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, 2021

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

Beth A. Wood, CPA
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, 2021, 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

Beth A. Wood, CPA
State Auditor

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State Auditor

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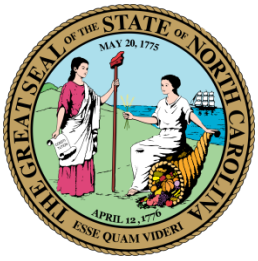
Chapter 147, Article 5A of the *North Carolina General Statutes*, gives the Auditor broad powers to examine all books, records, files, papers, documents, and financial affairs of every state agency and any organization that receives public funding. The Auditor also has the power to summon people to produce records and to answer questions under oath.



INDEPENDENT AUDITOR'S REPORT

STATE OF NORTH CAROLINA
Office of the State Auditor

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INDEPENDENT AUDITOR'S REPORT

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

Report on the Audit of the Financial Statements

Opinion

We have audited 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, 2021, and the related notes to the financial statements, which collectively comprise the Hospitals' basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the University of North Carolina Hospitals at Chapel Hill, as of June 30, 2021, and the changes in financial position and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* (GAGAS), issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the University of North Carolina Hospitals at Chapel Hill and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of Matter

As discussed in Note 1 to the financial statements, 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, 2021, 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, 2021, the University of North Carolina Hospitals at Chapel Hill adopted new accounting guidance, Governmental Accounting Standards Board (GASB) Statement No. 84, *Fiduciary Activities*, as amended by GASB Statement No. 97, *Certain Component Unit Criteria, and Accounting and Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans*. Our opinion is not modified with respect to this matter.

As discussed in Note 20 to the financial statements, during the year ended June 30, 2021, the University of North Carolina Hospitals at Chapel Hill transferred its blended component unit, Health System Properties, LLC, to the University of North Carolina Health Care System. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

The Hospitals' management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Hospitals' ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and GAGAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit 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, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Hospitals' ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

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 is the responsibility of management and, 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.

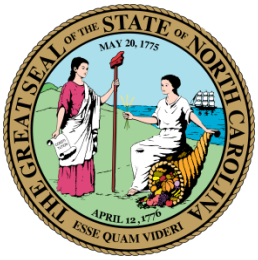
Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 27, 2021 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 27, 2021



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, 2021 and 2020. 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, 2021 and 2020.

	FY21	FY20 (As Restated)	Change	% Change
Current Assets	$ 734,633,692	$ 970,336,014	$ (235,702,322)	(24.3)%
Capital Assets, Net	909,517,356	814,760,061	94,757,295	11.6%
Other Noncurrent Assets	2,029,407,329	1,272,192,463	757,214,866	59.5%
TOTAL ASSETS	3,673,558,377	3,057,288,538	616,269,839	20.2%
TOTAL DEFERRED OUTFLOWS OF RESOURCES	373,419,314	338,722,994	34,696,320	10.2%
Current:				
Long-Term Liabilities - Current Portion	33,221,302	29,548,068	3,673,234	12.4%
Other Current Liabilities	673,861,976	584,651,783	89,210,193	15.3%
Noncurrent:				
Long-Term Liabilities	1,832,911,613	1,879,210,228	(46,298,615)	(2.5)%
Other Noncurrent Liabilities	105,101,385	68,351,134	36,750,251	53.8%
TOTAL LIABILITIES	2,645,096,276	2,561,761,213	83,335,063	3.3%
TOTAL DEFERRED INFLOWS OF RESOURCES	436,568,163	385,577,901	50,990,262	13.2%
Net Investment in Capital Assets	625,957,600	633,676,765	(7,719,165)	(1.2)%
Restricted for Expendable Uses	422,328,191	410,733,130	11,595,061	2.8%
Unrestricted	(82,972,539)	(595,737,477)	512,764,938	86.1%
TOTAL NET POSITION	**$ 965,313,252**	**$ 448,672,418**	**$ 516,640,834**	115.1%

Total assets increased $616.3 million as of June 30, 2021. This change in assets reflects a decrease of $235.7 million in current assets offset against increases of $94.8 million and $757.2 million in net capital assets and other noncurrent assets, respectively. The decrease in current assets is primarily due to a $323.7 million decrease in current cash and cash equivalents that was largely driven by a $454.0 million transfer of available cash to investments during fiscal year 2021. Total current accounts receivable increased by $60.5 million as a result of partial recovery in patient volume, however not to the pre-pandemic levels. Amounts due from the UNC Health Care System increased $27.1 million as a result of increased contract and retail pharmacy operations during the year. Inventory decreased by $6.1 million as pandemic supplies and costs began to stabilize.

Other noncurrent assets increased $757.2 million primarily due to the total investments increase of $808.4 million, which is attributable to the $454.0 million investment of available cash plus $357.1 million in realized and unrealized gains on investments recorded in fiscal year 2021.

Deferred outflows of resources increased from $338.7 million to $373.4 million primarily 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 and 13).

Other current liabilities increased $89.2 million from June 30, 2020. This increase was primarily from the $55.3 million increase in the current portion of estimated third party

settlements which was largely driven by increased Upper Payment Limit (UPL) reserves at year-end. The increase in other current liabilities also included a $100.0 million increase in amounts due to the UNC Health Care System and affiliates offset against a $96.8 million decrease in advanced payments resulting from the recognition of $80.0 million in UPL revenue and $16.8 million in recoupments for the Medicare Accelerated and Advanced Payments program.

Other noncurrent liabilities increased $36.8 million primarily from an increase in estimated third party settlements associated with Medicaid reserves.

