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, 2018

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, 2018, 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

Beth A. Wood, CPA
State Auditor

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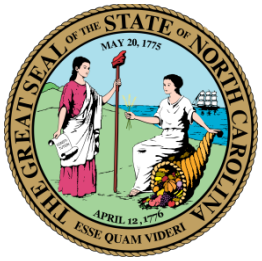
Article V, Chapter 147 of the *North Carolina General Statutes*, gives the Auditor broad powers to examine all books, records, files, papers, documents, and financial affairs of every state agency and any organization that receives public funding. The Auditor also has the power to summon people to produce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



INDEPENDENT AUDITOR'S REPORT

STATE OF NORTH CAROLINA
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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, 2018, 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, 2018, 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, 2018, 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.

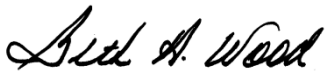
As discussed in Note 19 to the financial statements, during the year ended June 30, 2018, the University of North Carolina Hospitals at Chapel Hill adopted new accounting guidance, Governmental Accounting Standards Board Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions,* as amended by Governmental Accounting Standards Board Statement No. 85, *Omnibus 2017*. 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*

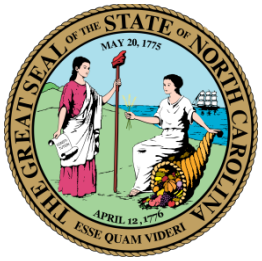
In accordance with *Government Auditing Standards*, we have also issued our report dated October 19, 2018 on our consideration of the Hospitals' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and 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, CPA
State Auditor

Raleigh, North Carolina

October 19, 2018



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, 2018 and 2017. 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, 2018 and 2017.

	FY18	FY17 (As Restated)	Change	% Change
Current Assets	$ 587,388,478	$ 646,153,789	$ (58,765,311)	(9.1)%
Capital Assets, Net	776,942,560	745,785,947	31,156,613	4.2%
Other Noncurrent Assets	1,047,177,475	875,016,296	172,161,179	19.7%
TOTAL ASSETS	2,411,508,513	2,266,956,032	144,552,481	6.4%
DEFERRED OUTFLOWS OF RESOURCES	211,481,035	278,071,601	(66,590,566)	(23.9)%
Other Current Liabilities	309,235,794	267,466,265	41,769,529	15.6%
Long-Term Liabilities	1,937,034,259	2,426,837,995	(489,803,736)	(20.2)%
Other Noncurrent Liabilities	72,208,278	87,912,663	(15,704,385)	(17.9)%
TOTAL LIABILITIES	2,318,478,331	2,782,216,923	(463,738,592)	(16.7)%
DEFERRED INFLOWS OF RESOURCES	472,996,323	19,929,791	453,066,532	2273.3%
Net Investment in Capital Assets	598,464,167	556,614,501	41,849,666	7.5%
Restricted for Expendable Uses	347,545,063	298,742,371	48,802,692	16.3%
Unrestricted	(1,114,494,336)	(1,112,475,953)	(2,018,383)	0.2%
TOTAL NET POSITION	$ (168,485,106)	$ (257,119,081)	$ 88,633,975	(34.5)%

Total assets increased $144.6 million as of June 30, 2018 primarily from operating performance, return on investments, and investment in capital assets. Included within this change, current assets decreased $58.8 million primarily due to investment purchases of $75 million. Capital assets increased $31.2 million resulting from construction and equipment purchases – see the capital assets section below for more details. Noncurrent assets increased $172.2 million primarily from increased investment activity.

Deferred outflows of resources decreased from $278.1 million to $211.5 million from adjustments required by the Governmental Accounting Standards Board (GASB) Statement No. 68 and Statement No. 75 as it relates to the State of North Carolina Teachers' and State Employees' Retirement System Plan and other postemployment benefits (see Notes 12, 13, and 19).

Total liabilities decreased $463.7 million from June 30, 2017 primarily from the change in the net pension liability and net other postemployment benefits liability in accordance with GASB Statement No. 68 and No. 75, respectively. See Notes 12 and 13 for further details related to the pension plan and other postemployment benefits. Current liabilities increased $41.8 million primarily due to the increase in estimated third party settlements and amounts due to State of North Carolina component units. Other changes in current liabilities include accrued salaries and benefits which are the result of the timing of year end liabilities and a decrease in accounts payable and accrued liabilities which resulted from paying these balances down.

Deferred inflows of resources increased $453.1 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 and other postretirement benefits in accordance with GASB Statements No. 68 and 75.

Net position increased $88.6 million during the fiscal year ended June 30, 2018 and was driven by operating income of $188.4 million and investment activity of $80.9 million. For further

information on this change, see the following statement of revenues, expenses, and changes in net position.

Capital Assets

The Hospitals expended $44.5 million on the acquisition and construction of buildings, infrastructure, and renovations during the fiscal year. An additional $46 million was expended during the year for capital equipment throughout the facilities and for clinical program development and software resulting in a total capital investment of approximately $90.5 million for the year as shown in Note 6. Capital spending is expected to increase in the future as planning continues for a new surgical tower which will modernize a significant number of operating rooms located on the UNC Chapel Hill campus. Surgical tower construction begins in Fall 2018 and will include operating rooms, inpatient patient beds, and related patient care support when it is completed in Spring 2022. This addition to the Medical Center Campus will improve operability, care, and the patient experience.

Long-term Debt Activities

At June 30, 2018, the Hospitals had outstanding bond indebtedness in the amount of $318 million, of which $13 million is due within the next year. Standard & Poor's and Moody's Rating Services classify these bonds at AA and Aa3, respectively. No material new lease commitments or bond issuances 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, 2018 and 2017:

	FY18	FY17 (As Restated)	Change	% Change
Net Patient Service Revenue	$ 1,846,906,307	$ 1,728,597,641	$ 118,308,666	6.8%
Other Operating Revenues	45,446,090	45,047,813	398,277	0.9%
TOTAL OPERATING REVENUES	1,892,352,397	1,773,645,454	118,706,943	6.7%
Salaries and Benefits	765,793,766	670,735,215	95,058,551	14.2%
Medical and Surgical Supplies	440,807,802	410,805,171	30,002,631	7.3%
Contracted Services	340,188,073	321,946,285	18,241,788	5.7%
Other Supplies and Services	97,654,506	94,969,535	2,684,971	2.8%
Depreciation and Amortization	59,513,258	59,651,888	(138,630)	(0.2)%
TOTAL OPERATING EXPENSES	1,703,957,405	1,558,108,094	145,849,311	9.4%
OPERATING INCOME	188,394,992	215,537,360	(27,142,368)	(12.6)%
Investment Income	80,895,781	62,823,790	18,071,991	28.8%
Other Nonoperating Revenues	1,942,524	2,210,291	(267,767)	(12.1)%
Nonoperating Expenses	(10,135,655)	(13,376,777)	3,241,122	(24.2)%
NET NONOPERATING REVENUES	72,702,650	51,657,304	21,045,346	40.7%
Health Care System Assessments	(172,463,667)	(171,862,223)	(601,444)	0.3%
INCREASE IN NET POSITION	88,633,975	95,332,441	(6,698,466)	(7.0)%
NET POSITION - BEGINNING OF YEAR, AS RESTATED	(257,119,081)	1,311,716,613	(1,568,835,694)	(119.6)%
RESTATEMENT: GASB 75 IMPLEMENTATION		(1,664,168,135)	1,664,168,135	(100.0)%
NET POSITION - END OF YEAR	$ (168,485,106)	$ (257,119,081)	$ 88,633,975	(34.5)%
TOTAL REVENUES	$ 1,975,190,702	$ 1,838,679,535	$ 136,511,167	7.4%
TOTAL EXPENSES	1,886,556,727	1,743,347,094	143,209,633	8.2%
INCREASE IN NET POSITION	$ 88,633,975	$ 95,332,441	$ (6,698,466)	(7.0)%

Net patient revenue increased $118.3 million and reflects a 1.0% increase in discharges and Emergency Department visits and a 4.5% increase in total surgeries. Volume and gross revenue has 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 $145.8 million over the prior year. Note that the $95.1 million increase in salaries and benefits is net of an unfavorable $40.9 million adjustment to pension and other postemployment benefits expense as required by GASB Statements No. 68 and No. 75. 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 $30.0 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.

Net nonoperating revenues increased $21.0 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 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 totaling $172.5 million were consistent from 2017 to 2018. These assessments are described in more detail in Note 16.

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.

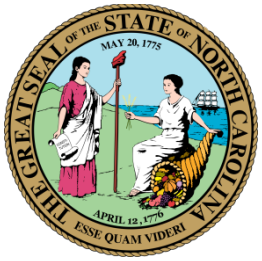
The Hospitals has sought to remain a leader by evolving to meet the changing health care environment. We are making infrastructure investments to modernize our patient care. The inpatient census at the Hospitals is regularly near maximum capacity. To address this need, we constructed and opened a 25-bed 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 that will begin construction in Fall 2018. 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.

The Hospitals also began a multi-year effort to optimize square footage utilization on the Medical Center campus and off-campus locations. These enhancements will provide patients access to services in the most appropriate care setting and allow the Hospitals to more effectively care for a growing number of behavioral health patients.

