. The Hospitals have been awarded Certificates of Need for an additional 95 acute patient beds which will be constructed with operating funds on the Chapel Hill and Hillsborough campuses.

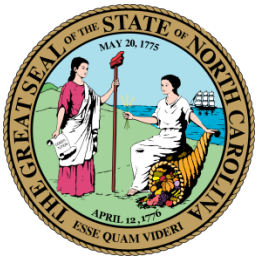
With the entire UNC Health Care System, the Hospitals completed an engagement known as *Carolina Value* to improve profitability by implementing targeted initiatives to reduce

operating expenses and increase net patient revenues. *Carolina Value* enabled UNC Health Care System to be more integrated operationally and clinically and generated more than $295 million in recurring annual financial improvements across the System.

On August 31, 2017, UNC Health Care and Carolinas HealthCare System signed a non-binding letter of intent (LOI) to create a joint operating company which will co-manage the operations of both organizations. Under the LOI, the two organizations have agreed to begin a period of exclusive negotiations, with the goal of entering into formal agreements by the end of the calendar year. The new organization will deliver world-class care to people in North Carolina by creating the most comprehensive network of primary, specialty and on-demand care in the Southeast. This partnership creates one of the leading non-profit healthcare systems in the nation, by blending the best of a high-performing comprehensive healthcare system with a renowned academically-based enterprise. This relationship will provide clear solutions for healthcare's most pressing challenges by focusing on four strategic areas: increasing access and affordability, advancing clinical care expertise, growing their renowned academic enterprise, and contributing to the region's economic vibrancy.

Third-party payors, including governmental sponsored programs, continue to migrate from fee-for-service to fee-for-value. UNC Health Care is positioning itself to be a leader in the new healthcare environment that will ultimately reimburse less for services currently provided to our patients. We have implemented programs aimed at different aspects of population health management at each of our medical institutions. These programs include an operational and strategic partnership with Alignment Healthcare for population management. Alignment Healthcare began offering a Medicare Advantage HMO product for seniors in Wake County, North Carolina in the fall of 2014. The Hospitals also participates in the UNC Health Alliance, a Clinically Integrated Network. The Health Alliance started participating in Centers for Medicare and Medicaid Services' (CMS's) Next Generation Accountable Care Organization (ACO) in January 2017. The Next Generation ACO Model is a value-based payment model that encourages providers to assume greater accountability in coordinating the health care of Medicare fee-for-service beneficiaries. Learning from these programs will allow UNC Health Care to more rapidly scale and ramp-up our initiatives when appropriate.

Continued reductions to payment levels for Medicaid patients, added legislative burdens, market consolidation, and cuts to the UNC School of Medicine place added pressures on the Hospitals. Management is committed to proper expense management while maintaining high quality patient care, innovation, and very satisfied patients. Our teams will continue to focus on our *Commitment to Caring* patient experience which has proven to be a differentiator in care delivered by the Hospitals for many years.



FINANCIAL STATEMENTS

University of North Carolina Hospitals at Chapel Hill
Statement of Net Position
June 30, 2017

ASSETS		
Current Assets:		
Cash and Cash Equivalents (Note 2)	$	155,188,019
Restricted Cash and Cash Equivalents (Note 2)		2,206,726
Receivables, Net:		
Patient Accounts Receivable, Net (Note 4)		196,917,238
Other Accounts Receivable, Net		22,462,126
Due from Primary Government		5,872,241
Due from State of North Carolina Component Units		111,526,009
Estimated Third Party Settlements (Note 5)		10,586,348
Inventories		54,151,683
Prepaid Expense		81,273,971
Notes Receivable (Note 15)		5,969,428
Total Current Assets		646,153,789
Noncurrent Assets:		
Restricted Cash and Cash Equivalents (Note 2)		94,977,040
Restricted Investments (Note 2)		283,799,567
Investments Designated for Capital Projects (Note 2)		428,086,238
Advanced Deposits with Liability Insurance Trust Fund (Note 13)		9,720,145
Patient Accounts Receivable, Net (Note 4)		879,573
Start-Up Cost, Net		369,561
Notes Receivable (Note 15)		39,123,718
Investments in Affiliates (Note 16)		15,768,668
Capital Assets - Nondepreciable (Note 6)		85,598,711
Capital Assets - Depreciable, Net (Note 6)		660,187,236
Total Noncurrent Assets		1,618,510,457
Total Assets		2,264,664,246
DEFERRED OUTFLOWS OF RESOURCES		
Deferred Loss on Refunding		8,173,492
Accumulated Decrease in Fair Value of Hedging Derivatives		12,558,232
Deferred Outflows Related to Pensions		219,597,646
Total Deferred Outflows of Resources		240,329,370
LIABILITIES		
Current Liabilities:		
Accounts Payable and Accrued Liabilities		88,625,483
Accrued Salaries and Benefits		54,735,996
Estimated Third Party Settlements (Note 5)		85,117,914
Due to Patients or Third Parties		9,935,041
Due to Primary Government		9,660,561
Due to State of North Carolina Component Units		16,619,046
Interest Payable		2,772,224
Long-Term Liabilities - Current Portion (Note 7)		36,358,229
Total Current Liabilities		303,824,494

Noncurrent Liabilities:	
Long-Term Liabilities (Note 7)	686,277,614
Hedging Derivative Liability (Note 8)	12,558,232
Estimated Third Party Settlements (Note 5)	75,354,431
Total Noncurrent Liabilities	774,190,277
Total Liabilities	1,078,014,771
DEFERRED INFLOWS OF RESOURCES	
Deferred Inflows Related to Pensions	19,929,791
NET POSITION	
Net Investment in Capital Assets	556,614,501
Restricted for Expendable:	
Maintenance Reserve Fund	283,799,567
Liability Insurance Trust Fund	9,720,145
Trust Fund Donations	611,177
Unrestricted	556,303,664
Total Net Position	$ 1,407,049,054

The accompanying notes to the financial statements are an integral part of this statement.

University of North Carolina Hospitals at Chapel Hill
Statement of Revenues, Expenses, and Changes in Net Position
For the Fiscal Year Ended June 30, 2017

Exhibit A-2

REVENUES		
Operating Revenues:		
Net Patient Service Revenue (Note 10)	$	1,728,597,641
Other Operating Revenues		45,047,813
Total Operating Revenues		1,773,645,454
EXPENSES		
Operating Expenses:		
Salaries and Benefits		670,735,215
Medical and Surgical Supplies		410,805,171
Contracted Services		321,946,285
Other Supplies and Services		70,618,861
Medical Malpractice Cost		3,059,619
Communications, Utilities, and Travel		21,291,055
Depreciation and Amortization		59,651,888
Total Operating Expenses		1,558,108,094
Operating Income		215,537,360
NONOPERATING REVENUES (EXPENSES)		
Noncapital Gifts and Grants		1,257,152
Federal Interest Subsidy on Debt		698,776
Investment Income (Net of Investment Expense of $1,387,840)		62,823,790
Interest and Fees on Debt		(11,955,531)
Loss on Disposal of Capital Assets		(1,421,246)
Other Nonoperating Revenues		254,363
Net Nonoperating Revenues		51,657,304
Income Before Other Expenses		267,194,664
Health Care System Assessments (Note 15)		(171,862,223)
Increase in Net Position		95,332,441
NET POSITION		
Net Position - July 1, 2016		1,311,716,613
Net Position - June 30, 2017	$	1,407,049,054

The accompanying notes to the financial statements are an integral part of this statement.

University of North Carolina Hospitals at Chapel Hill
Statement of Cash Flows
For the Fiscal Year Ended June 30, 2017

CASH FLOWS FROM OPERATING ACTIVITIES		
Received from Patients or Third Parties	$	1,733,954,637
Payments to Employees and Fringe Benefits		(635,086,847)
Payments to Vendors and Suppliers		(837,968,423)
Payments for Medical Malpractice		(132,598)
Other Payments		(41,454,514)
Net Cash Provided by Operating Activities		219,312,255
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Health Care System Assessments		(176,695,538)
Principal Paid on Revenue Bonds		(1,360,000)
Interest and Fees Paid on Revenue Bonds		(582,144)
Noncapital Gifts and Grants		1,257,152
Net Cash Used by Noncapital Financing Activities		(177,380,530)
CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES		
Proceeds from Capital Revenue Bonds		100,873,663
Proceeds from Sale of Capital Assets		19,104,873
Acquisition and Construction of Capital Assets		(36,096,730)
Principal Paid on Capital Revenue Bonds		(10,715,000)
Principal Paid on Capital Lease Payable		(5,925,159)
Interest and Fees Paid on Capital Debt and Leases		(7,958,082)
Federal Interest Subsidy on Debt Received		698,776
Net Cash Provided by Capital Financing and Related Financing Activities		59,982,341
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sales and Maturities of Investments		11,239,404
Investment Income		1,411,453
Purchase of Investments and Related Fees		(180,000,000)
Investment Returns from Affiliated Enterprises		1,275,488
Net Cash Used by Investing Activities		(166,073,655)
Net Decrease in Cash and Cash Equivalents		(64,159,589)
Cash and Cash Equivalents - July 1, 2016		316,531,374
Cash and Cash Equivalents - June 30, 2017	$	252,371,785

RECONCILIATION OF NET OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

Operating Income	$	215,537,360
Adjustments to Reconcile Operating Income to Net Cash Provided by Operating Activities:		
Depreciation/ Amortization Expense		59,651,888
Changes in Assets and Deferred Outflows of Resources:		
Patient Accounts Receivable, Net		10,741,892
Due from Primary Government		729,591
Due from State of North Carolina Component Units		(10,976,778)
Estimated Third Party Settlements		(207,377)
Other Accounts Receivable, Net		16,610,862
Inventories		(8,238,346)
Prepaid Expenses		(26,403,801)
Advanced Deposits with Liability Insurance Trust Fund		(3,434,249)
Deferred Outflows for Pensions		(166,094,225)
Changes in Liabilities and Deferred Inflows of Resources:		
Accounts Payable and Accrued Liabilities		(4,220,179)
Accrued Salaries and Benefits		6,677,948
Due to Patients or Third Parties		(5,799,611)
Due to Primary Government		(3,169,716)
Due to State of North Carolina Component Units		(41,119,437)
Net Pension Liability		192,678,945
Compensated Absences		1,339,743
Deferred Inflows for Pensions		(14,992,255)
Net Cash Provided by Operating Activities	$	219,312,255

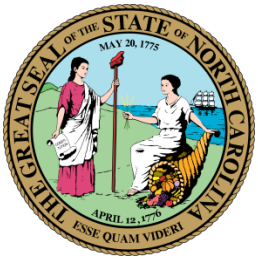
RECONCILIATION OF CASH AND CASH EQUIVALENTS

Current Assets:		
Cash and Cash Equivalents	$	155,188,019
Restricted Cash and Cash Equivalents		2,206,726
Noncurrent Assets:		
Restricted Cash and Cash Equivalents		94,977,040
Total Cash and Cash Equivalents - June 30, 2017	$	252,371,785

NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES

Assets Acquired through the Assumption of a Liability	$	4,747,803
Change in Fair Value of Investments		59,056,339
Loss on Disposal of Capital Assets		(1,421,246)
Amortization of Bond Premium		(35,718)

The accompanying notes to the financial statements are an integral part of this statement.



NOTES TO THE FINANCIAL STATEMENTS

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES

A. Organization - The University of North Carolina Hospitals at Chapel Hill (the Hospitals) is the only state-owned teaching hospital in North Carolina. With a licensed base of 929 beds, this facility serves as an acute care teaching hospital for The University of North Carolina at Chapel Hill. The Hospitals consists of North Carolina Memorial Hospital, North Carolina Children's Hospital, North Carolina Neurosciences Hospital, North Carolina Women's Hospital, North Carolina Cancer Hospital, and UNC Hospitals – Hillsborough Campus. As a state agency, the Hospitals is required to conform to financial requirements established by various statutory and constitutional provisions. While the Hospitals is exempt from both federal and state income taxes, a small portion of its revenue is subject to the unrelated business income tax.

B. Financial Reporting Entity - The concept underlying the definition of the financial reporting entity is that elected officials are accountable to their constituents for their actions. As required by accounting principles generally accepted in the United States of America (GAAP), the financial reporting entity includes both the primary government and all of its component units. An organization other than a primary government serves as a nucleus for a reporting entity when it issues separate financial statements.

The Hospitals is a part of the University of North Carolina (UNC) Health Care System, an affiliated enterprise of the multi-campus University of North Carolina System, a component unit of the State of North Carolina and an integral part of the State's *Comprehensive Annual Financial Report*.

The accompanying financial statements present all funds belonging to the Hospitals and its component unit for which the UNC Health Care System Board of Directors is responsible. While the Board of Governors of the University of North Carolina System has ultimate responsibility, the Board of Directors of the UNC Health Care System has delegated responsibilities for financial accountability of the Hospitals' funds. The Hospitals' component unit is blended in the Hospitals' financial statements. See below for further discussion of the Hospitals' component unit. Other related foundations and similar nonprofit corporations for which the Hospitals is not financially accountable are not part of the accompanying financial statements.

Blended Component Unit - Although legally separate, Health System Properties, LLC (the LLC), a component unit of the Hospitals, is reported as if it were part of the Hospitals.

The LLC was established to purchase, develop and/or lease real property. Because the UNC Health Care System is the sole member manager of the LLC, the elected directors of the LLC are the same members of the UNC Health Care System Board of Directors that directs Hospitals' operations, and as the LLC's primary purpose is to benefit the

Hospitals, its financial statements have been blended with those of the Hospitals.