Deferred inflows of resources increased $51.0 million as a result of changes in actuarial assumptions related to the other postemployment benefits in accordance with GASB Statement No. 75.

Net position increased $516.6 million, primarily due to the $165.9 million increase in operating income and the $332.5 million increase in net investment income. For further information on the changes in operating income and investment activity, see the following statement of revenues, expenses, and changes in net position section.

Capital Assets

The Hospitals expended $156.1 million on the acquisition and construction of buildings, infrastructure, major renovations, and the replacement of routine capital equipment during the fiscal year. Various capital projects are underway with the most notable being the surgical tower projects at the UNC Medical Center campus in Chapel Hill and the UNC Hospitals Hillsborough campus. The UNC Medical Center surgical tower project will provide new space and modernize a significant number of operating and intensive care rooms located on the UNC Medical Center campus. This project is expected to be completed in Spring 2024. The Hillsborough Bed Tower II project creates additional rehabilitation and medical and surgical capacity at the UNC Hospitals Hillsborough campus, which in turn should decompress and allow for new volume at the main UNC Medical Center campus. This project is expected to be completed in Spring 2022.

Work was also completed on the Ground Floor Neuroscience Behavioral Health Unit. This project renovated the ground floor of the Neurosciences Hospital to accommodate new patient behavioral health and medical rooms.

Finally, the generator plant project is currently underway and will provide a facility to house the generators required to provide emergency power for the entire UNC Medical Center campus. This project will also modernize the standard and emergency power equipment in each hospital building as required by code. More information on this activity can be found in Note 6.

Long-term Debt Activities

At June 30, 2021, the Hospitals had outstanding bond indebtedness in the amount of $475.5 million, of which $14.7 million is due within the next year. Standard & Poor's and Moody's Rating Services classify these bonds at AA and Aa3, respectively. During the current fiscal year, the Hospitals issued refunding bonds for the 2010B series bonds.

The current outstanding indebtedness of the Hospitals is described in Note 7.

Condensed 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, 2021 and 2020:

	FY21	FY20 (As Restated)	Change	% Change
Net Patient Service Revenue	$ 2,361,574,427	$ 2,062,880,244	$ 298,694,183	14.5%
Other Operating Revenues	36,225,406	36,755,943	(530,537)	(1.4)%
TOTAL OPERATING REVENUES	2,397,799,833	2,099,636,187	298,163,646	14.2%
Salaries and Benefits	879,417,764	876,410,973	3,006,791	0.3%
Medical and Surgical Supplies	692,954,059	556,821,522	136,132,537	24.4%
Contracted Services	394,052,872	390,304,913	3,747,959	1.0%
Other Supplies and Services	88,252,704	100,354,031	(12,101,327)	(12.1)%
Depreciation and Amortization	86,554,847	85,117,567	1,437,280	1.7%
TOTAL OPERATING EXPENSES	2,141,232,246	2,009,009,006	132,223,240	6.6%
OPERATING INCOME	256,567,587	90,627,181	165,940,406	183.1%
State Aid - Coronavirus	3,000,000	-	3,000,000	100.0%
Federal Aid - COVID-19	11,664,146	40,682,689	(29,018,543)	(71.3)%
Investment Income, Net	357,148,076	24,648,791	332,499,285	1348.9%
Other Nonoperating Revenues	16,967,108	1,391,560	15,575,548	1119.3%
Nonoperating Expenses	(15,898,207)	(16,110,476)	212,269	(1.3)%
NET NONOPERATING REVENUES	372,881,123	50,612,564	322,268,559	636.7%
Health Care System Assessments	(112,807,876)	(76,840,690)	(35,967,186)	46.8%
INCREASE IN NET POSITION	**516,640,834**	**64,399,055**	**452,241,779**	702.2%
NET POSITION - BEGINNING OF YEAR, AS RESTATED	**448,672,418**	**417,026,691**	**31,645,727**	7.6%
RESTATEMENTS		(32,753,328)	32,753,328	100.0%
NET POSITION - END OF YEAR	**$ 965,313,252**	**$ 448,672,418**	**$ 516,640,834**	115.1%
TOTAL REVENUES	$ 2,786,579,163	$ 2,166,359,227	$ 620,219,936	28.6%
TOTAL EXPENSES	2,269,938,329	2,101,960,172	167,978,157	8.0%
INCREASE IN NET POSITION	$ 516,640,834	$ 64,399,055	$ 452,241,779	702.2%

Net patient revenue increased $298.7 million or 14.5% year over year. Significant growth in the external contract and retail pharmacy operations contributed to $102.2 million of this net patient revenue increase. Fiscal year 2021 showed partial rebound in patient volume, however not fully to pre-pandemic levels. Most key statistics increased over prior year including a 3.2% increase in patient days and a 5.0% increase in total surgeries. Emergency visits continued to decline year over year by 7.4%. Volume and revenue decreased in the 3rd quarter of the fiscal year with the COVID surge, with improvements in the last quarter of the fiscal year.

Operating expenses increased $132.2 million over the prior year. The primary driver was medical and surgical supplies which increased by $136.1 million. $90.2 million of this increase was from increases to drug and pharmaceutical expenses. Volume growth in non-specialty, retail, and external contract pharmacy drove the increase in pharmaceutical expense. Other supplies and services decreased by $12.1 million year over year due to a decrease in the UNC Health Care shared services expense allocation. These savings were driven by labor and other expense efficiencies.