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. The Hospitals benefited from the continued recognition of these gains in 2018 as well as financial improvements generated by continuous improvement initiatives focused on patient access and patient progression.

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, 2018

ASSETS		
Current Assets:		
Cash and Cash Equivalents (Note 2)	$	49,824,782
Restricted Cash and Cash Equivalents (Note 2)		1,079,947
Receivables, Net:		
Patient Accounts Receivable, Net (Note 4)		236,748,865
Other Accounts Receivable, Net		51,843,662
Due from State of North Carolina Component Units		54,048,289
Estimated Third Party Settlements (Note 5)		10,403,574
Inventories		65,726,739
Prepaid Expense		111,592,235
Other Current Assets (Note 16)		6,120,385
Total Current Assets		587,388,478
Noncurrent Assets:		
Restricted Cash and Cash Equivalents (Note 2)		91,658,889
Restricted Investments (Note 2)		328,463,639
Assets Limited as to Use (Note 2)		530,781,119
Advanced Deposits with Liability Insurance Trust Fund (Note 14)		14,085,591
Patient Accounts Receivable, Net (Note 4)		999,123
Prepaid Expense		22,058,581
Investments in Affiliates (Note 17)		23,677,254
Capital Assets, Net (Note 6)		776,942,560
Net Other Postemployment Benefits Asset		2,449,946
Other Noncurrent Assets (Note 16)		33,003,333
Total Noncurrent Assets		1,824,120,035
Total Assets		2,411,508,513
DEFERRED OUTFLOWS OF RESOURCES		
Accumulated Decrease in Fair Value of Hedging Derivatives		7,919,195
Deferred Loss on Refunding		7,353,371
Deferred Outflows Related to Pensions		154,302,065
Deferred Outflows Related to Other Postemployment Benefits (Note 13)		41,906,404
Total Deferred Outflows of Resources		211,481,035
LIABILITIES		
Current Liabilities:		
Accounts Payable and Accrued Liabilities		70,191,424
Accrued Salary and Benefits		72,882,984
Due to State of North Carolina Component Units		40,291,710
Estimated Third Party Settlements (Note 5)		113,008,826
Due to Patients or Third Parties		10,004,947
Interest Payable		2,855,903
Long-Term Liabilities - Current Portion (Note 7)		33,991,602
Total Current Liabilities		343,227,396

Noncurrent Liabilities:	
Long-Term Liabilities (Note 7)	1,903,042,657
Hedging Derivative Liability (Note 8)	7,919,195
Estimated Third Party Settlements (Note 5)	64,289,083
Total Noncurrent Liabilities	1,975,250,935
Total Liabilities	2,318,478,331
DEFERRED INFLOWS OF RESOURCES	
Deferred Inflows Related to Pensions	12,303,816
Deferred Inflows Related to Other Postemployment Benefits (Note 13)	460,692,507
Total Deferred Inflows of Resources	472,996,323
NET POSITION	
Net Investment in Capital Assets	598,464,167
Restricted for Expendable (Note 1)	347,545,063
Unrestricted	(1,114,494,336)
Total Net Position	$ (168,485,106)

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, 2018

Exhibit A-2

REVENUES		
Operating Revenues:		
Net Patient Service Revenue (Note 11)	$	1,846,906,307
Other Operating Revenues		45,446,090
Total Operating Revenues		1,892,352,397
EXPENSES		
Operating Expenses:		
Salaries and Benefits		765,793,766
Medical and Surgical Supplies		440,807,802
Contracted Services		340,188,073
Other Supplies and Services		97,654,506
Depreciation and Amortization		59,513,258
Total Operating Expenses		1,703,957,405
Operating Income		188,394,992
NONOPERATING REVENUES (EXPENSES)		
Investment Income (Net of Investment Expense of $1,859,560)		80,895,781
Interest and Fees on Debt		(10,119,520)
Loss on Disposal of Capital Assets		(16,135)
Other Nonoperating Revenues		1,942,524
Net Nonoperating Revenues		72,702,650
Income Before Other Expenses		261,097,642
Health Care System Assessments (Note 16)		(172,463,667)
Increase in Net Position		88,633,975
NET POSITION		
Net Position - July 1, 2017, as Restated (Note 20)		(257,119,081)
Net Position - June 30, 2018	$	(168,485,106)

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, 2018

CASH FLOWS FROM OPERATING ACTIVITIES		
Received from Customers	$	1,828,794,370
Payments to Employees and Fringe Benefits		(676,640,403)
Payments to Vendors and Suppliers		(828,718,542)
Other Receipts		795,428
Net Cash Provided by Operating Activities		324,230,853
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Health Care System Assessments		(244,078,667)
Interest and Fees Paid on Revenue Bonds		(837,893)
Principal Paid on Revenue Bonds		(1,360,000)
Noncapital Gifts and Grants		1,152,236
Net Cash Used by Noncapital Financing Activities		(245,124,324)
CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES		
Principal Paid on Capital Revenue Bonds		(11,275,000)
Principal Paid on Capital Lease Payable		(6,545,718)
Interest and Fees Paid on Capital Debt and Leases		(8,413,545)
Acquisition and Construction of Capital Assets		(95,038,472)
Proceeds from Sale of Capital Assets		98,501
Federal Interest Subsidy on Debt Received		675,652
Net Cash Used by Capital Financing and Related Financing Activities		(120,498,582)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income		8,523,044
Purchase of Investments and Related Fees		(75,000,000)
Investments in and Loans to Affiliated Enterprises		(1,939,158)
Net Cash Used by Investing Activities		(68,416,114)
Net Decrease in Cash and Cash Equivalents		(109,808,167)
Cash and Cash Equivalents - July 1, 2017		252,371,785
Cash and Cash Equivalents - June 30, 2018	$	142,563,618

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

Operating Income	$	188,394,992
Adjustments to Reconcile Operating Income to Net Cash Provided by Operating Activities:		
Depreciation/ Amortization Expense		59,513,258
Changes in Assets and Deferred Outflows of Resources:		
Patient Accounts Receivable, Net		(34,078,936)
Due from State of North Carolina Component Units		57,477,720
Estimated Third Party Settlements		17,008,338
Other Accounts Receivable, Net		(29,367,752)
Inventories		(11,575,052)
Prepaid Expense		25,511,131
Advanced Deposits with Liability Insurance Trust Fund		(4,365,446)
Net Other Postemployment Benefits Asset		(156,276)
Deferred Outflows Related to Pensions		65,295,581
Deferred Outflows Related to Other Postemployment Benefits		(4,164,173)
Changes in Liabilities and Deferred Inflows of Resources:		
Accounts Payable and Accrued Liabilities		(20,803,019)
Accrued Salaries and Benefits		8,486,427
Due to Patients or Third Parties		69,906
Due to State of North Carolina Component Units		23,672,664
Net Pension Liability		(36,441,706)
Net Other Postemployment Benefits Liability		(437,060,094)
Compensated Absences		3,746,758
Deferred Inflows Related to Pensions		(7,625,975)
Deferred Inflows Related to Other Postemployment Benefits		460,692,507
Net Cash Provided by Operating Activities	$	324,230,853

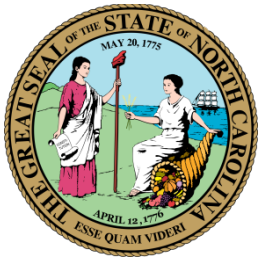
RECONCILIATION OF CASH AND CASH EQUIVALENTS

Current Assets:		
Cash and Cash Equivalents	$	49,824,782
Restricted Cash and Cash Equivalents		1,079,947
Noncurrent Assets:		
Restricted Cash and Cash Equivalents		91,658,889
Total Cash and Cash Equivalents - June 30, 2018	$	142,563,618

NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES

Change in Fair Value of Investments	$	77,605,008
Loss on Disposal of Capital Assets		(16,135)
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 933 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 LCC 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 18.

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 cash on deposit with fiscal agents and 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 a component of investment income.

G. Patient Accounts Receivable - The Hospitals' patient accounts receivable consists 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 used 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 & Equipment	3-20 years
General Infrastructure	5-25 years
Computer Software	3-10 years

K. Assets Limited as to Use - This classification represents investments 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).

I. 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 long-term debt and other long-term liabilities that will not be paid within the next fiscal year. Long-term debt includes: revenue bonds payable, capital leases payable, and financing agreements. Other long-term liabilities include: compensated absences, net pension liability, and net other postemployment benefits (OPEB) liability.

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 2017 *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 12 for further information regarding the Hospitals' policies for recognizing liabilities, expenses, deferred outflows of resources, and deferred inflows of resources related to pensions.

The net OPEB liability represents the Hospitals' proportionate share of the collective net OPEB liability reported in the State of North Carolina's 2017 *Comprehensive Annual Financial Report.* This liability represents the Hospitals' portion of the collective total OPEB liability less the fiduciary net position of the Retiree Health Benefit Fund. See Note 13 for further information regarding the Hospitals' policies for recognizing liabilities, expenses, deferred outflows of resources, and deferred inflows of resources related to OPEB.

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 80. 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: the accumulated decrease in fair value of hedging derivatives, deferred loss on refunding, deferred outflows related to pensions, and deferred outflows related to other postemployment benefits.