Separate financial statements for the LLC may be obtained from the President of UNC Health Care Network Hospitals, Executive Vice President & Chief Financial Officer, University of North Carolina Hospitals, 101 Manning Drive, Med Wing E – Room 310, Chapel Hill, North Carolina, 27514, or by calling (984) 974-5112.

Condensed combining information regarding the blended component unit is provided in Note 17.

C. Basis of Presentation - The accompanying financial statements are presented in accordance with accounting principles generally accepted in the United States of America as prescribed by the Governmental Accounting Standards Board (GASB).

Pursuant to the provisions of GASB Statement No. 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments*, as amended by GASB Statement No. 35, *Basic Financial Statements - and Management's Discussion and Analysis - for Public Colleges and Universities*, the full scope of the Hospitals' activities is considered to be a single business-type activity and accordingly, is reported within a single column in the basic financial statements.

D. Basis of Accounting - The financial statements of the Hospitals have been prepared using the economic resource measurement focus and the accrual basis of accounting. Under the accrual basis, revenues are recognized when earned, and expenses are recorded when an obligation has been incurred, regardless of the timing of the cash flows.

Nonexchange transactions, in which the Hospitals receives (or gives) value without directly giving (or receiving) equal value in exchange, include certain grants and donations. Revenues are recognized, net of estimated uncollectible amounts, as soon as all eligibility requirements imposed by the provider have been met, if probable of collection.

E. Cash and Cash Equivalents - This classification includes petty cash on hand and all highly liquid investments with an original maturity of three months or less when purchased, including deposits held by the State Treasurer in the Short-Term Investment Fund (STIF). The STIF maintained by the State Treasurer has the general characteristics of a demand deposit account in that participants may deposit and withdraw cash at any time without prior notice or penalty.

F. Investments - To the extent available, investments are recorded at fair value based on quoted market prices in active markets on a trade-date basis. Additional information regarding the fair value measurement of investments is disclosed in Note 3. Because of the inherent uncertainty in the use of estimates, values that are based on estimates may differ from the values that would have been used had a ready market existed for the

investments. The net change in the value of investments is recognized as component of investment income.

G. Patient Accounts Receivable - The Hospitals' patient accounts receivable consist of unbilled (in house patients, inpatients discharged but not final billed, and outpatients not final billed) and billed amounts. Payment of these charges comes primarily from Managed Care payers, Medicare, Medicaid and, to a lesser extent, the patient. These amounts are recorded in the financial statements net of charity care, contractual allowances, avoidable and other losses, and allowances for bad debt to determine the net realizable value of accounts receivable. See the section Net Patient Service Revenue later in the Significant Accounting Policies for a further discussion of these reductions.

The reserves recorded for these accounts are used to determine net patient accounts receivable and are calculated based on the historical collection rates realized for each payer. The collection rates are updated monthly in order to reflect the most up to date information available.

The Hospitals has established flexible payment arrangements for patient balances up to a maximum of 48 months depending on the outstanding balance due. Amounts due beyond one year under these arrangements are classified as noncurrent assets.

H. Other Receivables - In addition to patient accounts receivable, the Hospitals recognizes other receivables related to its operations. These items include the sales tax refund due from the North Carolina Department of Revenue, accrued interest receivable on deposits, education loan receivables, amounts due from affiliates and other state agencies, billings to outside companies for ancillary testing, critical care transportation, and pharmacy supplies. Receivables are recorded net of estimated uncollectible amounts.

I. Inventories - Inventories consist of medical supplies, surgical supplies, pharmaceuticals, prosthetics, and other supplies used to provide patient care or by service departments within the Hospitals. Inventories are valued at cost using the first-in, first-out method. Merchandise for resale is valued at the lower of cost or market using the retail inventory method.

J. Capital Assets - Capital asset acquisitions are recorded at cost or acquisition value at date of donation in the case of gifts, and include interest on funds used to finance the acquisition or construction of major capital projects. Assets under capital lease are stated at the present value of the minimum lease payments at the inception of the lease.

Expenditures for repairs and maintenance are charged to expense as incurred. The costs for major renewals and betterments are capitalized and depreciated over the estimated useful lives of the assets. Upon disposition, the asset and related accumulated depreciation accounts are relieved and any gain or loss is credited or charged to nonoperating revenues and expenses.

Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets in the following manner:

Asset Class	Estimated Useful Life
Buildings	10-40 years
Machinery and Equipment	3-20 years
General Infrastructure	5-25 years
Computer Software	3-10 years

K. Designated Assets - Investments designated for capital projects include assets set aside or designated for the acquisition or construction of capital assets (over which the UNC Health Care System Board retains control and may at its discretion subsequently use for other purposes).

L. Restricted Assets - Certain resources are reported as restricted assets because restrictions on asset use change the nature or normal understanding of the availability of the asset. Resources that are not available for current operations and are reported as restricted include funds equal to 7.5% of gross patient revenue as limited by applicable revenue bond covenants and resources designated for liability insurance claims. Current restricted resources include certain trust funds restricted because external parties or statute limits their use and resources legally segregated for the payment of principal and interest as required by debt covenants.

M. Noncurrent Long-Term Liabilities - Noncurrent long-term liabilities include principal amounts of revenue bonds payable, net pension liability, capital lease obligations, financing arrangements, and compensated absences that will not be paid within the next fiscal year.

Revenue bonds payable are reported net of unamortized premiums or discounts. The Hospitals amortizes bond premiums/discounts over the life of the bonds using the straight-line method that approximates the effective interest method. Deferred gains and losses on refundings are amortized over the life of the old debt or new debt (whichever is shorter) using the straight-line method, and are aggregated as deferred outflows of resources or deferred inflows of resources on the Statement of Net Position. Issuance costs are expensed in the reporting period in which they are incurred.

The net pension liability represents the Hospitals' proportionate share of the collective net pension liability reported in the State of North Carolina's 2016 *Comprehensive Annual Financial Report.* This liability represents the Hospitals' portion of the collective total pension liability less the fiduciary net position of the Teachers' and State Employees' Retirement System. See Note 11 for further information regarding the Hospitals' policies for recognizing liabilities, expenses, and deferred outflows of resources and deferred inflows of resources related to pensions.

N. Compensated Absences - The Hospitals' policy is to record the cost of annual leave when earned. Employees earn annual leave at varying rates depending upon years of service and the leave plan in which they participate.

Traditional Plan – The policy provides for a maximum accumulation of unused annual leave of 30 days that can be carried forward beyond the pay period that includes December 31 or for which an employee can be paid upon termination of employment. Also, any accumulated annual leave in excess of 30 days, during the pay period that includes December 31, is converted to sick leave. Employees earn holiday leave at the rate of 11 or 12 days per year with an unlimited accumulation. The Hospitals' policy requires that employees use holiday hours in excess of 40 prior to using earned annual leave. At termination, employees are paid for any accumulated holiday leave. Employees earn sick leave at the rate of one day per month with an unlimited accumulation.

Paid Time Off (PTO) Plan – The PTO program combines the various leave types that employees may earn into one earning rate that varies depending upon years of service. This program is mandatory for all new employees. The policy provides for a maximum accumulation of 280 hours of unused PTO at the last day of the last pay period of the calendar year that includes December 31. At that time, the excess accumulation over 280 hours is converted to long-term sick leave, which is treated similar to sick leave in the Traditional Plan. Upon termination of employment, employees are paid for their current balance in PTO based upon their years of service. Once an employee has more than five years of service, the entire accumulated balance is paid up to 280 hours. The PTO program has a quarterly sell-back feature with payouts in March, June, September, and December. This sell-back feature allows employees to sell back 25%, 50%, 75%, or 100% of all hours over 140. The minimum hours were phased down to 80 in November 2016. There is a 10% forfeiture of the cash value to comply with IRS regulations.

Liability Calculation – The liability for accumulated annual leave, holiday leave, and PTO leave for each employee at June 30 equals the leave carried forward at the previous December 31 plus the leave earned, less the leave taken between January 1 and June 30 with appropriate caps depending on plan type. The liability is equal to the accumulated hours multiplied by the employee's current hourly rate plus benefits for social security and state retirement.

When classifying compensated absences into current and noncurrent, leave is considered taken using a last-in, first-out (LIFO) method.

There is no liability for unpaid accumulated sick leave because the Hospitals has no obligation to pay sick leave upon termination or retirement. However, additional service credit for retirement pension benefits is given for accumulated sick leave upon retirement.

O. Deferred Outflows/Inflows of Resources - In addition to assets, the Statement of Net Position reports a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net position that applies to a future period(s) and so will not be recognized as an outflow of resources (expense) until then. The Hospitals has the following items that qualify for reporting in this category: deferred loss on refunding, the accumulated decrease in fair value of hedging derivatives, and deferred outflows related to pensions.

In addition to liabilities, the Statement of Net Position reports a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net position that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until then. The Hospitals has the following item that qualifies for reporting in this category: deferred inflows related to pensions.

P. Net Position - The Hospitals' net position is classified as follows:

Net Investment in Capital Assets - This represents the Hospitals' total investment in capital assets, net of outstanding liabilities related to those capital assets. To the extent debt has been incurred but not yet expended for capital assets, such amounts are not included as a component of Net Investment in Capital Assets. Additionally, deferred outflows of resources and deferred inflows of resources that are attributable to the acquisition, construction, or improvement of capital assets or related debt are also included in this component of net position.

Restricted Net Position- **Expendable** - Expendable restricted net position includes resources for which the Hospitals is legally or contractually obligated to spend in accordance with restrictions imposed by external parties.

Unrestricted Net Position - Unrestricted net position includes resources derived from patient care and ancillary services, unrestricted gifts, and investment income.

Restricted and unrestricted resources are tracked using a fund accounting system and are spent in accordance with established fund authorities. Fund authorities provide rules for the fund activity and are separately established for restricted and unrestricted activities. When both restricted and unrestricted funds are available for expenditure, the decision for funding is transactional based within the departmental management system in place at the Hospitals. For projects funded by tax-exempt debt proceeds and other sources, the debt proceeds are always used first. Both restricted and unrestricted net position include consideration of deferred outflows of resources and deferred inflows of resources.

Q. Revenue and Expense Recognition - The Hospitals classifies its revenues and expenses as operating or nonoperating in the accompanying Statement of Revenues, Expenses, and Changes in Net Position. Operating revenues and expenses generally result from providing services and producing and delivering goods in connection with the Hospitals' principal ongoing operations. Operating revenues include activities that have characteristics of exchange transactions, such as charges for inpatient and outpatient services as well as external customers who purchase medical services. Operating expenses are all expense transactions incurred other than those related to capital and noncapital financing or investing activities as defined by GASB Statement No. 9, *Reporting Cash Flows of Proprietary and Nonexpendable Trust Funds and Governmental Entities That Use Proprietary Fund Accounting*.

Nonoperating revenues include activities that have the characteristics of nonexchange transactions. Revenues from nonexchange transactions that represent subsidies or gifts to the Hospitals, as well as investment income and gain (loss) on disposal of capital assets, are considered nonoperating since these are either investing, capital, or noncapital financing activities. Health Care System assessments are presented separately after nonoperating revenues and expenses.

R. Net Patient Service Revenue - Patient service revenue is recorded at the Hospitals' established rates and includes all charges for inpatient accounts discharged after June 30, 2016, (less amounts previously recorded at June 30, 2016, for in house patients) and all charges on in house accounts and all charges for outpatient accounts registered after June 30, 2016. The difference between established rates and the estimated amount collectible is recognized as revenue deductions on an accrual basis and deducted from gross patient service revenue to report service revenue at net realizable value. Revenue deductions consist of charges for charity care, contractual allowances, avoidable and other losses, and bad debt.

Charity care provided represents health care services that were provided free of charge to individuals who meet the criteria of the Hospitals' charity care policy. Charity care provided is not considered to be revenue to the Hospitals and is deducted in determining gross patient service revenue.

Differences between the amounts paid for services under third party reimbursement programs and established rates are accounted for as contractual adjustments or avoidable and other losses.

Net patient service revenue also includes 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.

S. Medical Malpractice Cost - Medical malpractice costs represent the actuarially determined contribution to the Liability Insurance Trust Fund. See Note 13 for further discussion of the Liability Insurance Trust Fund.

T. Donated Services - No amounts have been included for donated services since no objective basis is available to measure the value of such services. However, a substantial number of volunteers donated significant amounts of their time to the Hospitals' operations.

NOTE 2 - DEPOSITS AND INVESTMENTS

A. Deposits – Pursuant to *North Carolina General Statute* 116-37.2, the Board of Directors of the UNC Health Care System may deposit or invest the Hospitals' funds as defined in this statute. This includes moneys received from fees and other payments for services rendered in its hospitals and/or clinical operations, gifts, grants, and moneys received from or for the operation of any of the Hospitals' self-supporting auxiliary enterprises. These moneys may be deposited or invested in interest-bearing accounts or other investments in the exercise of the Board's sound discretion, without regard to any statute or rule of law relating to the investment of funds by fiduciaries. The Hospitals may voluntarily deposit special funds, revenue bond proceeds, and debt service funds with the State Treasurer. Special funds consist of moneys for agency funds held directly by the Hospitals. Bond proceeds and debt service funds are invested in accordance with bond resolutions. These funds are currently on deposit with the State Treasurer and therefore, available on demand to comply with applicable bond covenants.