Net nonoperating revenues increased $322.3 million over last year primarily as a result of the increase in net investment income of $332.5 million that was largely the result of increased market performance of the UNC Investment Fund. 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. Federal Aid – COVID 19 decreased $29.0 million as a result of reduced funding received from the U.S. Department of Health and Human Services for the Provider Relief Funds program. Other nonoperating revenues increased $15.6 million primarily as a result of $16.4 million in noncapital contributions recognized under the Retiree Health Benefit Fund component of other postemployment benefits.

UNC 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. The assessments totaling $112.8 million are determined, in part, by financial performance and these assessments increased when comparing fiscal year 2021 to 2020. These assessments are described in more detail in Note 17.

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 continued investment in support of clinical education and research programs of UNC Faculty Physicians, 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. Infrastructure investments are being made to modernize our patient care as demonstrated by the level of ongoing capital investment despite economic pressures.

Inpatient census at the Hospitals is regularly near maximum capacity. We continue to address this need with the reallocation of six additional beds on the Neurosurgical ICU unit that were put in service during fiscal year 2021. The completion and opening of the Hillsborough Bed Tower II in Spring 2022 will create greater campus capacity and utilization, which will help to decompress the main campus in Chapel Hill. Work continues on the construction of a surgical tower on the Chapel Hill campus that began construction in Fall 2018 with expected completion in Spring 2024. These facilities are designed to optimize efficiency and the patient experience and allow for an appropriate and safe care environment. Continued focus on length of stay reduction is also targeted to help address capacity issues.

Strong growth in External Contract and Retail Pharmacy continued in fiscal year 2021 and is expected to continue for fiscal year 2022. Retail and Specialty Pharmacy contributed $107.0 million of the total fiscal year 2021 operating income, helping to offset other operations still impacted by COVID-19.

The Hospitals, in a joint effort with UNC Faculty Physicians, began a multi-year effort to optimize square footage utilization on the Medical Center campus and off-campus locations. These enhancements have and 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. The opening of the Eastowne multi-specialty clinic in Spring of 2021 reflects that direction.

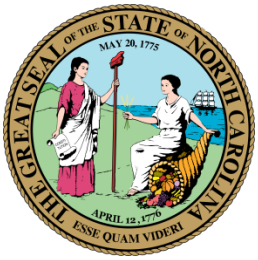
Third-party payors, including governmental sponsored programs, continue to migrate from fee-for-service to fee-for-value. UNC Health Care has positioned itself to be a leader in the new health care environment that will ultimately reimburse less for services currently provided to our patients. We have implemented programs aimed at different aspects of population health management at each of our medical institutions. The Hospitals also participates in the UNC Health Alliance, a Clinically Integrated Network. The Health Alliance started participating in Centers for Medicare & 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 has allowed UNC Health Care to more rapidly scale and ramp-up our initiatives when appropriate.

Risk to payment levels for Medicaid patients is expected in fiscal year 2022 with the transition to Medicaid Managed Care. Management is monitoring this closely to ensure minimization of denials and other adverse impacts.

While there was a rebound in key statistics from the beginning of the pandemic in fiscal year 2020, the Hospitals saw a surge of cases in the third quarter of fiscal year 2021 with a leveling off in the fourth quarter as a result of vaccinations, while State and Federal Aid associated with the coronavirus pandemic decreased when compared with prior year. Management put operational plans in place to maintain efficiency, productivity, and further mitigate operational challenges and associated financial impacts.

The introduction of the Delta variant, as well as a lower percentage of vaccinated individuals than expected, has created another significant surge in quarter one of fiscal year 2022 and creates continued uncertainty. Given the daily evolution of the COVID-19 pandemic and the global response to curb its spread, the Hospitals is not able to estimate the effects of the COVID-19 pandemic on its results of operations, financial condition, or liquidity for fiscal year 2022.

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, 2021

Exhibit A-1
Page 1 of 2

ASSETS		
Current Assets:		
Cash and Cash Equivalents (Note 2)	$	107,708,624
Restricted Cash and Cash Equivalents (Note 2)		1,382,273
Receivables:		
Patient Accounts Receivable, Net (Note 4)		276,677,436
Other Accounts Receivable		54,818,408
Due from State of North Carolina Component Units		138,450,193
Estimated Third Party Settlements (Note 5)		9,508,736
Inventories		95,691,404
Prepaid Expenses		50,396,618
Total Current Assets		734,633,692
Noncurrent Assets:		
Restricted Cash and Cash Equivalents (Note 2)		152,903,052
Restricted Investments (Note 2)		401,983,458
Assets Limited as to Use (Note 2)		1,285,584,996
Advanced Deposits with Liability Insurance Trust Fund (Note 14)		16,713,537
Patient Accounts Receivable, Net (Note 4)		1,087,805
Prepaid Expenses		142,087,705
Investments in Affiliates (Note 18)		27,313,777
Capital Assets, Net (Note 6)		909,517,356
Net Other Postemployment Benefits Asset		1,732,999
Total Noncurrent Assets		2,938,924,685
Total Assets		3,673,558,377
DEFERRED OUTFLOWS OF RESOURCES		
Accumulated Decrease in Fair Value of Hedging Derivatives		7,887,997
Deferred Loss on Refunding		4,893,008
Deferred Outflows Related to Pensions (Note 12)		152,178,950
Deferred Outflows Related to Other Postemployment Benefits (Note 13)		208,459,359
Total Deferred Outflows of Resources		373,419,314
LIABILITIES		
Current Liabilities:		
Accounts Payable and Accrued Liabilities		122,423,490
Advanced Payments (Note 16)		148,995,875
Accrued Salaries and Benefits		60,044,281
Due to State of North Carolina Component Units		167,930,356
Estimated Third Party Settlements (Note 5)		144,023,819
Due to Patients or Third Parties		25,446,380
Interest Payable		4,997,775
Long-Term Liabilities - Current Portion (Note 7)		33,221,302
Total Current Liabilities		707,083,278