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 items that qualify for reporting in this category: deferred inflows related to pensions and deferred inflows related to other postemployment benefits.

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.

The details of expendable restricted net position at June 30, 2018 are as follows:

Net Position Restricted for Expendable:		
Maintenance Reserve Fund	$	328,463,639
Liability Insurance Trust Fund		14,085,591
Employee Benefit Plan - DIPNC		4,317,506
Trust Fund Donations		678,327
Total Net Position Restricted for Expendable	$	347,545,063

Unrestricted Net Position - Unrestricted net position includes resources derived from patient care and ancillary services, unrestricted gifts, and investment income. It also includes the net position of accrued employee benefits such as compensated absences, pension plans, and other postemployment benefits.

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 or resources and deferred inflows of resources. See Note 10 for further information regarding deferred outflows of resources and deferred inflows of resources that had a significant effect on unrestricted net position.

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, 2017, (less amounts previously recorded at June 30, 2017, for in house patients) and all charges on in house accounts and all charges for outpatient accounts registered after June 30, 2017. 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. 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.

At June 30, 2018, the amount shown on the Statement of Net Position as cash and cash equivalents includes $46,682,047, 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 1.4 years as of June 30, 2018. 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.

Cash on hand at June 30, 2018 was $47,118. The carrying amount of the Hospitals' deposits not with the State Treasurer, including unspent bond proceeds of $91,658,889 held by a fiscal agent and deposited with the State Treasurer, was $95,834,453 and the bank balance was $96,307,235. 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, 2018, $725,880 of Hospitals' bank balance was insured and collateralized, and $3,804,726 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 investment:

UNC Investment Fund, LLC - At June 30, 2018, the Statement of Net Position reported investments and assets limited as to use of $859,244,758, 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.

C. Reconciliation of Deposits and Investments - A reconciliation of deposits and investments for the Hospitals at June 30, 2018, is as follows:

Cash on Hand	$	47,118
Amount of Deposits with Private Financial Institutions		95,834,453
Deposits in the Short-Term Investment Fund		46,682,047
UNC Investment Fund		859,244,758
Total Deposits and Investments	$	1,001,808,376
Deposits		
Current:		
Cash and Cash Equivalents	$	49,824,782
Restricted Cash and Cash Equivalents		1,079,947
Noncurrent:		
Restricted Cash and Cash Equivalents		91,658,889
Total Deposits		142,563,618
Investments		
Noncurrent:		
Restricted Investments		328,463,639
Assets Limited as to Use		530,781,119
Total Investments		859,244,758
Total Deposits and Investments	$	1,001,808,376

NOTE 3 - FAIR VALUE MEASUREMENTS

To the extent available, the Hospitals' investments and derivatives are recorded at fair value as of June 30, 2018. 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 deposits in the Short-Term Investment Fund, and derivatives within the fair value hierarchy at June 30, 2018:

		Fair Value Measurements Using		
	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs
Investments as a Position in an External Investment Pool				
Short-Term Investment Fund	$ 46,682,047			
UNC Investment Fund	859,244,758			
Total Investments as a Position in an External Investment Pool	$ 905,926,805			
Derivative Instruments				
Hedging Derivative Instruments				
Interest Rate Swap	$ (7,919,195)	$ 0	$ (7,919,195)	$ 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. Pool investments are measured at fair value in accordance with GASB 72. The Hospitals' position in the pool is measured and reported at fair value and the STIF is not required to be categorized within the fair value hierarchy.

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. Valuation of the underlying assets is performed by the custodian. Pool investments are measured at fair value in accordance with GASB 72. The Hospitals' position in the pool is measured and reported at fair value and the UNC Investment Fund is not required to be categorized within the fair value hierarchy.

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, 2018. 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, 2018:

	Amount
In House Patients	$ 86,771,840
Discharged (Not Final Billed) Patients	95,940,226
Total Unbilled	182,712,066
Discharged (Billed) Patients	362,086,594
Payment Arrangements	8,726,007
Charirty Care Provided	(33,246,847)
Current Gross	520,277,820
Allowance for Bad Debts	(108,009,333)
Contractual Allowances	(175,519,622)
Total Allowances	(283,528,955)
Current - Net	$ 236,748,865

The noncurrent net patient accounts receivable under flexible payment arrangement reflected in the accompanying Statement of Net Position is $999,123 as of June 30, 2018.

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 11 (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 2018. Medicare cost report settlements owed to Medicare are estimated to be $23,559,288 within the next twelve months and $35,599,429 on a noncurrent basis. Traditional Medicaid cost report settlements owed to Medicaid are estimated to be $7,190,590 within the next twelve months and $28,689,654 on a noncurrent basis. Tricare/Champus currently owes the Hospitals $10,403,574. 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, 2013 fiscal year and Medicaid audits are current through the June 30, 2014 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 $82,258,948 UPL liability at year end includes reserves for future UPL audits within the next twelve months. See Note 11 (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, 2018, is presented as follows:

	Balance July 1, 2017	Increases	Decreases	Balance June 30, 2018
Capital Assets, Nondepreciable:				
Land and Permanent Easements	$ 46,472,768	$ 0	$ 0	$ 46,472,768
Construction in Progress	31,421,414	44,504,096	17,084,090	58,841,420
Goodwill	7,704,529			7,704,529
Total Capital Assets, Nondepreciable	85,598,711	44,504,096	17,084,090	113,018,717
Capital Assets, Depreciable:				
Buildings	890,798,296	17,244,254		908,042,550
Machinery and Equipment	453,139,434	45,467,845	1,635,359	496,971,920
General Infrastructure	5,295,662			5,295,662
Computer Software	51,667,754	501,335		52,169,089
Total Capital Assets, Depreciable	1,400,901,146	63,213,434	1,635,359	1,462,479,221
Less Accumulated Depreciation/Amortization for:				
Buildings	336,206,789	35,127,693		371,334,482
Machinery and Equipment	350,659,648	23,485,732	1,619,224	372,526,156
General Infrastructure	5,003,150	60,210		5,063,360
Computer Software	48,844,323	787,057		49,631,380
Total Accumulated Depreciation/Amortization	740,713,910	59,460,692	1,619,224	798,555,378
Total Capital Assets, Depreciable, Net	660,187,236	3,752,742	16,135	663,923,843
Capital Assets, Net	$ 745,785,947	$ 48,256,838	$ 17,100,225	$ 776,942,560

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, 2018 is presented as follows:

	Balance July 1, 2017 (As Restated)	Additions	Reductions	Balance June 30, 2018	Current Portion
Long-Term Debt					
Revenue Bonds Payable	$ 330,585,000	$ 0	$ 12,635,000	$ 317,950,000	$ 13,015,000
Plus: Unamortized Premium	892,945		35,718	857,227	
Total Revenue Bonds Payable	331,477,945		12,670,718	318,807,227	13,015,000
Capital Leases Payable	16,404,567		6,545,717	9,858,850	5,012,054
Other Long-Term License Payable	3,387,310	3,458,530	4,290,787	2,555,053	1,316,793
Total Long-Term Debt	351,269,822	3,458,530	23,507,222	331,221,130	19,343,847
Other Long-Term Liabilities					
Compensated Absences	47,042,959	83,884,610	80,137,854	50,789,715	14,647,755
Net Pension Liability	324,323,062		36,441,706	287,881,356	
Net Other Postemployment Benefits Liability	1,704,202,152		437,060,094	1,267,142,058	
Total Other Long-Term Liabilities	2,075,568,173	83,884,610	553,639,654	1,605,813,129	14,647,755
Total Long-Term Liabilities	$ 2,426,837,995	$ 87,343,140	$ 577,146,876	$ 1,937,034,259	$ 33,991,602

Additional information regarding capital lease obligations is included in Note 9.
Additional information regarding the net pension liability is included in Note 12.
Additional information regarding the net other postemployment benefits liability is included in Note 13.
Additional information regarding the license payable is included in Note 16.

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, 2018	Principal Outstanding June 30, 2018
Rex Acquisition and Hospital Renovations	2001A	1.50% *	02/15/2031	$ 55,000,000	$ 11,800,000	$ 43,200,000
	2001B	1.50% *	02/15/2031	55,000,000	11,800,000	43,200,000
Refund Portion of 1996 Revenue Bonds	2003A	3.62% *	02/01/2029	63,770,000	14,470,000	49,300,000
	2003B	3.57% *	02/01/2029	34,245,000	7,735,000	26,510,000
Refund 1999 Revenue Bonds	2009A	3.71% *	02/01/2024	44,290,000	23,525,000	20,765,000
General Revenue Bonds	2010B	4.37% to 6.33% **	02/01/2031	43,290,000	8,260,000	35,030,000
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	$ 77,590,000	317,950,000
Plus: Unamortized Premium						857,227
Total Revenue Bonds Payable						$ 318,807,227

* For variable rate debt, interest rates in effect at June 30, 2018 are included. For variable rate debt with interest rate swaps, the synthetic fixed rates are included based on rates in effect at June 30, 2018.

**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. 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, 2018, 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 $86,400,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $22,730,400, $21,664,800, $20,455,200, $19,245,600, and $18,036,000 in years one, two, three, four, and five, respectively, under the installment loan agreement assuming a Base Rate of 6.00% (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.