Cash on hand at June 30, 2017 was $44,613. The carrying amount of the Hospitals' deposits not with the State Treasurer was $31,389,557, and the bank balance was $31,266,113. Custodial credit risk is the risk that in the event of a bank failure, the Hospitals' deposits may not be returned to it. Pursuant to G.S. 116-36.1, funds received for health care services not deposited with the State Treasurer shall be fully secured in the manner as prescribed by the State Treasurer for the security of public deposits. The Hospitals does not have a deposit policy for custodial credit risk. As of June 30, 2017, $630,280 of the Hospitals' bank balance was insured and collateralized, and $30,635,833 was exposed to custodial credit risk.

B. Investments – Pursuant to *North Carolina General Statute* 116-37(e), all receipts, except for General Fund appropriations, may be invested by the State Treasurer on behalf of the Hospitals as allowed in G.S. 147-69.2(b3).

NCGS § 116-37.2, as revised by S.L. 2011-145, Section 9.6E.(c)., allows UNC Health Care's Board to be responsible for the custody and management of funds, including developing policies for deposit, investment, and administration of funds. In addition to the Hospitals' assets, the Liability Insurance Trust Fund and UNC Health Care System assets can also be invested under the new guidelines. With this

legislative flexibility and under the guidance of the Finance Committee of the Board, the Hospitals has made the following investments:

Short-Term Investment Fund - At June 30, 2017, the amount shown on the Statement of Net Position as cash and cash equivalents includes $220,937,615, which represents the Hospitals' equity position in the State Treasurer's Short-Term Investment Fund (STIF). The STIF (a portfolio within the State Treasurer's Investment Pool, an external investment pool that is not registered with the Securities and Exchange Commission or subject to any other regulatory oversight and does not have a credit rating) had a weighted average maturity of 1.6 years as of June 30, 2017. Assets and shares of the STIF are valued at fair value. Deposit and investment risks associated with the State Treasurer's Investment Pool (which includes the State Treasurer's STIF) are included in the North Carolina Department of State Treasurer Investment Programs' separately issued audit report. This separately issued report can be obtained from the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604 or can be accessed from the Department of State Treasurer's website at https://www.nctreasurer.com/ in the Audited Financial Statements section.

UNC Investment Fund, LLC - At June 30, 2017, the Hospitals' investments include $707,885,805 which represents the Hospitals' equity position in the UNC Investment Fund, LLC (UNC Investment Fund). The UNC Investment Fund is an external investment pool that is not registered with the Securities and Exchange Commission, does not have a credit rating, and is not subject to any regulatory oversight. Investment risks associated with the UNC Investment Fund are included in audited financial statements of the UNC Investment Fund, LLC which may be obtained from UNC Management Company, Inc., 1400 Environ Way, Chapel Hill, NC 27517.

Carolina Research Venture Investment Fund, LLC - At June 30, 2017, the Hospitals' investments include $4,000,000 which represents funds committed to the Carolina Research Venture Investment Fund, LLC (CRVIF). In November 2016, UNC Health Care System became a subscribing member of CRVIF on behalf of the Hospitals. The CRVIF is not registered with the Securities and Exchange Commission, does not have a credit rating, and is not subject to any regulatory oversight. CRVIF is an associated entity of The University of North Carolina at Chapel Hill (UNC Chapel Hill) established to support entrepreneurial research by providing critical discovery and development capital for startups and other university-sourced companies. Investment risks associated with the CRVIF are included in audited financial statements of UNC Chapel Hill which may be obtained from UNC Chapel Hill's Controller's Office, Campus Box 1270, Chapel Hill, NC 27599-1270, or by calling (919) 962-1370.

C. Reconciliation of Deposits and Investments - A reconciliation of deposits and investments for the Hospitals as of June 30, 2017, is as follows:

Cash on Hand	$	44,613
Amount of Deposits with Private Financial Institutions		31,389,557
Deposits in the Short-Term Investment Fund		220,937,615
UNC Investment Fund		707,885,805
Carolina Research Venture Investment Fund		4,000,000
Total Deposits and Investments	$	964,257,590
Deposits		
Current:		
Cash and Cash Equivalents	$	155,188,019
Restricted Cash and Cash Equivalents		2,206,726
Noncurrent:		
Restricted Cash and Cash Equivalents		94,977,040
Total Deposits		252,371,785
Investments		
Noncurrent:		
Restricted Investments		283,799,567
Investments Designated for Capital Projects		428,086,238
Total Investments		711,885,805
Total Deposits and Investments	$	964,257,590

NOTE 3 - FAIR VALUE MEASUREMENTS

To the extent available, the Hospitals' investments and derivatives are recorded at fair value as of June 30, 2017. GASB Statement No. 72, *Fair Value Measurement and Application*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. This statement establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Inputs are used in applying the various valuation techniques and take into account the assumptions that market participants use to make valuation decisions. Inputs may include price information, credit data, interest and yield curve data, and other factors specific to the financial instrument. Observable inputs reflect market data obtained from independent sources. In contrast, unobservable inputs reflect the entity's assumptions about how market participants would value the financial instrument. Valuation techniques should maximize the use of observable inputs to the extent available.

A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. The following describes the hierarchy of inputs used to measure fair value and the

primary valuation methodologies used for financial instruments measured at fair value on a recurring basis:

Level 1 — Investments whose values are based on quoted prices (unadjusted) for identical assets (or liabilities) in active markets that a government can access at the measurement date.

Level 2 — Investments with inputs – other than quoted prices included within Level 1 – that are observable for an asset (or liability), either directly or indirectly.

Level 3 — Investments classified as Level 3 have unobservable inputs for an asset (or liability) and may require a degree of professional judgment.

The following table summarizes the Hospitals' investments, including the Short-Term Investment Fund, within the fair value hierarchy at June 30, 2017:

		Fair Value Measurements Using		
	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs
Investments by Fair Value Level				
Other Securities				
Short-Term Investment Fund	$ 220,937,615	$ 0	$ 220,937,615	$ 0
UNC Investment Fund	707,885,805			707,885,805
Carolina Research Venture Investment Fund	4,000,000			4,000,000
Total Investments by Fair Value Level	$ 932,823,420	$ 0	$ 220,937,615	$ 711,885,805
Derivative Instruments				
Hedging Derivative Instruments				
Interest Rate Swap	$ (12,558,232)	$ 0	$ (12,558,232)	$ 0

Short-Term Investment Fund - Ownership interest of the STIF is determined on a fair market valuation basis as of fiscal year end in accordance with the STIF operating procedures. Valuation of the underlying assets is performed by the custodian.

UNC Investment Fund - Ownership interests of the UNC Investment Fund are determined on a market unit valuation basis each month and in accordance with the UNC Investment Fund's operating procedures.

Carolina Research Venture Investment Fund - Ownership interests of the CRVIF are determined on a market unit valuation basis each month and in accordance with the CRVIF's operating procedures.

Derivative Instruments - The Hospitals' hedging derivative instruments are managed by Bank of America, N.A. Valuations of derivative instruments represent, or are derived from, mid-market values and consider benchmark interest rates and foreign exchange rates.

NOTE 4 - PATIENT ACCOUNTS RECEIVABLE, NET

Net patient accounts receivable consisted of amounts due from patients and third parties at estimated realizable value. Included in gross receivables are amounts receivable at established billing rates less payments received through June 30, 2017. Allowances for uncollectible accounts and contractual adjustments are estimated using historical collection statistics. The components of current net patient accounts receivable reflected in the accompanying Statement of Net Position are as follows at June 30, 2017:

	Amount
In House Patients	$ 94,653,725
Discharged (Not Final Billed) Patients	94,961,211
Total Unbilled	189,614,936
Discharged (Billed) Patients	317,927,213
Payment Arrangements	6,195,737
Charirty Care Provided	(37,297,415)
Current Gross	476,440,471
Allowance for Bad Debts	(119,713,130)
Contractual Allowances	(159,810,103)
Total Allowances	(279,523,233)
Current - Net	$ 196,917,238

The noncurrent net patient accounts receivable under flexible payment arrangement reflected in the accompanying Statement of Net Position is $879,573 as of June 30, 2017.

NOTE 5 - ESTIMATED THIRD PARTY SETTLEMENTS

The Hospitals provides care to patients covered by the Medicare, Medicaid, and Tricare/Champus programs. Inpatient acute care services rendered to Medicare patients are paid at prospectively determined rates per discharge. Medicare outpatient services are reimbursed at prospectively determined rates. Additionally, the Hospitals receives interim pass-through payments from Medicare for costs such as organs, graduate medical education, bad debts, etc., that are ultimately settled through the annual Medicare cost report. Prior to October 1, 2010, Medicaid inpatient services were reimbursed on an interim basis based on a prospectively determined rate per discharge and Medicaid outpatient services were reimbursed on an interim basis at an agreed upon rate. Ultimately, Medicaid inpatient and outpatient services were settled at allowable cost through the filing of an annual cost report. Beginning October 1, 2010, Medicaid pays inpatient and outpatient supplemental payments and no longer requires a cost settlement. See Note 10 (Net Patient Service Revenue) for more detail regarding the supplemental payments. In addition to Tricare/Champus payments for services on an interim basis, the

Tricare/Champus program reimburses the Hospitals for a portion of capital and direct medical education costs based on the Medicare cost report.

The Hospitals has calculated the estimated third party settlements for the outstanding Medicare, Medicaid, and Tricare/Champus cost reports during the fiscal year ended 2017. Medicare cost report settlements owed to Medicare are estimated to be $20,708,485 within the next twelve months and $46,781,370 on a noncurrent basis. Traditional Medicaid cost report settlements owed to Medicaid are estimated to be $6,904,683 within the next twelve months and $28,573,061 on a noncurrent basis. Tricare/Champus currently owes the Hospitals $10,586,348. An estimate is made for the current year's Medicare and Tricare/Champus settlements by using the most current statistics, costs, settlement data, and charges. The Hospitals also included in its estimated liability for both Medicare and Medicaid a reserve for the claims audit programs. The Centers for Medicare and Medicaid Services audit recovery programs are to identify improper underpayments or overpayments made to health care providers.

Once a cost report is filed, it is subject to an initial tentative settlement and a subsequent audit. Each cost report is audited by the programs for compliance with the applicable regulations established for the Medicaid, Medicare, and Tricare/Champus programs. Each cost report can also be re-opened or appealed for issues that the Hospitals or the Medicare or Medicaid programs feel are warranted. There are several such requests currently under consideration, as well as audits that are incomplete at this time. Any of the above can result in a change to the reimbursement requiring a refund from the program or payment to the program. Medicare audits are current through the June 30, 2010 fiscal year and Medicaid audits are current through the June 30, 2012 fiscal year.

Effective October 1, 2010, the Hospitals is participating in the UNC Upper Payment Limit (UPL) Plan specific to the UNC Health Care System of hospitals. The $57,504,746 UPL liability at year end includes reserves for future UPL audits within the next twelve months. See Note 10 (Net Patient Service Revenue) for more detail regarding the supplement.

NOTE 6 - CAPITAL ASSETS

A summary of changes in the capital assets for the year ended June 30, 2017, is presented as follows:

	Balance July 1, 2016	Increases	Decreases	Balance June 30, 2017
Capital Assets, Nondepreciable:				
Land and Permanent Easements	$ 46,807,242	$ 0	$ 334,474	$ 46,472,768
Construction in Progress	20,621,185	20,769,973	9,969,744	31,421,414
Goodwill	7,704,529			7,704,529
Total Capital Assets, Nondepreciable	75,132,956	20,769,973	10,304,218	85,598,711
Capital Assets, Depreciable:				
Buildings	883,331,766	9,969,744	2,503,214	890,798,296
Machinery and Equipment	437,872,338	20,236,058	4,968,962	453,139,434
General Infrastructure	5,295,662			5,295,662
Computer Software	50,895,490	1,068,214	295,950	51,667,754
Total Capital Assets, Depreciable	1,377,395,256	31,274,016	7,768,126	1,400,901,146
Less Accumulated Depreciation/Amortization for:				
Buildings	301,903,044	34,721,909	418,164	336,206,789
Machinery and Equipment	331,223,093	24,360,660	4,924,105	350,659,648
General Infrastructure	4,942,940	60,210		5,003,150
Computer Software	48,125,700	1,014,573	295,950	48,844,323
Total Accumulated Depreciation/Amortization	686,194,777	60,157,352	5,638,219	740,713,910
Total Capital Assets, Depreciable, Net	691,200,479	(28,883,336)	2,129,907	660,187,236
Capital Assets, Net	$ 766,333,435	$ (8,113,363)	$ 12,434,125	$ 745,785,947

NOTE 7 - LONG-TERM LIABILITIES

A. Changes in Long-Term Liabilities - A summary of changes in the long-term liabilities for the year ended June 30, 2017, is presented as follows:

	Balance July 1, 2016	Additions	Reductions	Balance June 30, 2017	Current Portion
Revenue Bonds Payable	$ 242,715,000	$ 99,945,000	$ 12,075,000	$ 330,585,000	$ 12,635,000
Plus: Unamortized Premium		928,663	35,718	892,945	
Total Revenue Bonds Payable	242,715,000	100,873,663	12,110,718	331,477,945	12,635,000
Net Pension Liability	131,644,117	192,678,945		324,323,062	
Capital Leases Payable	17,581,923	4,747,803	5,925,159	16,404,567	6,545,717
Compensated Absences	45,703,217	80,754,730	79,414,988	47,042,959	14,301,059
Other Long-Term License Payable	6,985,753	510,858	4,109,301	3,387,310	2,876,453
Total Long-Term Liabilities	$ 444,630,010	$ 379,565,999	$ 101,560,166	$ 722,635,843	$ 36,358,229

Additional information regarding capital lease obligations is included in Note 9.
Additional information regarding the net pension liability is included in Note 11.
Additional information regarding the license payable is included in Note 15.