Noncurrent Liabilities:	
Estimated Third Party Settlements (Note 5)	97,213,388
Hedging Derivative Liability (Note 8)	7,887,997
Long-Term Liabilities (Note 7)	1,832,911,613
Total Noncurrent Liabilities	1,938,012,998
Total Liabilities	2,645,096,276
DEFERRED INFLOWS OF RESOURCES	
Deferred Inflows Related to Pensions (Note 12)	0
Deferred Inflows Related to Other Postemployment Benefits (Note 13)	436,568,163
Total Deferred Inflows of Resources	436,568,163
NET POSITION	
Net Investment in Capital Assets	625,957,600
Restricted for Expendable (Note 1)	422,328,191
Unrestricted	(82,972,539)
Total Net Position	$ 965,313,252

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, 2021

Exhibit A-2

OPERATING REVENUES	
Net Patient Service Revenue (Note 11)	$ 2,361,574,427
Other Operating Revenues	36,225,406
Total Operating Revenues	2,397,799,833
OPERATING EXPENSES	
Salaries and Benefits	879,417,764
Medical and Surgical Supplies	692,954,059
Contracted Services	394,052,872
Other Supplies and Services	88,252,704
Depreciation and Amortization	86,554,847
Total Operating Expenses	2,141,232,246
Operating Income	256,567,587
NONOPERATING REVENUES (EXPENSES)	
State Aid - Coronavirus (Note 16)	3,000,000
Federal Aid - COVID-19 (Note 16)	11,664,146
Noncapital Contributions	16,379,463
Investment Income (Net of Investment Expense of $2,705,078)	357,148,076
Interest and Fees on Debt	(15,149,134)
Loss on Disposal of Capital Assets	(749,073)
Other Nonoperating Revenues	587,645
Net Nonoperating Revenues	372,881,123
Income Before Other Expenses	629,448,710
Health Care System Assessments (Note 17)	(112,807,876)
Increase in Net Position	516,640,834
NET POSITION	
Net Position - July 1, 2020, as Restated (Note 20)	448,672,418
Net Position - June 30, 2021	$ 965,313,252

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 — *Exhibit A-3*
For the Fiscal Year Ended June 30, 2021 —

CASH FLOWS FROM OPERATING ACTIVITIES	
Received from Patients or Third Parties	$ 2,318,465,449
Payments to Employees and Fringe Benefits	(873,741,642)
Payments to Vendors and Suppliers	(1,144,145,775)
Other Payments	(3,253,281)
Net Cash Provided by Operating Activities	297,324,751
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
State Aid - Coronavirus	3,000,000
Federal Aid - COVID-19	11,664,146
Health Care System Assessments	(73,000,190)
Principal Paid on Revenue Bonds	(1,496,000)
Interest and Fees Paid on Revenue Bonds	(211,026)
Noncapital Gifts and Grants	19,497
Net Cash Used by Noncapital Financing Activities	(60,023,573)
CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES	
Acquisition and Construction of Capital Assets	(147,432,719)
Principal Paid on Capital Revenue Bonds	(12,529,000)
Interest and Fees Paid on Capital Debt	(17,574,171)
Proceeds from Sale of Capital Assets	353,386
Federal Interest Subsidy on Debt Received	598,341
Net Cash Used by Capital Financing and Related Financing Activities	(176,584,163)
CASH FLOWS FROM INVESTING ACTIVITIES	
Interest Income	2,760,950
Investment Purchases	(454,000,000)
Investments in and Loans to Affiliated Enterprises	(1,985,204)
Net Cash Used by Investing Activities	(453,224,254)
Net Decrease in Cash and Cash Equivalents	(392,507,239)
Cash and Cash Equivalents - July 1, 2020	654,501,188
Cash and Cash Equivalents - June 30, 2021	$ 261,993,949

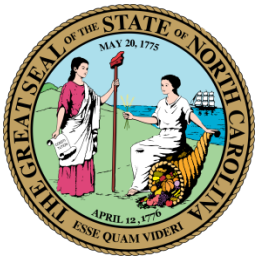
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

Operating Income	$	256,567,587
Adjustments to Reconcile Operating Income to Net Cash Provided by Operating Activities:		
Depreciation/Amortization Expense		86,554,847
Changes in Assets and Deferred Outflows of Resources:		
Patient Accounts Receivable, Net		(48,629,338)
Due from State of North Carolina Component Units		(27,138,262)
Estimated Third Party Settlements		95,797,826
Other Accounts Receivable		(12,340,425)
Inventories		6,116,240
Prepaid Expenses		(46,870,049)
Advanced Deposits with Liability Insurance Trust Fund		(928,095)
Net Other Postemployment Benefits Asset		(292,687)
Deferred Outflows Related to Pensions		(21,446,564)
Deferred Outflows Related to Other Postemployment Benefits		(17,582,870)
Changes in Liabilities and Deferred Inflows of Resources:		
Accounts Payable and Accrued Liabilities		12,564,577
Advanced Payments		(96,802,262)
Accrued Salaries and Benefits		4,918,156
Due to Patients or Third Parties		6,524,796
Due to State of North Carolina Component Units		60,231,187
Net Pension Liability		61,020,880
Net Other Postemployment Benefits Liability		(77,955,617)
Compensated Absences		6,024,562
Deferred Inflows Related to Pensions		(2,869,744)
Deferred Inflows Related to Other Postemployment Benefits		53,860,006
Net Cash Provided by Operating Activities	$	297,324,751

NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES

Change in Fair Value of Investments	$	357,092,204
Loss on Disposal of Capital Assets		(749,073)
Assets Acquired through the Assumption of a Liability		8,836,164
Amortization of Bond Premium		(1,742,762)
Decrease in Net Other Postemployment Benefits Liability Related to Noncapital Contributions		16,379,463
Funds Escrowed to Defease Debt		28,280,000

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 951 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 *Annual Comprehensive Financial Report*.