Fee of 0.33% for fiscal year 2018. Payments are made quarterly in arrears, on the first business day of each November, February, May, and August until the expiration date or termination date of the Agreement. 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, 2018, 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 $49,300,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $19,535,126, $18,590,213 and $17,357,705 in years one, two, and three, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 6.50% (Prime plus 1.50%). The current expiration date of the Agreement is July 2, 2021.

The 2003B Agreement with Wells Fargo Bank, N.A. required a Commitment Fee of 0.50% for fiscal year 2018. Payments are made quarterly in arrears, on the first business day of each February, May, August, and November until the expiration date or termination date of the Agreement. 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	0.65%
A-	A3	0.80%
BBB+	Baa1	1.00%
BBB	Baa2	1.25%
BBB-	Baa3	1.55%
Below Investment Grade	Below Investment Grade	2.55%

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 Base Rate plus 2.00%, 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, 2018, 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 monthly installments of principal, on the first business day of the second month 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 $26,510,000 of demand bonds was “put” and not resold, the Hospitals would be required to pay $27,702,950 within 364 days of the Purchase Date of the Bank Bonds assuming a maximum rate of 9.00%. The current expiration date of the agreement is July 31, 2019.

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. 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, 2018, there were no Bank Bonds held by the 2009A Liquidity Facility.

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 $20,765,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $6,182,209, $5,976,338, $5,669,129, and $5,361,922 in years one, two, three and four, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 5.00%.

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, 2018, are as follows:

	Annual Requirements		
	Revenue Bonds Payable		
Fiscal Year	Principal	Interest	Interest Rate Swaps, Net
2019	$ 13,015,000	$ 8,931,017	$ 1,982,427
2020	13,420,000	8,675,647	1,793,035
2021	14,025,000	8,395,897	1,586,671
2022	14,460,000	8,111,243	1,380,869
2023	15,115,000	7,807,739	1,164,161
2024-2028	86,265,000	33,774,588	2,964,573
2029-2033	61,705,000	23,771,889	102,453
2034-2038		21,239,000	
2039-2043	37,500,000	19,927,433	
2044-2046	62,445,000	4,496,883	
Total Requirements	$ 317,950,000	$ 145,131,336	$ 10,974,189

Interest on variable rate 2001 A&B, 2003 A&B, and 2009A revenue bonds is calculated at 1.50%, 1.50%, 1.51%, 1.46%, and 1.48% at June 30, 2018.

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 Investments.

NOTE 8 - DERIVATIVE INSTRUMENTS

Derivative instruments held at June 30, 2018 are as follows:

		Change in Value		Value at June 30, 2018	
Type	Notional Amount	Classification	Increase	Classification	Liability
Hedging Derivative Instruments					
Cash Flow Hedges					
Pay-Fixed Interest Rate Swap	$ 75,810,000	Deferred Outflow of Resources	$ 3,717,079	Hedging Derivative	$ (6,752,597)
Pay-Fixed Interest Rate Swap	20,765,000	Deferred Outflow of Resources	921,958	Hedging Derivative	(1,166,598)
Total Derivative Instruments			$ 4,639,037		$ (7,919,195)

Hedging derivative instruments held at June 30, 2018 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	$ 75,810,000	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	20,765,000	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, 2018.

The Hospitals' interest rate swap hedging derivatives have been determined to be effective as of June 30, 2018 using the synthetic instrument method.

Hedging Derivative Risks

Credit Risk: As of June 30, 2018, 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, 2018, the credit rating for Bank of America, N.A. is Aa31 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, 2018. 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, 2018.

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, 2018:

Fiscal Year	Amount
2019	$ 5,126,186
2020	4,882,957
Total Minimum Lease Payments	10,009,143
Amount Representing Interest (1% to 4% Rate of Interest)	150,293
Present Value of Future Lease Payments	$ 9,858,850

Medical equipment acquired under capital lease amounted to $27,717,959 at June 30, 2018.

Depreciation for the capital assets associated with capital leases is included in depreciation expense, and accumulated depreciation for assets acquired under capital lease totaled $15,467,529 at June 30, 2018.

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, 2018:

Fiscal Year	Amount
2019	$ 11,410,773
2020	10,073,002
2021	8,573,556
2022	8,935,778
2023	9,041,789
2024-2028	44,155,117
2029-2033	7,336,206
2034-2038	2,644,869
Total Minimum Lease Payments	$ 102,171,090

Rental expense for all operating leases during the year was $12,443,440.

NOTE 10 - NET POSITION

The deficit in unrestricted net position of $1,114,494,336 has been significantly affected by transactions that resulted in the recognition of deferred outflows of resources and deferred inflows of resources. A summary of the balances reported within unrestricted net position relating to the reporting of net pension liability and net other postemployment benefits (OPEB) liability, and the related deferred outflows of resources and deferred inflows of resources is presented as follows:

	TSERS	Retiree Health Benefit Fund	Total
Deferred Outflows Related to Pensions	$ 154,302,065	$ 0	$ 154,302,065
Deferred Outflows Related to OPEB		39,777,201	39,777,201
Noncurrent Liabilities:			
Long-Term Liabilities:			
Net Pension Liability	287,881,356		287,881,356
Net OPEB Liability		1,267,142,058	1,267,142,058
Deferred Inflows Related to Pensions	12,303,816		12,303,816
Deferred Inflows Related to OPEB		460,430,864	460,430,864
Net Effect on Unrestricted Net Position	$ (145,883,107)	$ (1,687,795,721)	$ (1,833,678,828)

See Notes 12 and 13 for detailed information regarding the amortization of the deferred outflows of resources and deferred inflows of resources relating to pensions and OPEB, respectively.

NOTE 11 - NET PATIENT SERVICE REVENUE

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 ($79,648,435). The UPL Plan was effective on October 1, 2010.

Commercial/Managed Care Payer Agreements: The Hospitals has 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. The two largest contracts include incentives for achieving quality targets. 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 has agreements with the major

Medicare Advantage plans in their various markets. These plans reimburse according to the 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, 2018 follows:

	2018
Inpatient	$ 2,224,662,727
Outpatient	2,567,681,179
Charity Care Provided	(225,136,044)
Prior Year Third Party Settlements	21,396,958
Gross Patient Service Revenue	4,588,604,820
Medicare Contractual Allowance	(1,217,545,985)
Medicaid Contractual Allowance	(744,280,950)
Upper Payment Limit	143,218,077
Managed Care Contractual Allowance	(802,359,594)
Other Contractual Allowances	(29,402,126)
Bad Debt	(91,327,935)
Contractual Adjustments	(2,741,698,513)
Net Patient Service Revenue	$ 1,846,906,307

NOTE 12 - 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, 2018 was 10.78% of covered payroll. Employee contributions to the pension plan were $32,256,300, and the Hospitals' contributions were $57,953,818 for the year ended June 30, 2018.

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 2017 *Comprehensive Annual Financial Report*. An electronic version of this report is available on the North Carolina Office of the State Controller's website at https://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 External Investment Pool. TSERS and other pension plans of the State of North Carolina are the sole participants in the

Long-Term Investment, Fixed Income Investment, Equity Investment, Real Estate Investment, Alternative Investment, Opportunistic Fixed Income Investment, and Inflation Sensitive Investment Portfolios. The Fixed Income Asset Class includes the Long-Term Investment and 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 External Investment Pool. Detailed descriptions of the methods and significant assumptions regarding investments of the State Treasurer are provided in the 2017 *Comprehensive Annual Financial Report*.

Net Pension Liability: At June 30, 2018, the Hospitals reported a liability of $287,881,356 for its proportionate share of the collective net pension liability. The net pension liability was measured as of June 30, 2017. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of December 31, 2016, and update procedures were used to roll forward the total pension liability to June 30, 2017. 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, 2017, the Hospitals' proportion was 3.63%, which was an increase of 0.10 from its proportion measured as of June 30, 2016, which was 3.53%.

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	12/31/2016
Inflation	3%
Salary Increases*	3.50% - 8.10%
Investment Rate of Return**	7.20%

* Salary increases include 3.5% inflation and productivity factor.

** Investment rate of return includes inflation assumption and is of pension plan investment expense.

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 mortality rates also contain a provision to reflect future mortality improvements.

The actuarial assumptions used in the December 31, 2016 valuations were based on the results of an actuarial experience review for the period January 1, 2010 through December 31, 2014.

Future ad hoc Cost of Living Adjustment 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, 2017 (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%
Opportunistic Fixed Income	6.0%
Inflation Sensitive	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. The long-term expected real rate of return for the Bond Index Investment Pool as of June 30, 2017 is 1.3%.