B. Revenue Bonds Payable - The Hospitals was indebted for revenue bonds payable for the purposes shown in the following table:

Purpose	Series	Interest Rate/ Ranges	Final Maturity Date	Original Amount of Issue	Principal Paid Through June 30, 2017	Principal Outstanding June 30, 2017
Rex Acquisition and Hospital Renovations	2001A	0.89% *	02/15/2031	$ 55,000,000	$ 10,800,000	$ 44,200,000
	2001B	0.89% *	02/15/2031	55,000,000	10,800,000	44,200,000
Refund Portion of 1996 Revenue Bonds	2003A	3.64% *	02/01/2029	63,770,000	10,905,000	52,865,000
	2003B	3.59% *	02/01/2029	34,245,000	5,820,000	28,425,000
Refund 1999 Revenue Bonds	2009A	3.73% *	02/01/2024	44,290,000	20,500,000	23,790,000
General Revenue Bonds	2010B	4.22% to 6.33% **	02/01/2031	43,290,000	6,130,000	37,160,000
Surgical Tower and Support Facilities	2016A	4.00%	02/01/2046	74,945,000		74,945,000
	2016B	5.00%	02/01/2046	25,000,000		25,000,000
Total Revenue Bonds Payable (principal only)				$ 395,540,000	$ 64,955,000	330,585,000
Plus: Unamortized Premium						892,945
Total Revenue Bonds Payable						$ 331,477,945

* For variable rate debt, interest rates in effect at June 30, 2017 are included. For variable rate debt with interest rate swaps, the synthetic fixed rates are included.

**The Hospitals has elected to treat these bonds as federally taxable "Build America Bonds" for the purposes of the American Recovery and Reinvestment Act and to receive a cash subsidy from the U.S. Treasury equal to 32% of the interest payable on these bonds less any sequestration cuts that occur. For these bonds, the interest rate included is the taxable rate, which does not factor in the cash subsidy from the U.S. Treasury.

C. Demand Bonds - Included in bonds payable are several variable rate demand bond issues. Demand bonds are securities that contain a “put” feature that allows bondholders to demand payment before the maturity of the debt upon proper notice to the Hospitals’ remarketing or paying agents.

With regards to the following demand bonds, the Hospitals has entered into take-out agreements, which would convert the demand bonds not successfully remarketed into another form of long-term debt.

University of North Carolina Hospitals at Chapel Hill Revenue Bonds-Series 2001A and Series 2001B: On January 31, 2001, the Hospitals issued two series of tax-exempt variable rate demand bonds in the amount of $55,000,000 (2001A) and $55,000,000 (2001B) that have a final maturity date of February 15, 2031. The bonds are subject to mandatory sinking fund redemption that began on February 15, 2002. A portion of the proceeds was used to reimburse the Hospitals for $75,000,000 spent allowing the UNC Health Care System to acquire controlling interest in Rex Healthcare, Inc. The remaining proceeds were used for the renovation of space vacated after the opening of the North Carolina Women’s Hospital, North Carolina Children’s Hospital, and associated support services. While initially bearing interest in a daily mode, the mode on these bonds may change to a weekly rate, a unit pricing rate, a term rate, or a fixed rate.

While in daily mode, the bonds are subject to purchase on any business day upon demand by telephonic notice of tender to the Remarketing Agent on the purchase date and delivery to the bond Tender Agent, U.S. Bank, National Association. The Hospitals' Remarketing Agent, Wells Fargo Bank, N.A., has agreed to exercise its best efforts to remarket bonds for which a notice of purchase has been received. The quarterly remarketing fee is payable in arrears, on the first business day of each March, June, September, and December, commencing December 1, 2015 and is equal to 0.05% of the outstanding principal amount of the bonds assigned to the agent.

Under separate Standby Bond Purchase Agreements for the Series 2001A and Series 2001B (Agreements) between the Hospitals and Landesbank Hessen-Thuringen Girozentrale, a Liquidity Facility has been established for the Tender Agent to draw amounts sufficient to pay the purchase price and accrued interest on bonds delivered for purchase when remarketing proceeds or other funds are not available. These Agreements require an adjustable facility fee based on the long-term rating of the bonds, which is calculated as a percentage of the available commitment. Payments are made quarterly in arrears, on the first business day of each April, July, October, and January thereafter until the expiration date or the termination date of the Agreements. On September 1, 2015, the Hospitals entered into a new multiple year agreement with Landesbank Hessen-Thuringen to provide liquidity service at a fee of 0.28%, effective September 21, 2015. The applicable percentage will be determined based upon the long-term ratings of the bonds (without regard to any credit enhancement), as follows:

S&P	Moody's	Commitment Rate
AA- or better	Aa3	0.28%
A+	A1	0.38%
A	A2	0.48%
A-	A3	0.73%
BBB+ or lower	Baa1	1.78%

In the event that there is a disparity between Moody's and S&P's ratings on the bonds, the lower rating will prevail for the purpose of calculating the Commitment Fee. In addition, should an Event of Default occur or the long-term unenhanced ratings on the bonds or any Parity Debt be withdrawn or suspended by one or more of the rating agencies for credit-related reasons, the Fee Rate shall automatically increase to 1.78% per annum.

Under the Agreements, any bonds purchased through the Liquidity Facility become Bank Bonds and shall, from the date of such purchase to and including the 60th day thereafter and while they are Bank Bonds, bear interest at the Formula Rate (Base Rate equal to the higher of the Prime Rate plus 1.00% for such day or the sum of 1.00% plus the Federal Funds Rate) and from and including the 61st day following the Purchase Date and thereafter bear interest at the higher of the Formula Rate or 7.00%, subject to a maximum rate as permitted by law; provided

however, that at no time shall the Base Rate be less than the applicable rate of interest on the bonds which are not Bank Bonds. Upon remarketing of Bank Bonds and the receipt of the sales price by the Liquidity Provider, such bonds are no longer considered Bank Bonds. Payment of the interest on the Bank Bonds is due quarterly (the first business day of January, April, July, and October) for each period in which Bank Bonds are outstanding. At June 30, 2017, there were no Bank Bonds held by the Liquidity Facility.

Included in the Agreements is a take-out provision, in case the Remarketing Agent is unable to resell any bonds that are "put" within 90 days of the "put" date. In this situation, the Hospitals is required to redeem the Bank Bonds held by the Liquidity Facility. The Agreements allow the Hospitals to redeem Bank Bonds in equal quarterly installments, on the first business day of January, April, July, and October. The payments will commence with the first business day of any such month that is at least 90 days following the applicable Purchase Date of the Bank Bond and end no later than the fifth anniversary of such Purchase Date. If the take out agreement were to be exercised because the entire outstanding $88,400,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $23,146,067, $22,166,300, $20,928,700, $19,691,100, and $18,453,500 in years one, two, three, four, and five, respectively, under the installment loan agreement assuming a Base Rate of 5.25% (Prime Rate plus 1.00%) for the first 60 days and a maximum rate of 7.00% thereafter.

The current expiration date of the Agreements is September 20, 2020. The Hospitals may request additional extensions of at least one year from the previous termination date. Extensions are at the discretion of the Liquidity Provider.

University of North Carolina Hospitals at Chapel Hill Revenue Refunding Bonds-Series 2003A and Series 2003B: On February 13, 2003, the Hospitals issued two series of tax-exempt variable rate demand bonds in the amount of $63,770,000 (2003A) and $34,245,000 (2003B) that have a final maturity date of February 1, 2029. The bonds are subject to mandatory sinking fund redemption that began on February 1, 2004. The proceeds were used to advance refund $88,325,000 of the Series 1996 Bonds. While initially bearing interest in a weekly mode, the mode on these bonds may change to a daily rate, a unit pricing rate, a term rate, or a fixed rate.

While in the weekly mode, the bonds are subject to purchase on demand with seven days' notice to the Remarketing Agent and delivery to the bond Tender Agent, U.S. Bank, National Association. The Hospitals' Remarketing Agents, Banc of America Securities, LLC (Series 2003A) and Wells Fargo Bank, N.A. (Series 2003B), have agreed to exercise their best efforts to remarket bonds for which a notice of purchase has been received. The quarterly remarketing fee is payable in arrears and is equal to 0.08% of the outstanding principal amount of the bonds assigned to the Remarketing Agent for Series 2003A and is equal to 0.07% of the

outstanding principal amount of the bonds assigned to the Remarketing Agent for Series 2003B.

Under separate Standby Bond Purchase Agreements for the Series 2003A and Series 2003B (Agreements) between the Hospitals and Bank of America, N.A. (Series 2003A) and Wells Fargo Bank, N.A. (Series 2003B), Liquidity Facilities have been established for the Tender Agent to draw amounts sufficient to pay the purchase price on bonds delivered for purchase when remarketing proceeds or other funds are not available.

The 2003A Agreement with Bank of America, N.A. required a Commitment Fee of 0.33% for fiscal year 2017. Payments are made quarterly in arrears, on the first business day of each November, February, May, and August thereafter through July 2, 2018. The Commitment Rate remains in effect over the life of the Agreement so long as the rating assigned to Parity Debt by Moody's and S&P is A1/A+ or higher. If the rating assigned to Parity Debt by either Moody's or S&P is downgraded below A1 or A+, respectively, the Commitment Rate assigned to such lower rating as set forth below shall apply, effective as of the public announcement of the rating:

S&P	Moody's	Commitment Rate
A	A2	0.53%
A- or lower	A3 or lower	0.73%

Provided, however, that the Commitment Rate shall be increased (A) by 150 basis points (1.50%) upon the occurrence and during the continuance of an Event of Default, and (B) by 150 basis points (1.50%) if either Moody's or S&P withdraws or suspends its rating for any reason (other than for the payment in full or defeasance of the Bonds). Any such increase in the Commitment Rate shall take effect as of the date of any such event described in the preceding sentence. All such increases in the Commitment Rate contemplated above shall be cumulative.

Under the 2003A Agreement, any bonds purchased through the Liquidity Facility become Bank Bonds and shall, from the date of such purchase and while they are Bank Bonds, bear interest at the Bank Bond Interest Rate equal to the greater of the Prime Rate plus 1.50% or the Federal Funds Rate plus 3.00%, the Base Rate, for the first 90 days and then the Base Rate plus 0.50% from the 91st day to the 367th day following the date of purchase and the Base Rate plus 1.00% from the 368th day following such date of purchase and thereafter subject to a maximum rate as permitted by law. Upon remarketing of Bank Bonds and the receipt of the sales price by the Liquidity Provider, such bonds are no longer considered Bank Bonds. Payment of the interest on the Bank Bonds is on the first business day of each calendar month following the date on which such Bank Bond became a Bank Bond. At June 30, 2017, there were no Bank Bonds held by the 2003A Liquidity Facility.

Included in the 2003A Agreement is a take-out provision, in case the Remarketing Agent is unable to resell any bonds that are "put" within the

earlier of the termination date and 367 days of the "put" date. In this situation, the Hospitals is required to redeem the Bank Bonds held by the Liquidity Facility. The Series 2003A Agreement allows the Hospitals to redeem Bank Bonds in six consecutive, equal, semi-annual installments of principal beginning on the first business day of the month that occurs at least five and not more than six months following the termination date, until fully paid. In any event, all principal and accrued and unpaid interest shall be due and payable on the date the sixth installment is due. If the take out agreement were to be exercised because the entire outstanding $52,865,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $20,584,311, $19,703,229, and $18,513,765 in years one, two, and three, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 5.75% (Prime plus 1.50%).

The 2003B Agreement with Wells Fargo Bank, N.A. required a Commitment Fee of 0.35% for fiscal year 2017. Payments are made quarterly in arrears, on the first business day of each February, May, August, and November thereafter until July 31, 2018. The Commitment Fee remains in effect over the life of the Agreement; however, the Commitment Rate shall be increased to the per annum percentage described in the table below if (i) the debt rating assigned by Moody's or S&P to the long-term debt of the Hospitals, without regard to third-party credit enhancement, falls to the corresponding levels specified in such table, (ii) such rating is withdrawn or suspended or (iii) an Event of Default occurs and is continuing hereunder. After any such increases are made, the Commitment Rate shall be decreased to the per annum percentage described in the table below if the debt rating assigned by Moody's or S&P to the long-term debt of the Hospitals, without regard to third-party credit enhancement, rises to the corresponding levels specified in such table. Any such increases (or decreases, as the case may be) in the Commitment Rate shall be effective as of the date of such downgrade, upgrade, withdrawal, suspension or Event of Default, as applicable. The Commitment Rate shall be the fee listed below which corresponds to the lowest debt rating assigned to the Hospitals specified in the table below:

S&P	Moody's	Commitment Rate
A	A2	0.50%
A-	A3	0.65%
BBB+	Baa1	0.85%
BBB	Baa2	1.10%
BBB-	Baa3	1.40%
Below Investment	Below Investment	2.40%

Under the 2003B Agreement, any bonds purchased through the Liquidity Facility become Bank Bonds and shall, from the date of such purchase and while they are Bank Bonds, bear interest at the Bank Bond interest rate equal to the greater of the Prime Rate plus 1.00%; the Federal Funds Rate plus 2.00%, or 7.00%, subject to a maximum rate as permitted by law. Upon remarketing of Bank Bonds and the receipt of the sales price

by the Liquidity Provider, such bonds are no longer considered Bank Bonds. At June 30, 2017, there were no Bank Bonds held by the 2003B Liquidity Facility.