The accompanying financial statements present all funds belonging to the Hospitals 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. Other related foundations and similar nonprofit corporations for which the Hospitals is not financially accountable are not part of the accompanying financial statements.

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,* and GASB Statement No. 84, *Fiduciary Activities,* 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 state appropriations, 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 72 months depending on the outstanding

balance due. A third-party financing option is made available for all patients needing longer than the 140-day collection cycle to pay. These payment plans are monitored by a third-party partner. 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, billings to outside companies for ancillary testing, critical care transportation, and pharmacy supplies.

I. Prepaid Expenses - Prepaid expenses represent prepayments for services to be rendered in future periods. Prepaid expenses that will be consumed within the next fiscal year are classified as current, while prepaid expenses that will be consumed beyond the next fiscal year are classified as noncurrent. These prepayments are amortized over a period of 2 to 18 years using the straight-line method.

J. 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.

K. Capital Assets - Capital asset acquisitions are recorded at cost or acquisition value at date of donation in the case of gifts. Donated capital assets acquired prior to July 1, 2015 are stated at fair value as of the date of donation. The value of assets constructed includes all material direct and indirect construction costs.

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

L. 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).

M. 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, unspent debt proceeds, and resources designated for liability insurance claims. Current restricted resources include certain trust funds restricted because external parties or statute limits their use.

N. Accounting and Reporting of Fiduciary Activities - Pursuant to the provisions of GASB Statement No. 84, *Fiduciary Activities*, custodial funds that are normally expected to be received and disbursed within a 3-month period or otherwise do not meet the fiduciary activity criteria defined by GASB Statement No. 84 continue to be reported in the Statement of Net Position as a component of Due to Patients or Third Parties and as operating activities in the Statement of Cash Flows.

There are no other trust or custodial funds meeting the criteria of a fiduciary activity that are required to be reported in separate fiduciary fund financial statements.

O. 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. Debt is defined as a liability that arises from a contractual obligation to pay cash (or other assets that may be used in lieu of cash) in one or more payments to settle an amount that is fixed at the date the contractual obligation is established. Long-term debt includes revenue bonds payable. Other long-term liabilities include: compensated absences, net pension liability, net other postemployment benefits (OPEB) liability, and other liabilities.

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 2020 *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 2020 *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.

P. 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 25% 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.

Q. Deferred Outflows/Inflows of Resources - Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. Deferred inflows of resources represent an acquisition of net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then.

R. 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, 2021 are as follows:

Net Position Restricted for Expendable:		
Maintenance Reserve Fund	$	401,983,458
Liability Insurance Trust Fund		16,713,537
Employee Benefit Plan - DIPNC		2,911,520
Trust Fund Donations		719,676
Total Net Position Restricted for Expendable	$	422,328,191

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.

S. 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.

T. 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, 2020, (less amounts previously recorded at June 30, 2020, for in house patients) and all charges on in house accounts and all charges for outpatient accounts registered after June 30, 2020. 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.

U. 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 statue 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, 2021, the amount shown on the Statement of Net Position as cash and cash equivalents includes $99,442,823, 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 1.3 years as of June 30, 2021. 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, 2021 was $39,641. The carrying amount of the Hospitals' deposits not with the State Treasurer, including unspent bond proceeds of $152,903,052 held by a fiscal agent and invested with the State Treasurer, was $162,511,485, and the bank balance was $164,084,333. 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, 2021, $750,000 of the Hospitals' bank balance was insured and collateralized, and $10,431,281 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, 2021, the Statement of Net Position reported investments and assets limited as to use of $1,687,568,454, 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.

NOTE 3 - FAIR VALUE MEASUREMENTS

To the extent available, the Hospitals' investments and derivatives are recorded at fair value as of June 30, 2021. 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, within the fair value hierarchy at June 30, 2021:

		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	$ 99,442,823			
UNC Investment Fund	1,687,568,454			
Total Investments as a Position in an External Investment Pool	$ 1,787,011,277			
Derivative Instruments				
Hedging Derivative Instruments				
Interest Rate Swap	$ (7,887,997)	$ 0	$ (7,887,997)	$ 0

Short-Term Investment Fund - Ownership interests of the STIF are 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, 2021. 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, 2021:

	Amount
In House Patients	$ 118,413,539
Discharged (Not Final Billed) Patients	157,702,082
Total Unbilled	276,115,621
Discharged (Billed) Patients	389,469,185
Payment Arrangements	2,142,905
Charity Care Provided	(48,905,637)
Current Gross	618,822,074
Allowance for Bad Debts	(100,983,493)
Contractual Allowances	(241,161,145)
Total Allowances	(342,144,638)
Current - Net	$ 276,677,436

The noncurrent net patient accounts receivable under flexible payment arrangement reflected in the accompanying Statement of Net Position is $1,087,805 as of June 30, 2021.