Discount Rate: The discount rate used to measure the total pension liability was lowered from 7.25% to 7.20% for the December 31, 2016 valuation. The discount rate is in line with the long-term nominal expected return on pension plan investments. The calculation of the net pension liability is a present value calculation of the future net pension payments. These net pension payments assume that contributions from plan members will be made at the current statutory contribution rate and that contributions from employers will be made at the contractually 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 at June 30, 2017 calculated using the discount rate of 7.20%, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower (6.20%) or 1-percentage point higher (8.20%) than the current rate:

Net Pension Liability		
1% Decrease (6.20%)	Current Discount Rate (7.20%)	1% Increase (8.20%)
$ 592,864,813	$ 287,881,356	$ 32,599,288

Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions: For the year ended June 30, 2018, the Hospitals recognized pension expense of $79,529,466. At June 30, 2018, 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	$ 6,240,735	$ 9,418,103
Changes of Assumptions	45,870,604	
Net Difference Between Projected and Actual Earnings on Plan Investments	38,960,112	
Change in Proportion and Differences Between Employer's Contributions and Proportionate Share of Contributions	5,276,796	2,885,713
Contributions Subsequent to the Measurement Date	57,953,818	
Total	$ 154,302,065	$ 12,303,816

The amount of $57,953,818 reported as deferred outflows of resources related to contributions subsequent to the measurement date will be included as a reduction of the net pension liability in the fiscal year ended June 30, 2019. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as 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
2019	$ 17,644,110
2020	54,676,793
2021	27,315,789
2022	(15,592,261)
Total	$ 84,044,431

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 ORP instead of TSERS. The Board of Governors of the University of North Carolina is responsible for the administration of ORP and designates the companies authorized to offer investment products or the trustee responsible for the investment of contributions under ORP and approves the form and contents of the contracts and trust agreements.

Participants in ORP are immediately vested in the value of employee contributions. The value of employer contributions is vested after five years of participation in 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. Member and employer contribution rates are set each year by the North Carolina General Assembly. For the year ended June 30, 2018, these rates were set at 6% of covered payroll for members and 6.84% of covered payroll for employers. The Hospitals assumes no liability other than its contribution.

For the current fiscal year, the Hospitals had a total payroll of $767,352,736, of which $119,869,400 was covered under ORP. Total employee and employer contributions for pension benefits for the year were $7,192,164 and $8,199,067, respectively. The amount of expense recognized in the current year related to ORP is equal to the employer contributions.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS

The Hospitals participates in two postemployment benefit plans, the Retiree Health Benefit Fund and the Disability Income Plan of North Carolina, that are administered by the State of North Carolina as pension and other employee benefit trust funds. Each plan's financial information, including all information about the plans' 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 2017 *Comprehensive Annual Financial Report.* An electronic version of this report is available on the North Carolina Office of the

State Controller's website at https://www.osc.nc.gov/ or by calling the State Controller's Financial Reporting Section at (919) 707-0500.

A. Summary of Significant Accounting Policies and Plan Asset Matters

Basis of Accounting: The financial statements of these plans were prepared using the accrual basis of accounting. Employer contributions are recognized when due and the employer has made a formal commitment to provide the contributions. Benefits are recognized when due and payable in accordance with the terms of each plan. The fiduciary net position of each plan was determined using the same basis as the other postemployment benefit (OPEB) plans.

Methods Used to Value Plan Investments: Pursuant to *North Carolina General Statutes*, the State Treasurer is the custodian and administrator of the other postemployment benefits funds. The State Treasurer maintains various investment portfolios in its External Investment Pool. The Retiree Health Benefit Fund participates in the External Investment Pool. The Disability Income Plan of North Carolina is invested in the Short-Term Investment Portfolio of the External Investment Pool and the Bond Index External Investment Pool. The investment balance of each other employee benefit 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 2017 *Comprehensive Annual Financial Report.*

B. Plan Descriptions

1. Health Benefits

Plan Administration: The State of North Carolina administers the North Carolina State Health Plan for Teachers and State Employees, referred to as the State Health Plan (the Plan), a healthcare plan exclusively for the benefit of employees of the State, the University of North Carolina System, community colleges, and certain other component units. In addition, Local Education Agencies (LEAs), charter schools, and some select local governments that are not part of the State's financial reporting entity also participate. Health benefit programs and premium rates are determined by the State Treasurer upon approval of the Plan Board of Trustees.

The Retiree Health Benefit Fund (RHBF) has been established as a fund to provide health benefits to retired and disabled employees and their applicable beneficiaries. RHBF is established by General Statute 135-7, Article 1. RHBF is a cost-sharing, multiple-employer, defined benefit healthcare plan, exclusively for the benefit of eligible former employees of the State, the University of North Carolina System, and community colleges. In addition, LEAs, charter schools, and some select local governments that are not part of the State's financial reporting entity also participate.

By statute, RHBF is administered by the Board of Trustees of the Teachers' and State Employees' Retirement System (TSERS). RHBF is supported by a percent of payroll contribution from participating employing units. Each year the percentage is set in legislation, as are the maximum per retiree contributions from RHBF to the Plan. The State Treasurer, with the approval of the Plan Board of Trustees, then sets the employer contributions (subject to the legislative cap) and the premiums to be paid by retirees, as well as the health benefits to be provided through the Plan.

Benefits Provided: Plan benefits received by retired employees and disabled employees from RHBF are OPEB. The healthcare benefits for retired and disabled employees who are not eligible for Medicare are the same as for active employees as described in Note 14. The plan options change when former employees become eligible for Medicare. Medicare retirees have the option of selecting one of two fully-insured Medicare Advantage/Prescription Drug Plan options or the self-funded Traditional 70/30 Preferred Provider Organization plan option that is also offered to non-Medicare members. If the Traditional 70/30 Plan is selected by a Medicare retiree, the self-funded State Health Plan coverage is secondary to Medicare.

Those former employees who are eligible to receive medical benefits from RHBF are long-term disability beneficiaries of the Disability Income Plan of North Carolina and retirees of TSERS, the Consolidated Judicial Retirement System, the Legislative Retirement System, the University Employees' Optional Retirement Program (ORP), and a small number of local governments, with five or more years of contributory membership service in their retirement system prior to disability or retirement, with the following exceptions: for employees first hired on or after October 1, 2006, and members of the General Assembly first taking office on or after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to the requirement that the future retiree have 20 or more years of retirement service credit in order to receive coverage on a noncontributory basis. Employees first hired on or after October 1, 2006 and members of the General Assembly first taking office on or after February 1, 2007 with 10 but less than 20 years of retirement service credit are eligible for coverage on a partially contributory basis. For such future retirees, the State will pay 50% of the State Health Plan's total noncontributory premium.

The Plan's and RHBF's benefit and contribution provisions are established by Chapter 135-7, Article 1, and Chapter 135, Article 3B of the General Statutes and may be amended only by the North Carolina General Assembly. RHBF does not provide for automatic post-retirement benefit increases.

Contributions: Contribution rates to RHBF, which are intended to finance benefits and administrative expenses on a pay-as-you-go basis, are determined by the General Assembly in the Appropriations

Bill. The Hospitals' contractually-required contribution rate for the year ended June 30, 2018 was 6.05% of covered payroll. The Hospitals' contributions to the RHBF were $39,777,201 for the year ended June 30, 2018.

2. Disability Income

Plan Administration: As discussed in Note 14, short-term and long-term disability benefits are provided through the Disability Income Plan of North Carolina (DIPNC), a cost-sharing, multiple-employer, defined benefit plan, to the eligible members of TSERS which includes employees of the State, the University of North Carolina System, community colleges, certain participating component units, LEAs which are not part of the reporting entity, and the University Employees' ORP. By statute, DIPNC is administered by the Department of State Treasurer and the Board of Trustees of TSERS.

Benefits Provided: Long-term disability benefits are payable as an OPEB from DIPNC after the conclusion of the short-term disability period or after salary continuation payments cease, whichever is later, for as long as an employee is disabled. An employee is eligible to receive long-term disability benefits provided the following requirements are met: (1) the employee has five or more years of contributing membership service in TSERS or the University Employees' ORP, earned within 96 months prior to the end of the short-term disability period or cessation of salary continuation payments, whichever is later; (2) the employee must make application to receive long-term benefits within 180 days after the conclusion of the short-term disability period or after salary continuation payments cease or after monthly payments for Workers' Compensation cease (excluding monthly payments for permanent partial benefits), whichever is later; (3) the employee must be certified by the Medical Board to be mentally or physically disabled for the further performance of his/her usual occupation; (4) the disability must have been continuous, likely to be permanent, and incurred at the time of active employment; (5) the employee must not be eligible to receive an unreduced retirement benefit from TSERS; and (6) the employee must terminate employment as a permanent, full-time employee. An employee is eligible to receive an unreduced retirement benefit from TSERS after (1) reaching the age of 65 and completing five years of membership service, or (2) reaching the age of 60 and completing 25 years of creditable service, or (3) completing 30 years of creditable service, at any age.

For employees who had five or more years of membership service as of July 31, 2007, during the first 36 months of the long-term disability period, the monthly long-term disability benefit is equal to 65% of one-twelfth of an employee's annual base rate of compensation last payable to the participant or beneficiary prior to the beginning of the short-term disability period, plus the like percentage of one-twelfth of the annual longevity payment and local supplements to which the

participant or beneficiary would be eligible. The monthly benefits are subject to a maximum of $3,900 per month reduced by any primary Social Security disability benefits and by monthly payments for Workers' Compensation to which the participant or beneficiary may be entitled, but the benefits payable shall be no less than $10 a month. After the first 36 months of the long-term disability, the long-term benefit is calculated in the same manner as described above except the monthly benefit is reduced by an amount equal to a monthly primary Social Security disability benefit to which the participant or beneficiary might be entitled had Social Security disability benefits been awarded. When an employee qualifies for an unreduced service retirement allowance from TSERS, the benefits payable from DIPNC will cease, and the employee will commence retirement under TSERS or the University Employees' ORP.