Included in the 2003B Agreement is a take-out provision, in case the Remarketing Agent is unable to resell any bonds that are "put" by the termination date. In this situation, the Hospitals is required to redeem the Bank Bonds held by the Liquidity Facility. The Series 2003B Agreement allows the Hospitals to redeem Bank Bonds in 11 equal quarterly installments of principal, on the first business day of each February, May, August, and November, beginning on the first of such dates that occurs at least 90 days after the Purchase Date of such Bank Bonds. The Hospitals shall pay interest of the Base Rate plus 2.00% in arrears on each date that would be an Interest Payment Date for the Series 2003B Bonds, beginning on the first Interest Payment Date that occurs after the Loan Date. If the take out agreement were to be exercised because the entire outstanding $28,425,000 of demand bonds was “put” and not resold, the Hospitals would be required to pay $9,535,298, $11,983,721, and $10,995,307 in years one, two, and three, respectively, following the Purchase Date of the Bank Bonds assuming a Base Rate of 7.00%.

University of North Carolina Hospitals at Chapel Hill Revenue Refunding Bonds-Series 2009A: On February 12, 2009, the Hospitals issued series 2009A tax-exempt variable rate demand bonds in the amount of $44,290,000 that have a final maturity date of February 1, 2024. The bonds are subject to mandatory sinking fund redemption that began on February 1, 2010. The proceeds were used to advance refund $43,505,000 of the Series 1999 Bonds. While initially bearing interest in a weekly mode, the mode on these bonds may change to a daily rate, a unit pricing rate, a term rate, or a fixed rate.

While in the weekly mode, the Hospitals’ Remarketing Agent, TD Securities (USA) LLC, has agreed to exercise its best efforts to remarket bonds for which a notice of purchase has been received. The quarterly remarketing fee is payable in arrears and is equal to 0.07% of the outstanding principal amount of the bonds assigned to the Remarketing Agent for Series 2009A.

Effective September 21, 2015, the Hospitals has contracted with TD Bank, N.A. as the liquidity provider for Series 2009A bonds through a Standby Bond Purchase Agreement (2009A Agreement). Under the 2009A Agreement, any bonds purchased through the Liquidity Facility become Bank Bonds and shall, from the date of such purchase and while they are Bank Bonds, bear interest at a rate equal to the Base Rate until 180 days after the initial date of purchase, and thereafter at the Base Rate plus 1.00% per annum and thereafter. Upon remarketing of Bank Bonds and the receipt of the sales price by the Liquidity Provider, such bonds are no longer considered Bank Bonds. Payment of the interest on the Bank Bonds is on the first business day of each calendar month following the date on which such Bank Bond became a Bank Bond.

The 2009A Agreement with TD Bank, N.A. requires a Commitment Fee of 0.32% commencing November 1, 2015. Payments are to be made quarterly in arrears, on the first business day of each February, May, August, and November, commencing November 1, 2015. The Commitment Rate remains in effect over the life of the Agreement so long as the rating assigned to Parity Debt by Moody's and S&P is A+/A1 or higher. If the rating assigned to Parity Debt by either Moody's or S&P is downgraded below A+ or A1, respectively, the Commitment Rate assigned to such lower rating as set forth below shall apply, effective as of the public announcement of the rating:

S&P	Moody's	Commitment Rate
A1 or higher	A+	0.32%
A2	A	0.57%
A3	A-	0.89%

In the event that there is a disparity between Moody's and S&P's ratings on the Bonds, the lower rating will prevail for the purpose of calculating the Commitment Fee. In addition, should an Event of Default occur or the long-term unenhanced ratings on the bonds or any Parity Debt be withdrawn or suspended by one or more of the rating agencies for credit-related reasons, the Fee Rate shall automatically increase to 1.50% per annum. All such increases in the Commitment Rate contemplated above will be adjusted at the beginning of the quarter following the rate change.

Included in the 2009A Agreement is a take-out provision, in case the Remarketing Agent is unable to resell any bonds that are "put" within the earlier of the termination date and 365 days of the "put" date. In this situation, the Hospitals is required to redeem the Bank Bonds held by the Liquidity Facility. The Series 2009A Agreement allows the Hospitals to redeem Bank Bonds in monthly installments of principal beginning on the first business day of the month until the fourth anniversary of the Purchase Date, until fully paid. If the take out agreement were to be exercised because the entire outstanding $23,790,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $6,927,005, $6,734,526, $6,426,558, and $6,118,593 in years one, two, three, and four, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 4.25%.

The current expiration date of the agreement is September 21, 2020. The Hospitals may request additional extensions of at least one year from the previous termination date. Extensions are at the discretion of the liquidity provider.

D. Annual Requirements - The annual requirements to pay principal and interest on the long-term obligations at June 30, 2017, are as follows:

Fiscal Year	Annual Requirements Revenue Bonds Payable Principal	Interest	Interest Rate Swaps, Net
2018	$ 12,635,000	$ 8,044,553	$ 2,786,803
2019	13,015,000	7,859,251	2,548,325
2020	13,420,000	7,667,526	2,305,040
2021	14,025,000	7,458,245	2,040,875
2022	14,460,000	7,242,491	1,777,015
2023-2027	82,675,000	32,427,887	4,983,947
2028-2032	80,410,000	24,598,179	483,556
2033-2037		21,239,000	
2038-2042	18,360,000	20,978,900	
2043-2046	81,585,000	7,693,216	
Total Requirements	$ 330,585,000	$ 145,209,248	$ 16,925,561

Interest on variable rate 2001 A&B, 2003 A&B, and 2009A revenue bonds is calculated at 0.89%, 0.89%, 0.92%, 0.87%, and 0.89% at June 30, 2017.

This schedule also includes the debt service requirements for debt associated with interest rate swaps. More detailed information about interest rate swaps is presented in Note 8 Derivative Instruments.

NOTE 8 - DERIVATIVE INSTRUMENTS

Derivative instruments held at June 30, 2017 are as follows:

Type	Notional Amount	Change in Fair Value Classification	Change in Fair Value Increase	Fair Value at June 30, 2017 Classification	Fair Value at June 30, 2017 Liability
Hedging Derivative Instruments					
Cash Flow Hedges					
Pay-Fixed Interest Rate Swap	$ 81,290,000	Deferred Outflow of Resources	$ 5,527,644	Hedging Derivative	$ (10,469,676)
Pay-Fixed Interest Rate Swap	23,790,000	Deferred Outflow of Resources	1,337,022	Hedging Derivative	(2,088,556)
Total Derivative Instruments			$ 6,864,666		$ (12,558,232)

Hedging derivative instruments held at June 30, 2017 are as follows:

Type	Objective	Notional Amount	Effective Date	Maturity Date	Terms
Pay-Fixed Interest Rate Swap	Hedge of Changes in Cash on the 2003 A & B Series Bonds	$ 81,290,000	02/13/2003	02/01/2029	Pay 3.48%, Receive 67% LIBOR
Pay-Fixed Interest Rate Swap	Hedge of Changes in Cash on the 2009A Series Bonds	23,790,000	02/12/2009	02/01/2024	Pay 3.61%, Receive 67% LIBOR

The fair value of the pay-fixed interest rate swaps was estimated by Bank of America, N.A. (BOA) using a methodology it deems reasonable and appropriate. In its sole discretion it may use a variety of models, methodologies, and assumptions to prepare the valuations depending upon the type of transaction, its characteristics, whether there is a liquid market and

other factors. As stated in BOA's derivative disclosure statement, valuations for derivative instruments represent, or are derived from, mid-market values and represent the value of the trade as of the date indicated. The Mark-to-Market value in the above table represents the value of the trade as of June 30, 2017.

The Hospitals' interest rate swap hedging derivatives have been determined to be effective as of June 30, 2017 using the synthetic instrument method.

Hedging Derivative Risks

Credit Risk: As of June 30, 2017, the Hospitals is not exposed to credit risk because the swaps have a negative fair value. However, should interest rates change and the fair value of the swaps becomes positive, the Hospitals would be exposed to credit risk in the amount of the derivative's fair value. The Hospitals has a policy of requiring collateral to support hedging derivative instruments subject to credit risk. This policy states that at such time that BOA's ratings fall below A3 for Moody's or below A- for S&P, BOA will be required to collateralize a portion of its exposure (up to 100%). The following instruments can serve as eligible collateral: Cash, U.S. Treasury Obligations, U.S. Government Agency Fixed Rate Fixed Maturity Securities, U.S. Government Agency Single Class Mortgage-Backed Securities, U.S. Treasury STRIPS, and other U.S. Government Agency Mortgage-Backed Securities. Posted collateral received will be entered in one or more accounts with a domestic office of a commercial bank, trust company, or financial institution organized under the laws of the United States (or any state or a political subdivision thereof). As of June 30, 2017, the credit rating for Bank of America, N.A. is A1 by Moody's and A+ by S&P.

The Hospitals entered into a master agreement with the International Swap Dealers Association, Inc. (ISDA) in January 2003. In this agreement, master netting arrangements were established between the contractual parties. All derivative instruments held by the Hospitals are subject to this agreement.

Interest Rate Risk: The Hospitals is exposed to interest rate risk on its interest rate swaps. The fair values of these instruments are highly sensitive to interest rate changes. Because rates have changed since the effective dates of the swaps, both of the swaps have a negative fair value as of June 30, 2017. The negative fair value may be countered by a reduction in total interest payments required under the variable-rate bonds, creating lower synthetic interest rates. Because the coupons on the Hospitals' variable-rate bonds adjust to changing interest rates, the bonds do not have corresponding fair value increases. As the yield curve rises, the value of the swaps will increase and as rates fall, the value of the swaps will decrease. The fair values reported are the market values as of June 30, 2017.

Basis Risk: The Hospitals receives 67% of 1-month LIBOR-BBA Index from BOA and pays a floating rate to its bondholders set by the Remarketing Agent. The Hospitals incurs basis risk when its bonds trade at a yield above 67% of 1-month LIBOR-BBA Index. If the relationship of the Hospitals' bonds trade to a percentage of LIBOR greater than 67%, the Hospitals will experience an increase in debt service above the fixed rate on the swap.

Termination Risk: The Hospitals is exposed to termination risk because the derivative contracts use the ISDA Master Agreement, which includes standard termination events, such as failure to pay and bankruptcy. The Hospitals or the counterparty may terminate the swap if the other party fails to perform under the terms of the contract. If the swap is terminated, the associated variable-rate bonds would no longer carry synthetic interest rates. Also, if at the time of termination the swap has a negative fair value, the Hospitals would be liable to the counterparty for that amount. Termination could result in the Hospitals being required to make an unanticipated termination payment.

NOTE 9 - LEASE OBLIGATIONS

A. Capital Lease Obligations - Capital lease obligations relating to medical equipment are recorded at the present value of the minimum lease payments. Future minimum lease payments under capital lease obligations consist of the following at June 30, 2017:

Fiscal Year	Amount
2018	$ 6,833,490
2019	5,126,186
2020	4,882,957
Total Minimum Lease Payments	16,842,633
Amount Representing Interest (1% to 7% Rate of Interest)	438,066
Present Value of Future Lease Payments	$ 16,404,567

Medical equipment acquired under capital lease amounted to $27,717,959 at June 30, 2017.

Depreciation for the capital assets associated with capital leases is included in depreciation expense, and accumulated depreciation for assets acquired under capital lease totaled $11,869,558 at June 30, 2017.

B. Operating Lease Obligations - The Hospitals entered into operating leases for space rental. Future minimum lease payments under noncancelable operating leases consist of the following at June 30, 2017:

Fiscal Year	Amount
2018	$ 13,017,682
2019	12,599,665
2020	11,181,647
2021	9,828,863
2022	10,184,331
2023-2027	52,740,220
2028-2032	22,027,621
2033-2036	9,078,685
Total Minimum Lease Payments	$ 140,658,714

Rental expense for all operating leases during the year was $7,610,455.

NOTE 10 - NET PATIENT SERVICE REVENUES

Medicare: The Hospitals is reimbursed for inpatient acute care services under the provisions of the Prospective Payment System (PPS). Under PPS, payment is made at predetermined rates for treating various diagnoses and performing procedures that have been grouped into defined Medicare Severity Diagnosis-Related Groups (MSDRGs) applicable to each patient discharge, rather than on the basis of the Hospitals' allowable charges. The difference in the standard hospital charge and the prospective payment for such services is reflected as an adjustment from patient service revenue. The claims payments are MSDRG payments, including capital related costs and add-on payments for indirect medical education and disproportionate share.

Medicare makes payments for Direct Graduate Medical Education (DGME) in support of the direct costs of residency training. Medicare also pays a portion of Medicare bad debts and organ acquisition costs for the Medicare beneficiaries. These pass-through payments are discussed further in Note 5, Estimated Third Party Settlements.

Medicare reimburses the Hospitals for inpatient hospital services furnished in the inpatient rehabilitation unit, referred to as an inpatient rehabilitation facility (IRF), under the provisions of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).

Medicare reimburses the Hospitals for services furnished in the inpatient psychiatric unit under the provisions of the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

With the Balanced Budget Act of 1997, most outpatient services are paid on a prospective payment system. The system became effective August 1, 2000, and is based on ambulatory payment classifications (APC). It applies to most hospital outpatient services other than ambulance, rehabilitation services, clinical diagnostic laboratory services, non-implantable durable medical equipment, prosthetic devices, and orthotics which are paid based on fee schedules.

Medicaid: Medicaid reimburses inpatient services on an interim basis under a prospective payment system using diagnostic related groups as its basis. Medicaid reimburses most outpatient services on an interim basis at an agreed upon rate based on documented costs. Several services such as hearing aids, durable medical equipment (DME), outpatient pharmaceuticals, home health, and diagnostic laboratory services are paid on fee schedules and not subject to the Upper Payment Limit program (UPL) which is described below.