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 2021. Medicare cost report settlements owed to Medicare are estimated to be $23,721,685 within the next twelve months and $45,320,843 on a noncurrent basis. Traditional Medicaid cost report settlements owed to Medicaid are estimated to be $8,061,264 within the next twelve months and $51,892,545 on a noncurrent basis. Tricare/Champus currently owes the Hospitals $9,508,736. 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, 2018 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 $112,240,870 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, 2021, is presented as follows:

	Balance July 1, 2020 (As Restated)	Increases	Decreases	Balance June 30, 2021
Capital Assets, Nondepreciable:				
Land and Permanent Easements	$ 37,867,360	$ 0	$ 0	$ 37,867,360
Construction in Progress	160,348,682	133,293,703	25,518,172	268,124,213
Goodwill	7,704,529			7,704,529
Total Capital Assets, Nondepreciable	205,920,571	133,293,703	25,518,172	313,696,102
Capital Assets, Depreciable:				
Buildings	914,803,256	26,505,014		941,308,270
Machinery and Equipment	477,027,724	21,684,474	1,203,708	497,508,490
General Infrastructure	5,254,227			5,254,227
Computer Software	10,244,185	126,646		10,370,831
Total Capital Assets, Depreciable	1,407,329,392	48,316,134	1,203,708	1,454,441,818
Less Accumulated Depreciation/Amortization for:				
Buildings	420,054,867	34,252,352		454,307,219
Machinery and Equipment	364,395,724	25,988,514	798,805	389,585,433
General Infrastructure	5,171,604	37,013		5,208,617
Computer Software	8,867,707	651,588		9,519,295
Total Accumulated Depreciation/Amortization	798,489,902	60,929,467	798,805	858,620,564
Total Capital Assets, Depreciable, Net	608,839,490	(12,613,333)	404,903	595,821,254
Capital Assets, Net	$ 814,760,061	$ 120,680,370	$ 25,923,075	$ 909,517,356

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, 2021, is presented as follows:

	Balance June 30, 2020	Additions	Reductions	Balance June 30, 2021	Current Portion
Long-Term Debt					
Revenue Bonds Payable	$ 441,510,000	$ 28,280,000	$ 42,305,000	$ 427,485,000	$ 14,700,000
Plus: Unamortized Premium	49,721,102		1,742,762	47,978,340	
Total Long-Term Debt	491,231,102	28,280,000	44,047,762	475,463,340	14,700,000
Other Long-Term Liabilities					
Other Liabilities	1,579,020	432,019		2,011,039	
Employee Benefits					
Compensated Absences	45,315,492	86,149,691	80,125,129	51,340,054	18,521,302
Net Pension Liability	308,079,994	61,020,880		369,100,874	
Net Other Postemployment Benefits Liability	1,062,552,688		94,335,080	968,217,608	
Total Other Long-Term Liabilities	1,417,527,194	147,602,590	174,460,209	1,390,669,575	18,521,302
Total Long-Term Liabilities	$ 1,908,758,296	$ 175,882,590	$ 218,507,971	$ 1,866,132,915	$ 33,221,302

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.

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, 2021	Principal Outstanding June 30, 2021
Rex Acquisition and Hospital Renovations	2001A	0.02%*	02/15/2031	$ 55,000,000	$ 14,900,000	$ 40,100,000
	2001B	0.02%*	02/15/2031	55,000,000	14,900,000	40,100,000
Refund Portion of 1996 Revenue Bonds	2003A	3.45%**	02/01/2029	63,770,000	25,990,000	37,780,000
	2003B	3.45%**	02/01/2029	34,245,000	13,930,000	20,315,000
Refund 1999 Revenue Bonds	2009A	3.58%**	02/01/2024	44,290,000	33,320,000	10,970,000
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
Surgical Tower and Support Facilities	2019	3.00% to 5.00%	02/01/2049	149,995,000		149,995,000
Refund 2010 Revenue Bonds	2021A	1.74%	02/01/2031	28,280,000		28,280,000
Total Revenue Bonds Payable (principal only)				$ 530,525,000	$ 103,040,000	427,485,000
Plus: Unamortized Premium						47,978,340
Total Revenue Bonds Payable						$ 475,463,340

* For variable rate debt, interest rates in effect at June 30, 2021 are included. For variable rate debt with interest rate swaps, the synthetic fixed rates are included based on rates in effect at June 30, 2021.

** For variable rate debt with interest rate swaps, the synthetic fixed rates are included based on rates in effect at June 30, 2021.

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 legal 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.

On September 11, 2020, the Hospitals exercised its prerogative under Section 9.4 of the Series Indenture to remove Wells Fargo Bank, N.A., as the remarketing agent for both series. On that date, TD Securities (USA) LLC agreed to act as the exclusive agent in connection with the remarketing and sale of both series.

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, TD Securities (USA) LLC has agreed to exercise its best efforts to remarket the 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 February, May, August, and November, commencing November 1, 2020 and is equal to 0.05% of the outstanding principal amount of the bonds assigned to each agent.

Under separate Standby Bond Purchase Agreements for the Series 2001A and Series 2001B (Agreements) between the Hospitals and TD Bank, N.A., 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 February, May, August, and November thereafter until the expiration date or the termination date of the Agreements. On September 11, 2020, the Hospitals entered into a new multiple year agreement with TD Bank, N.A. to provide liquidity service at a fee of 0.32%, effective September 11, 2020. 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
A+	A1	0.32%
A	A2	0.57%
A-	A3	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 any 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.