For employees who had less than five years of membership service as of July 31, 2007, and meet the requirements for long-term disability on or after August 1, 2007, during the first 36 months of the long-term disability period, the monthly long-term benefit shall be reduced by an amount equal to the monthly primary Social Security retirement benefit to which the employee might be entitled should the employee become age 62 during the first 36 months. This reduction becomes effective as of the first day of the month following the month of initial entitlement to Social Security benefits. After the first 36 months of the long-term disability, no further benefits are payable under the terms of this section unless the employee has been approved and is in receipt of primary Social Security disability benefits.

Contributions: Although DIPNC operates on a calendar year, disability income benefits are funded by actuarially determined employer contributions that are established in the Appropriations Bill by the General Assembly and coincide with the State's fiscal year. The Hospitals' contractually-required contribution rate for the year ended June 30, 2018 was 0.14% of covered payroll. The Hospitals' contributions to DIPNC were $920,464 for the year ended June 30, 2018.

C. Net OPEB Liability (Asset)

Net OPEB Liability: At June 30, 2018, the Hospitals reported a liability of $1,267,142,058 for its proportionate share of the collective net OPEB liability for RHBF. The net OPEB liability was measured as of June 30, 2017. The total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of December 31, 2016, and update procedures were used to roll forward the total OPEB liability to June 30, 2017. The Hospitals' proportion of the net OPEB 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, 2017, the Hospitals' proportion was 3.86%, which was a decrease of 0.06 from its proportion measured as of June 30, 2016, which was 3.92%.

Net OPEB Asset: At June 30, 2018, the Hospitals reported an asset of $2,449,946 for its proportionate share of the collective net OPEB asset for DIPNC. The net OPEB asset was measured as of June 30, 2017. The total OPEB asset used to calculate the net OPEB asset was determined by an actuarial valuation as of December 31, 2016, and update procedures were used to roll forward the total OPEB asset to June 30, 2017. The Hospitals' proportion of the net OPEB asset 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, 2017, the Hospitals' proportion was 4.01%, which was an increase of 0.32 from its proportion measured as of June 30, 2016, which was 3.69%.

Actuarial Assumptions: The total OPEB liabilities (assets) for RHBF and DIPNC were determined by actuarial valuations as of December 31, 2016, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified. The total OPEB liabilities (assets) were then rolled forward to June 30, 2017 utilizing update procedures incorporating the actuarial assumptions.

	Retiree Health Benefit Fund	Disability Income Plan of N.C.
Valuation Date	12/31/2016	12/31/2016
Inflation	2.75%	3.00%
Salary Increases*	3.50% - 8.10%	3.50% - 8.10%
Investment Rate of Return**	7.20%	3.75%
Healthcare Cost Trend Rate - Medical	5.00% - 6.50%	N/A
Healthcare Cost Trend Rate - Prescription Drug	5.00% - 7.25%	N/A
Healthcare Cost Trend Rate - Medicare Advantage	4.00% - 5.00%	N/A
Healthcare Cost Trend Rate - Administrative	3.00%	N/A

* Salary increases include 3.5% inflation and productivity factor.

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

N/A - Not Applicable

The OPEB plans currently use 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 studies that cover significant portions of the U.S. population. The healthy mortality rates also contain a provision to reflect future mortality improvements.

The projected long-term investment returns and inflation assumptions are developed through a 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 projects 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. DIPNC is primarily invested in the Bond Index Investment Pool as of June 30, 2017.

Best estimates of real rates of return for each major asset class included in RHBF's target asset allocation as of June 30, 2017 (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%
Opportunistic Fixed Income	6.0%
Inflation Sensitive	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. The long-term expected real rate of return for the Bond Index Investment Pool as of June 30, 2017 was 1.3%.

Actuarial valuations of the plans involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

The actuarial assumptions used for RHBF are consistent with those used to value the pension benefits of TSERS where appropriate. These assumptions are based on the most recent pension valuations available. The discount rate used for RHBF reflects a pay-as-you-go approach.

Projections of benefits for financial reporting purposes of the plans are based on the substantive plan (the plan as understood by the employer and plan members) and include the types of benefits provided at the time of each valuation and historical pattern of sharing of benefit costs between the employer and plan members to that point. Historically, the benefits funded solely by employer contributions applied equally to all retirees. Currently, as described earlier in the note, benefits are dependent on membership requirements.

The actuarial methods and assumptions used for DIPNC include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

The actuarial assumptions used in the December 31, 2016 valuations were based on the results of an actuarial experience study prepared as of December 31, 2014.

Discount Rate: The discount rate used to measure the total OPEB liability for RHBF was 3.58%. The projection of cash flows used to determine the discount rate assumed that contributions from employers will be made at the current statutorily determined contribution rate. Based on the above assumptions, the plan's fiduciary net position was not projected to be available to make projected future benefit payments of current plan members. As a result, a municipal bond rate of 3.58% was used as the discount rate used to measure the total OPEB liability. The 3.58% rate is based on the Bond Buyer 20-year General Obligation Index as of June 30, 2017.

The discount rate used to measure the total OPEB asset for DIPNC was 3.75%. 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 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 plan investments was applied to all periods of projected benefit payments to determine the total OPEB asset.

Sensitivity of the Net OPEB Liability (Asset) to Changes in the Discount Rate: The following presents the Hospitals' proportionate share of the net OPEB liability (asset) of the plans, as well as what the plans' net OPEB liability (asset) would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current discount rate:

	Net OPEB Liability (Asset)		
	1% Decrease (2.58%)	Current Discount Rate (3.58%)	1% Increase (4.58%)
RHBF	$ 1,509,744,816	$ 1,267,142,058	$ 1,071,893,436
	1% Decrease (2.75%)	Current Discount Rate (3.75%)	1% Increase (4.75%)
DIPNC	$ (2,083,636)	$ (2,449,946)	$ (2,819,030)

Sensitivity of the Net OPEB Liability(Asset) to Changes in the Healthcare Cost Trend Rates: The following presents the net OPEB liability (asset) of the plans, as well as what the plans' net OPEB liability (asset) would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	1% Decrease (Medical - 4.00 - 5.50%, Pharmacy - 4.00 - 6.25%, Med. Advantage - 3.00 - 4.00%, Administrative - 2.00%)	Current Healthcare Cost Trend Rates (Medical - 5.00 - 6.50%, Pharmacy - 5.00 - 7.25%, Med. Advantage - 4.00 - 5.00%, Administrative - 3.00%)	1% Increase (Medical - 6.00 - 7.50%, Pharmacy - 6.00 - 8.25%, Med. Advantage - 5.00 - 6.00%, Administrative - 4.00%)
RHBF Net OPEB Liability	$ 1,033,849,006	$ 1,267,142,058	$ 1,573,542,163
DIPNC Net OPEB Asset	N/A	N/A	N/A

Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB: For the year ended June 30, 2018, the Hospitals recognized OPEB expense of $58,795,189 for RHBF and $1,214,440 for DIPNC. At June 30, 2018, the Hospitals reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

Employer Balances of Deferred Outflows of Resources Related to OPEB by Classification:

	RHBF	DIPNC	Total
Differences Between Actual and Expected Experience	$ 0	$ 671,731	$ 671,731
Changes of Assumptions			0
Net Difference Between Projected and Actual Earnings on Plan Investments		537,008	537,008
Changes in Proportion and Differences Between Employer's Contributions and Proportionate Share of Contributions			0
Contributions Subsequent to the Measurement Date	39,777,201	920,464	40,697,665
Total	$ 39,777,201	$ 2,129,203	$ 41,906,404

Employer Balances of Deferred Inflows of Resources Related to OPEB by Classification:

	RHBF	DIPNC	Total
Differences Between Actual and Expected Experience	$ 90,856,416	$ 0	$ 90,856,416
Changes of Assumptions	348,965,138		348,965,138
Net Difference Between Projected and Actual Earnings on Plan Investments	470,925		470,925
Changes in Proportion and Differences Between Employer's Contributions and Proportionate Share of Contributions	20,138,385	261,643	20,400,028
Total	$ 460,430,864	$ 261,643	$ 460,692,507

Amounts reported as deferred outflows of resources related to contributions subsequent to the measurement date will be recognized as a reduction of the net OPEB liability related to RHBF and an increase of the net OPEB asset related to DIPNC in the fiscal year ended June 30, 2019. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB 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 OPEB Expense:

Year Ended June 30:	RHBF	DIPNC
2019	$ (92,109,719)	$ 271,018
2020	(92,109,719)	271,018
2021	(92,109,719)	270,898
2022	(92,109,719)	134,162
2023	(91,991,988)	
Total	$ (460,430,864)	$ 947,096

NOTE 14 - 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 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 contributions. Certain plans also require contributions from employees. The Plan has contracted with third parties to process claims. See Note 13, Other Postemployment Benefits, for additional information regarding retiree health benefits.