In addition to the above, Medicaid also pays inpatient and outpatient supplemental payments for hospital services to hospitals owned or controlled

by the University of North Carolina Health Care System, including the Hospitals. The total amount of payments to all of the eligible hospitals is the difference between what Medicare would pay for the services rendered to Medicaid patients and what Medicaid otherwise pays. These payments are called upper payment limit (UPL) payments. The Hospitals also receives disproportionate share hospital (DSH) payments, which are special payments for hospitals which serve a disproportionate share of low income patients. The Hospitals has historically been eligible to receive "Basic" DSH payments. Hospitals owned or controlled by the University of North Carolina Health Care System, including the Hospitals, are eligible to receive UNC DSH payments up to the unreimbursed cost of serving uninsured patients. The University of North Carolina Health Care System is responsible for providing the non-federal share of the UPL payments and UNC DSH payments. The Hospitals is responsible for ensuring the State receives an amount equal to the federal share of the cost of providing care to uninsured patients at the Hospitals ($72,503,045). The UPL Plan was effective on October 1, 2010.

The UPL payments of $146,814,923 for federal fiscal year 2016 were received in June 2016 and October 2016 of which $36,388,021 was related to the Hospitals' 2017 fiscal year. A UPL payment of $123,114,525 for three quarters of federal fiscal year 2017 was received in June 2017.

Commercial/Managed Care Payer Agreements: The Hospitals has entered into reimbursement agreements with most commercial insurance carriers and managed care organizations to accept patients on a discounted fee for service basis. The basis for reimbursement under these agreements includes case rates per discharge, discounts from established charges, fee schedules, and per diem rates. Global rate reimbursements exist for solid organ and stem cell transplants. They include reimbursement amounts for both hospital and physician services. In addition, the Hospitals have agreements with the major Medicare Advantage plans in their various markets. These plans reimburse according to Centers for Medicare and Medicaid Services' methodology.

In general, most commercial payments for inpatient and outpatient services are subject to deductibles and co-payments that are the patient's responsibility. Insurance plans may reimburse their subscribers but make direct payment to the Hospitals on an assignment of benefits basis as long a contract remains in force.

A summary of net patient service revenue for the year ended June 30, 2017 follows:

	2017
Inpatient	$ 2,075,422,773
Outpatient	2,304,092,414
Charity Care Provided	(226,004,487)
Prior Year Third Party Settlements	22,077,644
Gross Patient Service Revenue	4,175,588,344
Medicare Contractual Allowance	(1,050,602,322)
Medicaid Contractual Allowance	(678,050,864)
Upper Payment Limit	147,664,945
Managed Care Contractual Allowance	(738,180,187)
Other Contractual Allowances	(29,600,361)
Bad Debt	(98,221,914)
Contractual Adjustments	(2,446,990,703)
Net Patient Service Revenue	$ 1,728,597,641

NOTE 11 - PENSION PLANS

A. Defined Benefit Plan

Plan Administration: The State of North Carolina administers the Teachers' and State Employees' Retirement System (TSERS) plan. This plan is a cost-sharing, multiple-employer, defined benefit pension plan established by the State to provide pension benefits for general employees and law enforcement officers (LEOs) of the State, general employees and LEOs of its component units, and employees of Local Education Agencies (LEAs) and charter schools not in the reporting entity. Membership is comprised of employees of the State (state agencies and institutions), universities, community colleges, and certain proprietary component units along with the LEAs and charter schools that elect to join the Retirement System. Benefit provisions are established by General Statute 135-5 and may be amended only by the North Carolina General Assembly.

Benefits Provided: TSERS provides retirement and survivor benefits. Retirement benefits are determined as 1.82% of the member's average final compensation times the member's years of creditable service. A member's average final compensation is calculated as the average of a member's four highest consecutive years of compensation. General employee plan members are eligible to retire with full retirement benefits at age 65 with five years of creditable service, at age 60 with 25 years of creditable service, or at any age with 30 years of creditable service. General employee plan members are eligible to retire with partial retirement benefits at age 50 with 20 years of creditable service or at age 60 with five years of creditable service. Survivor benefits are available to eligible beneficiaries of general members who die while in active service or within 180 days of their last day of service and who also have either

completed 20 years of creditable service regardless of age, or have completed five years of service and have reached age 60. Eligible beneficiaries may elect to receive a monthly Survivor's Alternate Benefit for life or a return of the member's contributions. The plan does not provide for automatic post-retirement benefit increases. Increases are contingent upon actuarial gains of the plan.

Contributions: Contribution provisions are established by General Statute 135-8 and may be amended only by the North Carolina General Assembly. Employees are required to contribute 6% of their annual pay. The contribution rate for employers is set each year by the North Carolina General Assembly in the Appropriations Act based on the actuarially-determined rate recommended by the actuary. The Hospitals' contractually-required contribution rate for the year ended June 30, 2017 was 9.98% of covered payroll. Employee contributions to the pension plan were $30,946,118, and the Hospitals' contributions were $51,473,710 for the year ended June 30, 2017.

The TSERS plan's financial information, including all information about the plan's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and fiduciary net position, is included in the State of North Carolina's fiscal year 2016 *Comprehensive Annual Financial Report*. An electronic version of this report is available on the North Carolina Office of the State Controller's website at http://www.osc.nc.gov/ or by calling the State Controller's Financial Reporting Section at (919) 707-0500.

TSERS Basis of Accounting: The financial statements of the TSERS plan were prepared using the accrual basis of accounting. Plan member contributions are recognized in the period in which the contributions are due. Employer contributions are recognized when due and the employer has a legal requirement to provide the contributions. Benefits and refunds are recognized when due and payable in accordance with the terms of each plan. The plan's fiduciary net position was determined on the same basis used by the pension plan.

Methods Used to Value TSERS Investment: Pursuant to North Carolina General Statutes, the State Treasurer is the custodian and administrator of the retirement systems. The State Treasurer maintains various investment portfolios in its Investment Pool. The pension trust funds are the primary participants in the Long-term Investment portfolio and the sole participants in the External Fixed Income Investment, Equity Investment, Real Estate Investment, Alternative Investment, Credit Investment, and Inflation Protection Investment portfolios. The Fixed Income Asset Class Includes the Long-Term Investment and External Fixed Income Investment Portfolios. The Global Equity Asset Class includes the Equity Investment Portfolio. The investment balance of each pension trust fund represents its share of the fair market value of the net position of the various portfolios within the pool. Detailed descriptions of the methods and significant assumptions regarding investments of the

State Treasurer are provided in the 2016 *Comprehensive Annual Financial Report*.

Net Pension Liability: At June 30, 2017, the Hospitals reported a liability of $324,323,062 for its proportionate share of the collective net pension liability. The net pension liability was measured as of June 30, 2016. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of December 31, 2015, and update procedures were used to roll forward the total pension liability to June 30, 2016. The Hospitals' proportion of the net pension liability was based on the present value of future salaries for the Hospitals relative to the present value of future salaries for all participating employers, actuarially-determined. As of June 30, 2016, the Hospitals' proportion was 3.53%, which was a decrease of 0.04 from its proportion measured as of June 30, 2015.

Actuarial Assumptions: The following table presents the actuarial assumptions used to determine the total pension liability for the TSERS plan at the actuarial valuation date:

Valuation Date	12/31/2015
Inflation	3%
Salary Increases*	3.5% - 8.10%
Investment Rate of Return**	7.25%

* Salary increases include 3.5% inflation and productivity factor.

** Investment rate of return is net of pension plan investment expense, including inflation.

TSERS currently uses mortality tables that vary by age, gender, employee group (i.e. teacher, general, law enforcement officer) and health status (i.e. disabled and healthy). The current mortality rates are based on published tables and based on studies that cover significant portions of the U.S. population. The healthy mortality rates also contain a provision to reflect future mortality improvements.

The actuarial assumptions used in the December 31, 2015 valuations were based on the results of an actuarial experience study for the period January 1, 2010 through December 31, 2014.

Future ad hoc Cost of Living Adjustment (COLA) amounts are not considered to be substantively automatic and are therefore not included in the measurement.

The projected long-term investment returns and inflation assumptions are developed through review of current and historical capital markets data, sell-side investment research, consultant whitepapers, and historical performance of investment strategies. Fixed income return projections reflect current yields across the U.S. Treasury yield curve and market expectations of forward yields projected and interpolated for multiple tenors and over multiple year horizons. Global public equity return

projections are established through analysis of the equity risk premium and the fixed income return projections. Other asset categories and strategies' return projections reflect the foregoing and historical data analysis. These projections are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. Best estimates of arithmetic real rates of return for each major asset class included in the pension plan's target asset allocation as of June 30, 2016 (the valuation date) are summarized in the following table:

Asset Class	Long-Term Expected Real Rate of Return
Fixed Income	1.4%
Global Equity	5.3%
Real Estate	4.3%
Alternatives	8.9%
Credit	6.0%
Inflation Protection	4.0%

The information in the preceding table is based on 30-year expectations developed with the consulting actuary and is part of the asset, liability, and investment policy of the North Carolina Retirement Systems. The long-term nominal rates of return underlying the real rates of return are arithmetic annualized figures. The real rates of return are calculated from nominal rates by multiplicatively subtracting a long-term inflation assumption of 3.05%. Return projections do not include any excess return expectations over benchmark averages. All rates of return and inflation are annualized.

Discount Rate: The discount rate used to measure the total pension liability was 7.25%. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current contribution rate and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of the current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Sensitivity of the Net Pension Liability to Changes in the Discount Rate: The following presents the net pension liability of the plan calculated using the discount rate of 7.25%, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower (6.25%) or 1-percentage point higher (8.25%) than the current rate:

Net Pension Liability		
1% Decrease (6.25%)	Current Discount Rate (7.25%)	1% Increase (8.25%)
$ 610,215,462	$ 324,323,062	$ 84,148,387

Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions: For the year ended June 30, 2017, the Hospitals recognized pension expense of $63,006,280. At June 30, 2017, the Hospitals reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

Employer Balances of Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions by Classification:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference Between Actual and Expected Experience	$ 0	$ 15,327,959
Changes of Assumptions	47,829,770	
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	115,664,001	
Change in Proportion and Differences Between Agency's Contributions and Proportionate Share of Contributions	4,630,165	4,601,832
Contributions Subsequent to the Measurement Date	51,473,710	
Total	$ 219,597,646	$ 19,929,791

The amount of $51,473,710 reported as deferred outflows of resources related to pensions will be included as a reduction of the net pension liability in the fiscal year ended June 30, 2018. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Schedule of the Net Amount of the Employer's Balances of Deferred Outflows of Resources and Deferred Inflows of Resources That will be Recognized in Pension Expense:

Year Ended June 30:	Amount
2018	$ 25,522,418
2019	25,513,634
2020	61,869,929
2021	35,288,164
Total	$ 148,194,145

B. Defined Contribution Plan - The Optional Retirement Program (ORP) is a defined contribution pension plan that provides retirement benefits with options for payments to beneficiaries in the event of the participant's death. Eligible employees of the Hospitals may join the ORP instead of the TSERS. The Board of Governors of the University of North Carolina is responsible for the administration of the ORP and designates the

companies authorized to offer investment products or the trustee responsible for the investment of contributions under the ORP and approves the form and contents of the contracts and trust agreements.

Participants in the ORP are immediately vested in the value of employee contributions. The value of employer contributions is vested after five years of participation in the ORP. Participants become eligible to receive distributions when they terminate employment or retire.

Participant eligibility and contributory requirements are established by General Statute 135-5.1. Employer and member contribution rates are set each year by the North Carolina General Assembly. For the year ended June 30, 2017, these rates were set at 6.84% of covered payroll for employers and 6% of covered payroll for members. The Hospitals assumes no liability other than its contribution.

For the current fiscal year, the Hospitals had a total payroll of $623,674,404 of which $76,833,428 was covered under the Optional Retirement Program. Total employer and employee contributions for pension benefits for the year were $5,255,406 and $4,610,006, respectively. The amount of expense recognized in the current year related to ORP is equal to the employer contributions.

NOTE 12 - OTHER POSTEMPLOYMENT BENEFITS

A. Health Benefits - The Hospitals participates in the Comprehensive Major Medical Plan (the Plan), a cost-sharing, multiple-employer defined benefit health care plan that provides postemployment health insurance to eligible former employees. Eligible former employees include long-term disability beneficiaries of the Disability Income Plan of North Carolina and retirees of the Teachers' and State Employees' Retirement System (TSERS) or the Optional Retirement Program (ORP). Coverage eligibility varies depending on years of contributory membership service in their retirement system prior to disability or retirement.

The Plan's benefit and contribution provisions are established by Chapter 135, Article 3B, of the General Statutes, and may be amended only by the North Carolina General Assembly. The Plan does not provide for automatic post-retirement benefit increases.

By General Statute, a Retiree Health Benefit Fund (the Fund) has been established as a fund in which accumulated contributions from employers and any earnings on those contributions shall be used to provide health benefits to retired and disabled employees and applicable beneficiaries. By statute, the Fund is administered by the Board of Trustees of TSERS and contributions to the Fund are irrevocable. Also by law, Fund assets are dedicated to providing benefits to retired and disabled employees and applicable beneficiaries and are not subject to the claims of creditors of the employers making contributions to the Fund. Contribution rates to the Fund, which are intended to finance benefits and administrative

expenses on a pay-as-you-go basis, are established by the General Assembly.