Under the Agreements, 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 Base Rate (equal to the greater

of the Prime Rate, the Federal Funds Rate plus 0.50%, or 3.00%) until 180 days after the initial date of purchase, and thereafter bear interest at the Base Rate plus 1.00% per annum and thereafter. Upon remarketing of Bank Bonds and the receipt of the sales price by the Liquidity Provider, such bonds are no longer considered Bank Bonds. Payment of the interest on the Bank Bonds is on the first business day of each calendar month following the date on which such Bank Bond became a Bank Bond. As of June 30, 2021, 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 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 Agreements 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 $80,200,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $22,651,693, $22,186,150, $21,345,697, and $20,505,244, in years one, two, three, and four, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 3.25% (Prime Rate) for the first 180 days and a rate of 4.25% (Base Rate plus 1.00%) thereafter. The expiration date of the Agreements is September 10, 2027.

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.

On July 24, 2020, the Hospitals entered into a Standby Bond Purchase Agreement with TD Bank, N.A. replacing Wells Fargo Bank, N.A. Also, on July 24, 2020, the Hospitals exercised its prerogative under Section 9.4 of the Series Indenture and signed a new remarketing agent agreement with TD Securities (USA) LLC (Series 2003B) removing Wells Fargo Bank, N.A. as remarketing agent.

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, Bank of America Securities, LLC (Series 2003A) and TD Securities (USA) LLC (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 0.05% of the

outstanding principal amount of the bonds assigned to the Remarketing Agent for Series 2003B. Bank of America Securities, LLC agreed to reduce their remarketing fee to 0.05% effective June 16, 2021 for the Series 2003A.

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 TD Securities (USA) LLC (Series 2003B), Liquidity Facilities have been established for the Tender Agent to draw amounts sufficient to pay the purchase price on bonds delivered for purchase when remarketing proceeds or other funds are not available.

The 2003A Agreement with Bank of America, N.A. required a Commitment Fee of 0.31% for fiscal year 2021. Payments are made quarterly in arrears, on the first business day of each November, February, May, and August thereafter 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	0.51%
B- or lower	A3 or lower	0.71%

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, 2021, 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 $37,780,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $14,364,275, $13,860,539, and $13,136,423 in years one, two, and three, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 4.75% (Prime plus 1.50%). The current expiration date of the Agreement is July 2, 2024.

The 2003B Agreement with TD Bank, N.A. required a Commitment Fee of 0.32% for fiscal year 2021. Payments are to be made quarterly in arrears, on the first business day of each February, May, August, and November, commencing August 3, 2020. 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+	0.032%
A2	A	0.057%
A3	A-	0.089%

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 purposed of calculating the Commitment Fee. In addition, should any 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.

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 Base Rate (equal to the greater of the Prime Rate, the Federal Funds Rate plus 0.50%, or 3.00%) until 180 days after the initial date of purchase, and thereafter bear interest 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. As of June 30, 2021, 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" 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 2003B 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 $20,315,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $5,737,770, $5,619,846, $5,406,955, and $5,194,065 in years one, two, three, and four, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 3.25% (Prime Rate) for the first 180 days and a rate of 4.25% (Base Rate plus 1.00%) thereafter. The expiration date of the agreement is July 8, 2027.

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 contracted with TD Bank, N.A. as the Liquidity Provider for Series 2009A bonds through a Standby Bond Purchase Agreement which was subsequently amended and restated on August 28, 2020 (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 (equal to the greater of the Prime Rate, the Federal Funds Rate plus 0.50%, or 3.00%) until 180 days after the initial date of purchase, and bear interest thereafter at the Base Rate plus 1.00% per annum and thereafter. Upon remarketing of Bank Bonds and the receipt of the sales price by the Liquidity Provider, such bonds are no longer considered Bank Bonds. Payment of the interest on the Bank Bonds is on the first business day of each calendar month following the date on which such Bank Bond became a Bank Bond. At June 30, 2021, there were no Bank Bonds held by the 2009A Liquidity Facility.

The 2009A Agreement with TD Bank, N.A. requires a Commitment Fee of 0.27% commencing on August 28, 2020. Payments are to be made quarterly in arrears, on the first business day of each February, May, August, and November, commencing November 2, 2020. 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+	0.27%
A2	A	0.52%
A3	A-	0.84%

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 $10,970,000 of demand bonds was "put" and not resold, the Hospitals would be required to pay $3,098,367, $3,036,287, $2,921,327, and $2,806,367 in years one, two, three and four, respectively, following the termination date under the installment loan agreement assuming a Base Rate of 3.25% (Prime Rate) for the first 180 days and a rate of 4.25% (Base Rate plus 1.00%) thereafter. The expiration date of the agreement is February 1, 2024.

D. Terms of Debt Agreements - The Hospitals' debt agreements are subject to the following collateral requirements and terms with finance-related consequences:

Revenue Bonds Payable - The Hospitals has pledged future revenues as collateral for the revenue bonds payable, and certain funds held have been reserved as restricted equal to 7.5% of gross patient revenues as stipulated by the bond covenants. In the event of default, the bonds will become immediately due and payable. At such time, the UNC Board of

Governors may require that a sum sufficient to pay all matured installments of principal and interest due, be deposited with the Hospitals' Trustee. Additionally, the bonds can be replaced with a replacement indenture. The owners of the outstanding bonds may be required to accept the replacement bonds in lieu of the bonds held by them. Any such replacement may result in a reduction or material alteration in the covenants and other provisions provided to secure payment of the outstanding bonds.