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.

3. Disability Income Plan

Short-term and long-term disability benefits are provided to Hospitals employees through the Disability Income Plan of North Carolina (DIPNC), part of the State's Pension and Other Employee Benefit Trust Funds. Short-term benefits are paid by the Hospitals up to the first six months of benefits and reimbursed by DIPNC for any additional short-term benefits. As discussed in Note 13, long-term disability benefits are payable as other postemployment benefits from DIPNC after the conclusion of the short-term disability period or after salary continuation payments cease, whichever is later, for as long as an employee is disabled.

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 is on a scheduled vehicle basis, per the schedule on file through the AutoWeb System. 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 $100,000 blanket limit of insurance with $1,000 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, 2017, through June 30, 2018, 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, 2018, 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, 2018, the Hospitals' assets in the Trust Fund totaled $23,553,459 while Hospitals' liabilities totaled $9,467,868 resulting in net position of $14,085,591.

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 1007, Chapel Hill, NC 27517.

NOTE 15 - 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 $56,119,074 and on other purchases were $14,127,490 at June 30, 2018.

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 16 - RELATED PARTIES

University of North Carolina Health Care System 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, contract pharmacy, 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 (presented as other assets on the Statement of Net Position). This note and related implementation receivables from the System Fund totaled $39,123,718 and $3,264,133, respectively, at yearend. There are additional receivables at yearend from the System Fund of $658,001 for asset acquisitions and shared services expenses. The Hospitals' $2,555,053 other long-term license payable (Note 7) is offset by these receivables. The Hospitals was assessed $93,866,279 to fund initiatives supported by the System Fund and $78,597,388 to fund System affiliates. The Hospitals has payables to the System Fund of $28,466,751 as of June 30, 2018.

University of North Carolina Faculty Physicians - The UNC Faculty Physicians (UNCFP) is the clinical service component of the UNC School of Medicine. At the heart of UNCFP are the approximately 1,150 physicians who provide a full range of specialty and primary care services for patients of UNC Health Care. While the great majority of services are rendered at the inpatient units of the Hospitals and the outpatient clinics on the UNC campus, there is a growing range of services provided at clinics in the community. There are 19 clinical departments, two affiliated departments, and an administrative unit that collectively form UNCFP.

While UNCFP is affiliated with UNC Health Care, the net position of UNCFP is held in UNC Chapel Hill (UNC-CH) trust funds. The operating income and expenses for UNCFP are incorporated into UNC-CH's accounting

infrastructure, and as such, its operational results are included in the annual audit for UNC-CH.

The Hospitals provides pass-through billings to UNCFP for payroll salary and benefit costs, supplies, services, space rental, and utilities while UNCFP provides medical director leadership and other clinical services to the Hospitals. These transactions resulted in the Hospitals receiving $127,700,441 and the Hospitals paying $53,836,899 to UNCFP during the year ended June 30, 2018. The Hospitals has receivables from and payables to UNCFP of $7,519,874 and $6,829,140, respectively, as of June 30, 2018.

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 $4,742,630 from Rex and the Hospitals paying $10,874,277 to Rex during the year ended June 30, 2018. The Hospitals has receivables from and payables to Rex of $3,241,000 and $1,984,000, respectively, as of June 30, 2018.

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 $2,509,838 and the Hospitals paying $361,165 to Chatham Hospital, Inc. during the fiscal year for those services. The Hospitals has receivables from and payables to Chatham Hospital, Inc. of $322,014 and $63,539, respectively, as of June 30, 2018.

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 eighty-five 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 $8,290,092 for supplies and services during the fiscal year, and the Hospitals paid $99,521 to UNC

Physicians Network during the year ended June 30, 2018. The Hospitals has receivables from and payables to UNC Physicians Network, LLC of $2,706,810 and $13,610, respectively, as of June 30, 2018.

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 ten years. On September 4, 2013 this agreement was extended to a term of 25 years.

Pardee Memorial Hospital paid the Hospitals $2,793,516 for services received during fiscal year 2018 and the Hospitals paid $2,598,819 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 $2,577,630 for services received during fiscal year 2018 and the Hospitals paid HPRH $10,162,957 for supplies and services during the fiscal year. The Hospitals has receivables from and payables to HPRH of $418,535 and $2,235,948, respectively, as of June 30, 2018.

On September 1, 2018, UNC Health Care transitioned the ownership of High Point Regional Health to Wake Forest Baptist Medical Center.

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 $757,053 for services during fiscal year 2018. The Hospitals paid Caldwell Memorial Hospital $7,002,186 for supplies and services during the fiscal year. The Hospitals has receivables from and payables to Caldwell Memorial Hospital of $58,337 and $698,722, respectively, as of June 30, 2018.

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 $2,590,571 for services received during fiscal year 2018. The Hospitals paid Nash Health Care Systems $4,740,614 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 $780,269 for services received during fiscal year 2018. The Hospitals paid Johnston Health Services Corporation $2,746,278 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 UNC Health Care System on January 1, 2016 to provide certain management services over an initial term of 10 years.

Wayne Health Corporation paid the Hospitals $441,522 for services received during fiscal year 2018.

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 UNC Health Care System on May 17, 2016 to provide certain management services over an initial term of 10 years.

Lenoir Memorial Hospital, Inc. paid the Hospitals $224,413 for services received during fiscal year 2018.

NOTE 17 - INVESTMENT IN AFFILIATES

The Hospitals has investments in affiliates and joint ventures accounted for on the equity method. Investments in affiliates were $23,677,254 at June 30, 2018. 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:

	2018 (Unaudited)
Total Affiliate Activity	
Current Assets	$ 31,409,419
Noncurrent Assets	20,563,768
Current Liabilities	4,113,121
Noncurrent Liabilities	80,504
Shareholders' Equity	47,779,562
Revenue	33,517,536
Net Gain	10,384,574
Hospitals' Share of Activity	
Realized Affiliate Gain - Ongoing Operations	$ 5,559,086

NOTE 18 - BLENDED COMPONENT UNIT

Condensed combining information for the Hospitals' blended component unit for the year ended June 30, 2018, is presented as follows:

Condensed Statement of Net Position
June 30, 2018

	Health System Properties, LLC
ASSETS	
Current Assets	$ 135,045
Capital Assets, Net	22,607,245
Total Assets	22,742,290
TOTAL DEFERRED OUTFLOWS OF RESOURCES	0
LIABILITIES	0
TOTAL DEFERRED INFLOWS OF RESOURCES	0
NET POSITION	
Investment in Capital Assets	22,607,245
Unrestricted	135,045
Total Net Position	$ 22,742,290

Condensed Statement of Revenues, Expenses, and Changes in Net Position
For the Fiscal Year Ended June 30, 2018

	Health System Properties, LLC
OPERATING REVENUES	
Rental Income	$ 645,212
OPERATING EXPENSES	
Operating Expenses	2,088,412
Depreciation	716,005
Total Operating Expenses	2,804,417
Operating Loss	(2,159,205)
NONOPERATING REVENUES	0
Capital Contributions	3,157,980
Increase in Net Position	998,775
NET POSITION	
Net Position, July 1, 2017	21,743,515
Net Position, June 30, 2018	$ 22,742,290

Condensed Statement of Cash Flows
June 30, 2018

	Health System Properties, LLC
Net Cash Used by Operating Activities	$ (1,443,200)
Net Cash Provided by Capital Financing and Related Activities	1,443,110
Net Decrease in Cash and Cash Equivalents	(90)
Cash and Cash Equivalents, July 1, 2017	135,135
Cash and Cash Equivalents, June 30, 2018	$ 135,045

NOTE 19 - CHANGES IN FINANCIAL ACCOUNTING AND REPORTING

For the fiscal year ended June 30, 2018, the Hospitals implemented the following pronouncement issued by the Governmental Accounting Standards Board (GASB):

GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*

GASB Statement No. 85, *Omnibus 2017*

GASB Statement No. 75 improves accounting and financial reporting requirements by state and local governments for postemployment benefits other than pensions (OPEB). It also improves information provided by state and local governmental employers about financial support for OPEB that is provided by other entities. This Statement replaces the requirements of Statements No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, as amended, and No. 57, *OPEB Measurements by Agent Employers and Agent Multiple-Employer Plans*, for OPEB. In addition,

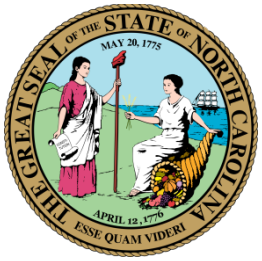
this Statement details the recognition and disclosure requirements for employers with payables to defined benefit OPEB plans that are administered through trusts that meet the specified criteria and for employers whose employees are provided with defined contribution OPEB.

GASB Statement No. 85 addresses practice issues that have been identified during implementation and application of certain GASB Statements. This Statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits (pensions and OPEB).