For the period July 1, 2016 through December 31, 2016, the Hospitals contributed 5.60% of the covered payroll under TSERS and ORP to the Fund, and for the period January 1, 2017 through June 30, 2017, the Hospitals contributed 6.02% of the covered payroll under TSERS and ORP to the Fund. Required contributions rates for the years ended June 30, 2016, and 2015, were 5.60% and 5.49%, respectively. The Hospitals made 100% of its annual required contributions to the Plan for the years ended June 30, 2017, 2016, and 2015, which were $30,362,284, $29,104,124, and $24,807,472, respectively. The Hospitals assumes no liability for retiree health care benefits provided by the programs other than its required contribution.

Additional detailed information about these programs can be located in the State of North Carolina's *Comprehensive Annual Financial Report.* An electronic version of this report is available on the North Carolina Office of the State Controller's website at http://www.osc.nc.gov/ or by calling the State Controller's Financial Reporting Section at (919) 707-0500.

B. Disability Income - The Hospitals participates in the Disability Income Plan of North Carolina (DIPNC), a cost-sharing, multiple-employer defined benefit plan, to provide short-term and long-term disability benefits to eligible members of TSERS and ORP. Benefit and contribution provisions are established by Chapter 135, Article 6, of the General Statutes, and may be amended only by the North Carolina General Assembly. The Plan does not provide for automatic post-retirement benefit increases.

Disability income benefits are funded by actuarially determined employer contributions that are established by the General Assembly. For the fiscal year ended June 30, 2017, the Hospitals made a statutory contribution of .38% of covered payroll under TSERS and ORP to the DIPNC. Required contribution rates for the years ended June 30, 2016, and 2015, were .41% in both years. The Hospitals made 100% of its annual required contributions to the DIPNC for the years ended June 30, 2017, 2016, and 2015, which were $1,985,829, $2,130,838, and $1,852,653, respectively. The Hospitals assumes no liability for long-term disability benefits under the Plan other than its contribution.

Additional detailed information about the DIPNC is disclosed in the State of North Carolina's *Comprehensive Annual Financial Report*.

NOTE 13 - RISK MANAGEMENT

The Hospitals is exposed to various risks of loss related to torts, theft of, damage to, and destruction of assets, errors and omissions, injuries to employees; and natural disasters. These exposures to loss are handled via a

combination of methods, including participation in state-administered insurance programs, purchase of commercial insurance, and self-retention of certain risks. There have been no significant reductions in insurance coverage from the previous year, and settled claims have not exceeded coverage in any of the past three fiscal years.

A. Employee Benefit Plans

1. State Health Plan

Hospitals employees and retirees are provided comprehensive major medical care benefits. Coverage is funded by contributions to the State Health Plan (Plan), a discretely presented component unit of the State of North Carolina. The Plan is funded by employer and employee contributions. The Plan has contracted with third parties to process claims.

2. Death Benefit Plan of North Carolina

Term life insurance (death benefits) of $25,000 to $50,000 is provided to eligible workers. This Death Benefit Plan is administered by the State Treasurer and funded via employer contributions. The employer contribution rate was .16% for the current fiscal year.

B. Other Risk Management and Insurance Activities

1. Automobile, Fire, and Other Property Losses

The Hospitals is required to maintain fire and lightning coverage on all state-owned buildings and contents through the State Property Fire Insurance Fund (Fund), an internal service fund of the State. Premiums are paid based on square footage and the value of building contents. The Hospitals purchased through the Fund "all risks" replacement cost basis insurance for buildings and contents subject to a $25,000 per occurrence deductible.

All state-owned vehicles are covered by liability insurance through a private insurance company and handled by the North Carolina Department of Insurance. The liability limits for losses are $1,000,000 per claim and $10,000,000 per occurrence. The Hospitals pays premiums to the North Carolina Department of Insurance for the coverage. The Hospitals also has an insurance policy from a private insurance company through the North Carolina Department of Insurance for Auto Physical Damage. The coverage limit is the value of the vehicle. The deductible for vehicles valued up to $74,999 is $100 for comprehensive coverage and $250 for collision coverage. For vehicles valued at $75,000 or greater, the deductibles for comprehensive and collision coverages are on a sliding scale based upon the value of vehicle.

2. Public Officers' and Employees' Liability Insurance

The risk of tort claims of up to $1,000,000 per claimant is retained under the authority of the State Tort Claims Act. In addition, the State provides excess public officers' and employees' liability insurance up to $10,000,000 via contract with a private insurance company. The Hospitals pays the premium, based on a composite rate, directly to the private insurer.

3. Employee Dishonesty and Computer Fraud

The Hospitals is protected for losses from employee dishonesty and computer fraud. This coverage is with a private insurance company and is handled by the North Carolina Department of Insurance. The Hospitals is charged a premium by the private insurance company. Coverage limit is $5,000,000 per occurrence. The private insurance company pays 90% of each loss less a $100,000 deductible.

4. Statewide Workers' Compensation Program

The North Carolina Workers' Compensation Program provides benefits to workers injured on the job. All employees of the State and its component units are included in the program. When an employee is injured, the Hospitals' primary responsibility is to arrange for and provide the necessary treatment for work related injury. The Hospitals is responsible for paying medical benefits and compensation in accordance with the North Carolina Workers' Compensation Act. The Hospitals retains the risk for workers' compensation.

Additional details on the state-administered risk management programs are disclosed in the State's *Comprehensive Annual Financial Report*, issued by the Office of the State Controller.

5. Other Insurance Held by the Hospitals

The Hospitals purchased other authorized coverage from private insurance companies through the North Carolina Department of Insurance. The coverage includes:

- Boiler and Machinery insurance up to $50,000,000 with a deductible of $5,000 per occurrence;

- Directors and Officers (DNO) Liability insurance up to $10,000,000 aggregate with retention of $250,000 DNO, and First Excess insurance with limits of $10,000,000 and Second Excess insurance with limits of $5,000,000;

- Master Crime insurance up to $500,000 per occurrence with a deductible of $1,000;

- Comprehensive General Liability insurance up to $1,000,000 per occurrence, $2,000,000 aggregate with a deductible of $10,000 per occurrence and Umbrella Excess insurance with limits of $5,000,000 per occurrence and aggregate;

- General Liability for Helipad on Premises and Non-Owned Aircraft insurance up to $20,000,000 with no deductible;

- Fine Arts Floater insurance up to $5,000 per item and $100,000 policy aggregate with no deductible;

- Surety Bond of $300,000 for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies Medicare Program (DMEPOS);

- Lawyers Professional Liability insurance with limits of $5,000,000 aggregate and $25,000 retention.

Liability Insurance Trust Fund - The Hospitals participates in the Liability Insurance Trust Fund (Trust Fund), a claims-servicing public entity risk pool for healthcare professional liability protection. The Trust Fund services professional liability claims, managing separate accounts for each participant from which the losses of that participant are paid. Although participant assessments are determined on an actuarial basis, ultimate liability for claims remains with the participants and, accordingly, the insurance risks are not transferred to the Trust Fund.

The Trust Fund is an unincorporated entity created by Chapter 116, Article 26, of the *North Carolina General Statutes* and the University of North Carolina Board of Governors Resolution of June 9, 1978. The Trust Fund is a self-insurance program established to provide professional medical malpractice liability covering the Hospitals and The University of North Carolina at Chapel Hill Faculty Physicians (UNCFP), the program participants. The Trust Fund provides coverage for program participants and individual health care practitioners working as employees, agents, or officers of program participants. The Trust Fund is exempt from federal and state income taxes, and is not subject to regulation by the North Carolina Department of Insurance.

Participation in the Trust Fund is open to the University of North Carolina, any constituent institution of the University of North Carolina, the Hospitals, and any health care institution, agency or entity that has an affiliation agreement with the University of North Carolina, with a constituent institution of the University of North Carolina, or with the Hospitals. Only the UNCFP and the Hospitals have participated in the Trust Fund to date. Participants provide management and administrative services to the Trust Fund at no cost.

The Trust Fund is governed by the Liability Insurance Trust Fund Council (the Council). The Council consists of 13 members as follows: one member each appointed by the State Attorney General, the State Insurance Commissioner, the Director of the Office of State Budget and Management,

and the State Treasurer, (each serving at the pleasure of the appointer); and nine members appointed by the UNC System's Board of Governors.

The Trust Fund establishes claim liabilities based on estimates of the ultimate cost of claims (including future expenses and claim adjustment expenses) that have been reported but not settled and of claims incurred but not reported. Claim liabilities are recomputed annually based on an independent actuary's study to produce current estimates that reflect recent settlements, claims frequency, inflation, and other factors. Participant assessments are determined at a level to fund claim liabilities, discounted for future investment earnings. Each participant is required by statute to maintain a fund balance of $100,000 at all times. Participants are subject to additional premium assessments in the event of deficiencies.

For the period July 1, 2016, through June 30, 2017, the Trust Fund provided coverage on an occurrence basis of $3,000,000 per individual and $7,000,000 in the aggregate per claim. The Trust Fund entered into an excess of loss agreement with an unaffiliated reinsurer in prior years. However, excess reinsurance coverage has not been purchased for any policy year since June 30, 2006, as the Trust Fund chose to retain 100% of the liability. In lieu of reinsurance, the participants contributed $10,000,000 in the aggregate toward the Reimbursement Fund for future losses during fiscal year 2007. For the fiscal year ended June 30, 2017, the Trust Fund purchased a direct insurance policy to cover the first $1,000,000 per occurrence and $3,000,000 in the aggregate for dental residents. *North Carolina General Statutes* Chapter 116 was amended during 1987 to authorize the Trust Fund to borrow necessary amounts up to $30,000,000, in the event that the Trust Fund may have insufficient funds to pay existing and future claims. Any such borrowing would be repaid from the assets and revenues of program participants. No line of credit or borrowing has been established pursuant to this authorization. The Council believes adequate funds are on deposit in the Trust Fund to meet estimated losses based upon the results of the independent actuary's report.

The Trust Fund has purchased annuity contracts to settle claims for which the claimant has signed an agreement releasing the Trust Fund from further obligation. The related claim liabilities have been removed from estimated malpractice costs.

The Council may choose to terminate the Trust Fund, or the respective participants may choose to terminate their participation. In the event of such termination by either the Council or a participant, an updated actuarial study will be performed to determine amounts due to or from the participants based on loss experience up to the date of termination.

At June 30, 2017, the Hospitals' assets in the Trust Fund totaled $24,587,148 while Hospitals' liabilities totaled $14,867,003 resulting in net position of $9,720,145.

Additional disclosures relative to the funding status and obligations of the Trust Fund are set forth in the audited financial statements of the Liability Insurance Trust Fund. Copies of this report may be obtained from The

University of North Carolina Liability Insurance Trust Fund, University of North Carolina Health Care System, 211 Friday Center Drive, Hedrick Building, Room 2043, Chapel Hill, NC 27517.

NOTE 14 - COMMITMENTS AND CONTINGENCIES

A. Commitments - The Hospitals has established an encumbrance system to track its outstanding commitments on construction projects and other purchases. Outstanding commitments on construction contracts were $24,607,723 and on other purchases were $9,666,223 at June 30, 2017.

B. Pending Litigation and Claims – The Hospitals is a party to other litigation and claims in the ordinary course of its operations. Since it is not possible to predict the ultimate outcome of these matters, no provision for any liability has been made in the financial statements. Hospitals' management is of the opinion that the liability, if any, for any of these matters will not have a material adverse effect on the financial position of the Hospitals.

NOTE 15 - RELATED PARTIES

University of North Carolina Health Care System Enterprise and Related Funds (System Fund) - The Board of Directors of UNC Health Care System (System) authorized and approved the creation of the System Fund to enable fund transfers among the entities within the System in support of the System's vision and mission to be the nation's leading public academic health care system.

In accordance with this mission, the System provides and receives certain shared services (primarily information technology, revenue cycle, and administration) to the Hospitals and the affiliated entities. The System implemented a new electronic health record and patient accounting system that was funded, in part, by notes receivable extended to the System Fund. This note and related implementation receivables from the System Fund totaled $45,093,146 and $4,157,350, respectively, at year-end. There are additional receivables at year-end from the System Fund of $100,273,770 for asset acquisitions and shared services expenses. The Hospitals' $3,387,310 other long-term license payable (Note 7) is offset by these receivables. The Hospitals was assessed $84,652,187 to fund initiatives supported by the System Fund and $87,210,036 to fund System affiliates. The Hospitals has payables to the System Fund of $7,400,360 at year-end.

Rex Healthcare, Inc. (Rex) - Rex is a North Carolina not-for-profit corporation organized to provide a wide range of health care services to the residents of the Triangle area of North Carolina. The System is the sole member of Rex Healthcare, Inc.

The Hospitals provides certain management, legal, and contracting services to Rex. Likewise, Rex also provides certain employee contracting services to the

Hospitals. These transactions resulted in the Hospitals receiving $4,277,024 from Rex and the Hospitals paying $8,016,895 to Rex during the year ended June 30, 2017.

The Medical Foundation of North Carolina, Inc. - The Hospitals is a participant in The Medical Foundation of North Carolina, Inc. (Foundation), a nonprofit foundation for The University of North Carolina at Chapel Hill and the Hospitals, which solicits gifts and grants for both entities. The Board of Directors of the Medical Foundation administers the funds of the Foundation.

Chatham Hospital, Inc. - Chatham Hospital, Inc. is a private, nonprofit corporation that owns and operates a critical access facility located in Siler City, North Carolina. The System is the sole member of Chatham Hospital, Inc.

The Hospitals has entered into various administrative and clinical services agreements with Chatham Hospital, Inc. resulting in the Hospitals receiving $3,385,528 and the Hospitals paying $20,491 to Chatham Hospital, Inc. during the fiscal year for those services. The Hospitals has payables to Chatham Hospital, Inc. of $3,235,913 at year-end.

UNC Physicians Network, LLC - UNC Physicians Network is a wholly owned subsidiary of the System, but a private employer, that owns and operates more than forty community physician practices based primarily throughout the Triangle (Raleigh, Durham and Chapel Hill), North Carolina area.

It is a physician-led network structured to meet the needs of the community and community practice physicians by creating a partnership for physicians and the System to face the challenging health care environment.

UNC Physicians Network paid the Hospitals $9,391,363 for supplies and services during the fiscal year, and the Hospitals paid $146,093 to UNC Physicians Network during the fiscal year.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital (HCHC) - Henderson County is the sole member of HCHC, a North Carolina not-for-profit corporation, which is in turn the sole member of Henderson County Urgent Care Centers, Inc. and Western Carolina Medical Associates, Inc. HCHC was created by Henderson County to provide for the operation of a community hospital in Henderson County, North Carolina that is dedicated to serving the health care needs of Henderson County citizenry. On June 22, 2011, HCHC signed a management service agreement engaging the Hospitals to conduct and effectively manage the day-to-day operations of Margaret R. Pardee Memorial Hospital and HCHC's affiliated operations over a term of 10 years. On September 4, 2013 this agreement was extended to a term of 25 years.

Pardee Memorial Hospital paid the Hospitals $6,067,088 for services received during the fiscal year and the Hospitals paid $2,931,989 to Pardee Memorial Hospital for supplies and services during the fiscal year.

High Point Regional Health, Inc. (HPRH) - HPRH is a North Carolina not-for-profit corporation located in High Point, North Carolina and is organized to promote and advance charitable, educational and scientific purposes, and to provide and support health care services.

The System became the sole corporate member of HPRH on March 31, 2013. HPRH is the parent holding company of High Point Regional Health Foundation, High Point Health Care Ventures, Inc., and High Point Regional Health Services, Inc.

High Point Regional Health paid the Hospitals $7,573,879 for services received during the fiscal year and the Hospitals paid HPRH $36,200 for supplies and services during the fiscal year. The Hospitals has payables to HPRH of $2,339,947 at year-end.

Caldwell Memorial Hospital - Caldwell Memorial Hospital is a private, not-for-profit community hospital located in Lenoir, North Carolina and is an acute care hospital with a provider network of primary and specialty care physicians and advanced practice professionals. The System became the sole member of Caldwell Memorial Hospital on May 1, 2013.

Caldwell Memorial Hospital paid the Hospitals $1,015,935 for services during the fiscal year. The Hospitals paid Caldwell Memorial Hospital $534,876 for supplies and services during the fiscal year.

Nash Health Care Systems - Nash Health Care Systems is a non-profit hospital authority comprised of Nash General Hospital, Nash Day Hospital, the Bryant T. Aldridge Rehabilitation Center, Community Hospital and Coastal Plain Hospital. It serves Nash, Edgecombe, Halifax, Wilson, and Johnston counties, but draws patients from beyond these areas as well.

Nash Health Care Systems signed a management service agreement engaging the System to conduct and manage its operations effective April 1, 2014.

Nash Health Care Systems paid the Hospitals $8,762,975 for services received during the fiscal year. The Hospitals paid Nash Health Care Systems $2,883,381 for supplies and services during the fiscal year.

Johnston Health Services Corporation (JHSC) - Effective February 1, 2014, Johnston Memorial Hospital Authority (JMHA) and the System entered into a Master Agreement to form JHSC, a joint venture created to achieve the long term vision of providing high quality health care to the residents of Johnston County. Oversight and governance of the joint venture is controlled by a Board of Directors consisting of appointees from both JMHA and the System. The System manages the day-to-day operations of JHSC under the terms of a Management Services Agreement entered into and effective November 1, 2013.

Johnston Health Services Corporation paid the Hospitals $4,453,859 for services received during the fiscal year. The Hospitals paid Johnston Health

Services Corporation $2,295,670 for supplies and services during the fiscal year.

Wayne Health Corporation - Wayne Health Corporation is a private, not for profit health corporation located in Goldsboro, North Carolina that operates Wayne Memorial Hospital, Wayne Health Physicians, Wayne MRI, Wayne Health Enterprises, American Management Associates, Wayne Health Properties, and Wayne Health Foundation. It serves patients primarily from Wayne and neighboring counties. Wayne Health Corporation signed a management services agreement with the System on January 1, 2016 to provide certain management services over an initial term of 10 years.

Wayne Health Corporation paid the Hospitals $1,480,696 for services received during the fiscal year.

Lenoir Memorial Hospital, Inc. - Lenoir Memorial Hospital, Inc. is a private, not for profit hospital located in Kinston, North Carolina that operates Lenoir Memorial Hospital and several physician practices. It serves patients primarily from Lenoir and neighboring counties. Lenoir Memorial Hospital, Inc. signed a management services agreement with the System on May 17, 2016 to provide certain management services over an initial term of 10 years.

Lenoir Memorial Hospital, Inc. paid the Hospitals $941,951 for services received during the fiscal year.

NOTE 16 - INVESTMENT IN AFFILIATES

The Hospitals has investments in affiliates and joint ventures accounted for on the equity method. Investments in affiliates were $15,768,668 at June 30, 2017. The Hospitals' share of these affiliates and joint ventures is not significant individually. The summarized financial information below represents an aggregation of the ongoing affiliates and joint ventures:

	2017 (Unaudited)
Total Affiliate Activity	
Current Assets	$ 23,741,191
Noncurrent Assets	13,274,863
Current Liabilities	5,573,705
Shareholders' Equity	31,442,349
Revenue	26,571,859
Net Gain	7,399,769
Hospitals' Share of Activity	
Realized Affiliate Gain - Ongoing Operations	$ 4,662,183

NOTE 17 - BLENDED COMPONENT UNIT

Condensed combining information for the Hospitals' blended component unit for the year ended June 30, 2017, is presented as follows:

Condensed Statement of Net Position
June 30, 2017

	Health System Properties, LLC
ASSETS	
Current Assets	$ 135,135
Capital Assets, Net	21,608,380
Total Assets	21,743,515
TOTAL DEFERRED OUTFLOWS OF RESOURCES	0
LIABILITIES	0
TOTAL DEFERRED INFLOWS OF RESOURCES	0
NET POSITION	
Investment in Capital Assets	21,608,380
Unrestricted	135,135
Total Net Position	$ 21,743,515

Condensed Statement of Revenues, Expenses, and Changes in Net Position
For the Fiscal Year Ended June 30, 2017

	Health System Properties, LLC
OPERATING REVENUES	
Rental Income	$ 653,853
OPERATING EXPENSES	
Operating Expenses	1,828,637
Depreciation	716,205
Total Operating Expenses	2,544,842
Operating Loss	(1,890,989)
NONOPERATING REVENUES (EXPENSES)	0
Capital Contributions	2,190,856
Increase in Net Position	299,867
NET POSITION	
Net Position, July 1, 2016	21,443,648
Net Position, June 30, 2017	$ 21,743,515

Condensed Statement of Cash Flows
June 30, 2017

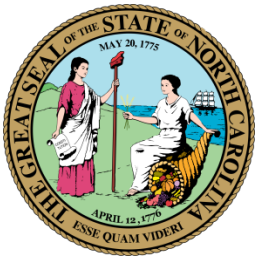
	Health System Properties, LLC
Net Cash Used by Operating Activities	$ (81)
Cash and Cash Equivalents, July 1, 2016	135,216
Cash and Cash Equivalents, June 30, 2017	$ 135,135

NOTE 18 - CHANGES IN FINANCIAL ACCOUNTING AND REPORTING

For the fiscal year ended June 30, 2017, the Hospitals implemented the following pronouncement issued by the Governmental Accounting Standards Board (GASB):

> GASB Statement No. 82, *Pension Issues – An amendment of GASB Statement No. 67, No. 68, and No. 73*

GASB Statement No. 82 addresses certain issues with respect to Statements No. 67, *Financial Reporting for Pension Plans ,* No. 68, *Accounting and Financial Reporting for Pensions ,* and No. 73, *Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement 68, and Amendments to Certain Provisions of GASB Statements 67 and 68 .* Specifically, this Statement addresses issues regarding (1) the presentation of payroll-related measures in required supplementary information, (2) the selection of assumptions and the treatment of deviations from the guidance in an Actuarial Standard of Practice for financial reporting purposes, and (3) the classification of payments made by employers to satisfy employee (plan member) contribution requirements.



REQUIRED SUPPLEMENTARY INFORMATION

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of the Proportionate Net Pension Liability
Teachers' and State Employees' Retirement System
Last Four Fiscal Years *Exhibit B-1*

	2016	2015	2014	2013
Proportionate Share Percentage of Collective Net Pension Liability	3.53%	3.57%	3.66%	3.40%
Proportionate Share of TSERS Collective Net Pension Liability	$ 324,323,062	$ 131,644,117	$ 42,860,194	$ 206,542,137
Covered Payroll	$ 505,864,160	$ 463,324,935	$ 455,896,086	$ 438,969,093
Net Pension Liability as a Percentage of Covered Payroll	64.11%	28.41%	9.40%	47.05%
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability	87.32%	94.64%	98.24%	90.60%

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of Hospitals Contributions
Teachers' and State Employees' Retirement System
Last Ten Fiscal Years *Exhibit B-2*

	2017	2016	2015	2014	2013
Contractually Required Contribution	$ 51,473,710	$ 46,286,571	$ 42,394,233	$ 39,617,587	$ 36,566,116
Contributions in Relation to the Contractually Determined Contribution	51,473,710	46,286,571	42,394,233	39,617,587	36,566,116
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 515,768,637	$ 505,864,160	$ 463,324,935	$ 455,896,086	$ 438,969,093
Contributions as a Percentage of Covered Payroll	9.98%	9.15%	9.15%	8.69%	8.33%

	2012	2011	2010	2009	2008
Contractually Required Contribution	$ 31,904,755	$ 19,493,557	$ 13,220,302	$ 11,724,115	$ 9,802,290
Contributions in Relation to the Contractually Determined Contribution	31,904,755	19,493,557	13,220,302	11,724,115	9,802,290
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 428,827,355	$ 395,406,814	$ 370,315,946	$ 348,927,541	$ 321,385,923
Contributions as a Percentage of Covered Payroll	7.44%	4.93%	3.57%	3.36%	3.05%

Note: Changes in benefit terms, methods, and assumptions are presented in the Notes to Required Supplementary Information (RSI) schedule following the pension RSI tables.

University of North Carolina Hospitals at Chapel Hill
Notes to Required Supplementary Information
Schedule of Hospitals Contributions
Teachers' and State Employees' Retirement System
Last Ten Fiscal Years

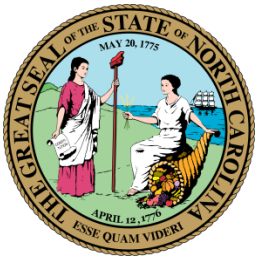
Changes of Benefit Terms:

Cost of Living Increase

2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
N/A	N/A	1.00%	N/A	N/A	N/A	2.20%	2.20%	3.00%	2.00%

Changes of assumptions. In 2008, 2012, and 2015, the actuarial assumptions were updated to more closely reflect actual experience. In 2015, the North Carolina Retirement Systems' consulting actuaries performed the quinquennial investigation of each retirement systems' actual demographic and economic experience (known as the "Experience Review"). The Experience Review provides the basis for selecting the actuarial assumptions and methods used to determine plan liabilities and funding requirements. The most recent Experience Review examined each plan's experience during the period between January 1, 2010, and December 31, 2014. Based on the findings, the Board of Trustees of the Teachers' and State Employees' Retirement System adopted a number of new actuarial assumptions and methods. The most notable changes to the assumptions include updates to the mortality tables and the mortality improvement projection scales to reflect reduced rates of mortality and significant increases in mortality improvements. These assumptions were adjusted to reflect the mortality projection scale MP-2015, released by the Society of Actuaries in 2015. In addition, the assumed rates of retirement, salary increases, and rates of termination from active employment were reduced to more closely reflect actual experience.

The Notes to Required Supplementary Information reflect the most recent available information included in the State of North Carolina's 2016 *Comprehensive Annual Financial Report*.



INDEPENDENT AUDITOR'S REPORT

STATE OF NORTH CAROLINA
Office of the State Auditor

Beth A. Wood, CPA
State Auditor

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INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDIT STANDARDS*

Board of Directors
University of North Carolina Health Care System
Chapel Hill, North Carolina

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the University of North Carolina Hospitals at Chapel Hill (Hospitals), which is a part of the University of North Carolina Health Care System that is an affiliated enterprise of the multi-campus University of North Carolina System, a component unit of the State of North Carolina, as of and for the year ended June 30, 2017, and the related notes to the financial statements, which collectively comprise the Hospitals' basic financial statements, and have issued our report thereon dated October 16, 2017.

As discussed in Note 1, the financial statements of the University of North Carolina Hospitals at Chapel Hill are intended to present the financial position, changes in financial position, and cash flows that are only attributable to the transactions of the University of North Carolina Hospitals at Chapel Hill. They do not purport to, and do not, present fairly the financial position of the University of North Carolina Health Care System nor the University of North Carolina System as of June 30, 2017, the changes in its financial position, or its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Hospitals' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospitals' internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospitals' internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the Hospitals' financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospitals' financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospitals' internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospitals' internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Beth A. Wood, CPA
State Auditor

Raleigh, North Carolina

October 16, 2017

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NC OSA
The Taxpayers' Watchdog

This audit required 1,104 hours at an approximate cost of $113,712.