NOTE 20 - NET POSITION RESTATEMENT

As of July 1, 2017, net position as previously reported was restated as follows:

		Amount
July 1, 2017 Net Position as Previously Reported	$	1,407,049,054
Restatement:		
Record the Hospitals' Net OPEB Asset and Liability and OPEB Related Deferred Outflows and Inflows of Resources Per GASB 75 Requirements.		(1,664,168,135)
July 1, 2017 Net Position as Restated	$	(257,119,081)



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 Five Fiscal Years *Exhibit B-1*

	2017	2016	2015	2014	2013
Proportionate Share Percentage of Collective Net Pension Liability	3.63%	3.53%	3.57%	3.66%	3.40%
Proportionate Share of TSERS Collective Net Pension Liability	$ 287,881,356	$ 324,323,062	$ 131,644,117	$ 42,860,194	$ 206,542,137
Covered Payroll	$ 515,768,637	$ 505,864,160	$ 463,324,935	$ 455,896,086	$ 438,969,093
Net Pension Liability as a Percentage of Covered Payroll	55.82%	64.11%	28.41%	9.40%	47.05%
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability	89.51%	87.32%	94.64%	98.24%	90.60%

Note: Information is presented for all years that were measured in accordance with the requirements of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions - An Amendment of GASB Statement No. 27* , as amended.

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*

	2018	2017	2016	2015	2014
Contractually Required Contribution	$ 57,953,818	$ 51,473,710	$ 46,286,571	$ 42,394,233	$ 39,617,587
Contributions in Relation to the Contractually Determined Contribution	57,953,818	51,473,710	46,286,571	42,394,233	39,617,587
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 537,604,995	$ 515,768,637	$ 505,864,160	$ 463,324,935	$ 455,896,086
Contributions as a Percentage of Covered Payroll	10.78%	9.98%	9.15%	9.15%	8.69%

	2013	2012	2011	2010	2009
Contractually Required Contribution	$ 36,566,116	$ 31,904,755	$ 19,493,557	$ 13,220,302	$ 11,724,115
Contributions in Relation to the Contractually Determined Contribution	36,566,116	31,904,755	19,493,557	13,220,302	11,724,115
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 438,969,093	$ 428,827,355	$ 395,406,814	$ 370,315,946	$ 348,927,541
Contributions as a Percentage of Covered Payroll	8.33%	7.44%	4.93%	3.57%	3.36%

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

2016	2015	2014	2013	2012	2011	2010	2009	2008	2007
N/A	N/A	N/A	1.00%	N/A	N/A	N/A	2.20%	2.20%	3.00%

Changes of assumptions. In 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 discount rate for Teachers' and State Employees' Retirement System was lowered from 7.25% to 7.20% for the December 31, 2016 valuation.

The Board of Trustees also adopted a new asset valuation method for the Teachers' and State Employees' Retirement System. For determining plan funding requirements, these plans now use a five-year smoothing method with a reset of the actuarial value of assets to market value as of December 31, 2014.

The Notes to Required Supplementary Information reflect the most recent available information included in the State of North Carolina's 2017 *Comprehensive Annual Financial Report*.

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of the Proportionate Net OPEB Liability (Asset)
Cost-Sharing, Multiple-Employer, Defined Benefit OPEB Plans
Last Two Fiscal Years *Exhibit B-3*

	2017	2016
Retiree Health Benefit Fund		
Proportionate Share Percentage of Collective Net OPEB Liability (Asset)	3.86%	3.92%
Proportionate Share of Collective Net OPEB Liability (Asset)	$ 1,267,142,058	$ 1,704,202,152
Covered Payroll	$ 592,602,065	$ 569,784,117
Net OPEB Liability (Asset) as a Percentage of Covered Payroll	213.83%	299.10%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability (Asset)	3.52%	2.41%
Disability Income Plan of North Carolina		
Proportionate Share Percentage of Collective Net OPEB Liability (Asset)	4.01%	3.69%
Proportionate Share of Collective Net OPEB Liability (Asset)	$ (2,449,946)	$ (2,293,670)
Covered Payroll	$ 592,602,065	$ 569,784,117
Net OPEB Liability (Asset) as a Percentage of Covered Payroll	(0.41)%	(0.40)%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability (Asset)	116.23%	116.06%

Note: Information is presented for all years that were measured in accordance with the requirements of GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* .

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of Hospitals Contributions
Cost-Sharing, Multiple-Employer, Defined Benefit OPEB Plans
Last Ten Fiscal Years

Exhibit B-4

Retiree Health Benefit Fund	**2018**	**2017**	**2016**	**2015**	**2014**
Contractually Required Contribution	$ 39,777,201	$ 34,430,180	$ 31,907,911	$ 27,972,372	$ 26,417,612
Contributions in Relation to the Contractually Determined Contribution	39,777,201	34,430,180	31,907,911	27,972,372	26,417,612
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 657,474,395	$ 592,602,065	$ 569,784,117	$ 509,514,972	$ 489,215,039
Contributions as a Percentage of Covered Payroll	6.05%	5.81%	5.60%	5.49%	5.40%

	2013	**2012**	**2011**	**2010**	**2009**
Contractually Required Contribution	$ 24,045,758	$ 21,441,368	$ 19,374,934	$ 16,664,218	$ 14,306,029
Contributions in Relation to the Contractually Determined Contribution	24,045,758	21,441,368	19,374,934	16,664,218	14,306,029
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 453,693,539	$ 428,827,355	$ 395,406,814	$ 370,315,946	$ 348,927,541
Contributions as a Percentage of Covered Payroll	5.30%	5.00%	4.90%	4.50%	4.10%

Disability Income Plan of North Carolina	**2018**	**2017**	**2016**	**2015**	**2014**
Contractually Required Contribution	$ 920,464	$ 2,251,888	$ 2,336,115	$ 2,089,011	$ 2,152,546
Contributions in Relation to the Contractually Determined Contribution	920,464	2,251,888	2,336,115	2,089,011	2,152,546
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 657,474,395	$ 592,602,065	$ 569,784,117	$ 509,514,972	$ 489,215,039
Contributions as a Percentage of Covered Payroll	0.14%	0.38%	0.41%	0.41%	0.44%

	2013	**2012**	**2011**	**2010**	**2009**
Contractually Required Contribution	$ 1,996,252	$ 2,229,902	$ 2,056,115	$ 1,925,643	$ 1,814,423
Contributions in Relation to the Contractually Determined Contribution	1,996,252	2,229,902	2,056,115	1,925,643	1,814,423
Contribution Deficiency (Excess)	$ 0	$ 0	$ 0	$ 0	$ 0
Covered Payroll	$ 453,693,539	$ 428,827,355	$ 395,406,814	$ 370,315,946	$ 348,927,541
Contributions as a Percentage of Covered Payroll	0.44%	0.52%	0.52%	0.52%	0.52%

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

Changes of Benefit Terms: Effective January 1, 2016, benefit terms related to copays, out-of-pocket maximums, and deductibles were changed for three of four options of the Retiree Health Benefit Fund. Most of the changes were an increase in the amount from the previous year.

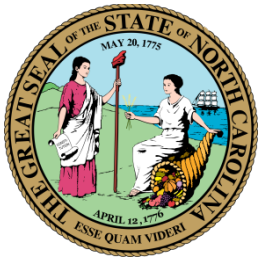
Effective January 1, 2017, benefit terms related to copays, coinsurance maximums, out-of-pocket maximums, and deductibles were changed for two of four options of the Retiree Health Benefit Fund. Most of the changes were an increase in the amount from the previous year.

Method and Assumptions Used in Calculations of Actuarially Determined Contributions: An actuarial valuation is performed for each plan each year. The actuarially determined contribution rates in the Schedule of Employer Contributions are calculated by the actuary as a projection of the required employer contribution for the fiscal year beginning six months following the date of the valuation results for the Retiree Health Benefit Fund. The actuarially determined contribution rates in the Schedule of Employer Contributions are calculated by the actuary as a projection of the required employer contribution for the fiscal year beginning 18 months following the date of the valuation results for the Disability Income Plan of North Carolina. See Note 13 for more information on the specific assumptions for each plan. The actuarially determined contributions for those items with covered payroll were determined using the actuarially determined contribution rate from the actuary and covered payroll as adjusted for timing differences and other factors such as differences in employee class. Other actuarially determined contributions are disclosed in the schedule as expressed by the actuary in reports to the plans.

Changes of assumptions: In 2015, the North Carolina Retirement Systems' consulting actuaries performed the quinquennial investigation of each retirement system's 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 Boards of Trustees of the Teachers' and State Employees' Retirement System and the State Health Plan adopted a number of new actuarial assumptions and methods for the Retiree Health Benefit Fund and the Disability Income Plan of North Carolina. 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 and rates of termination from active employment were reduced to more closely reflect actual experience.

In 2017, the medical and prescription health trend rates used in the December 31, 2016 actuarial valuation of the Retiree Health Benefit Fund were reduced based upon the plan's most recent experience.

The Notes to Required Supplementary Information reflect the most recent available information included in the State of North Carolina's 2017 *Comprehensive Annual Financial Report*.



INDEPENDENT AUDITOR'S REPORT

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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 AUDITING 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, 2018, and the related notes to the financial statements, which collectively comprise the Hospitals' basic financial statements, and have issued our report thereon dated October 19, 2018.

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, 2018, 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 19, 2018

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The Taxpayers' Watchdog

This audit required 1,405 hours at an approximate cost of $144,715.