E. Annual Requirements - The annual requirements to pay principal and interest on the long-term obligations at June 30, 2021, are as follows:

	Annual Requirements		
	Revenue Bonds Payable		
Fiscal Year	Principal	Interest	Interest Rate Swaps, Net
2022	$ 14,700,000	$ 12,047,050	$ 2,238,195
2023	15,320,000	11,997,928	1,890,383
2024	15,955,000	11,948,304	1,526,243
2025	16,665,000	11,896,921	1,209,644
2026	17,375,000	11,845,386	964,780
2027-2031	97,530,000	58,422,616	1,317,936
2032-2036	13,325,000	56,330,500	
2037-2041	16,675,000	53,232,450	
2042-2046	128,140,000	38,997,916	
2047-2049	91,800,000	9,329,250	
Total Requirements	$ 427,485,000	$ 276,048,321	$ 9,147,181

Interest on variable rate 2001 A&B, 2003 A&B, and 2009A revenue bonds is calculated at 0.02%, 0.02%, 0.03%, 0.03% and 0.03% at June 30, 2021.

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.

F. Bond Defeasance - The Hospitals has extinguished long-term debt obligations by the issuance of new long-term debt instruments as follows:

On February 1, 2021, the Hospitals issued $28,280,000 in Series 2021A revenue refunding bonds with an average interest rate of 1.74%. The bonds were issued for a current refunding of $28,280,000 of outstanding Series 2010B revenue bonds with an average interest rate of 6.25%. The refunding was undertaken to reduce total debt service payments by $7,440,582 over the next 10 years and resulted in an economic gain of $6,388,232. The substitution of essentially risk-free monetary assets with monetary assets that are not essentially risk-free is not prohibited.

NOTE 8 - DERIVATIVE INSTRUMENTS

Derivative instruments held at June 30, 2021 are as follows:

Type	Notional Amount	Change in Value Classification	Change in Value (Increase) Decrease	Value at June 30, 2021 Classification	Value at June 30, 2021 Liability
Hedging Derivative Instruments					
Cash Flow Hedges					
Pay-Fixed Interest Rate Swap	$ 58,095,000	Deferred Outflow of Resources	$ (3,028,534)	Hedging Derivative	$ 7,256,224
Pay-Fixed Interest Rate Swap	10,970,000	Deferred Outflow of Resources	(484,459)	Hedging Derivative	631,773
Total Derivative Instruments			$ (3,512,993)		$ 7,887,997

Hedging derivative instruments held at June 30, 2021 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	$ 58,095,000	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	10,970,000	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, 2021.

The Hospitals' interest rate swap hedging derivatives have been determined to be effective as of June 30, 2021 using the synthetic instrument method.

Hedging Derivative Risks

Credit Risk: As of June 30, 2021, 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, 2021, the credit rating for Bank of America, N.A. is Aa2 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, 2021. 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, 2021.

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 - 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, 2021:

Fiscal Year	Amount
2022	$ 10,809,770
2023	11,240,532
2024	11,063,978
2025	10,172,447
2026	8,957,304
2027-2031	24,956,082
2032-2036	1,789,694
Total Minimum Lease Payments	$ 78,989,807

Rental expense for all operating leases during the year was $21,842,876.

NOTE 10 - NET POSITION

Unrestricted net position has been significantly affected by transactions resulting from the recognition of deferred outflows of resources, deferred inflows of resources, and related long-term liabilities, as shown in the following table:

	Amount
Net Pension Liability and Related Deferred Outflows of Resources and Deferred Inflows of Resources	$ (216,921,924)
Net OPEB Liability (Retiree Health Benefit Fund) and Related Deferred Outflows of Resources and Deferred Inflows of Resources	(1,197,504,933)
Effect on Unrestricted Net Position	(1,414,426,857)
Total Unrestricted Net Position Before Recognition of Deferred Outflows of Resources, Deferred Inflows of Resources, and Related Long-Term Liabilities	1,331,454,318
Total Unrestricted Net Position	$ (82,972,539)

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 ($81,166,235). 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, 2021 follows:

	2021
Inpatient	$ 2,615,758,979
Outpatient	3,359,081,052
Charity Care Provided	(261,381,350)
Prior Year Third Party Settlements	19,146,054
Gross Patient Service Revenue	5,732,604,735
Medicare Contractual Allowance	(1,523,540,300)
Medicaid Contractual Allowance	(910,722,006)
Upper Payment Limit	195,670,179
Managed Care Contractual Allowance	(983,889,704)
Other Contractual Allowances	(47,030,465)
Bad Debt	(101,518,012)
Contractual Adjustments	(3,371,030,308)
Net Patient Service Revenue	$ 2,361,574,427

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 membership 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 membership 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.

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, 2021 was 14.78% of covered payroll. Employee contributions to the pension plan were $28,144,752, and the Hospitals' contributions were $69,329,906 for the year ended June 30, 2021.

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 2020 *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. For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the TSERS plan, and additions to/deductions from the TSERS plan's fiduciary net position have been determined on the same basis as they are reported by TSERS.

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 participate 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 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 2020 *Comprehensive Annual Financial Report*.

Net Pension Liability: At June 30, 2021, the Hospitals reported a liability of $369,100,874 for its proportionate share of the collective net pension liability. The net pension liability was measured as of June 30, 2020. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of December 31, 2019, and update procedures were used to roll forward the total pension liability to June 30, 2020. 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, 2020, the Hospitals' proportion was 3.05%, which was an increase of 0.08 from its proportion measured as of June 30, 2019, which was 2.97%.

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	12/31/2019
Inflation	3%
Salary Increases*	3.5% - 8.1%
Investment Rate of Return**	7%

* Salary increases include 3.5% inflation and productivity factor.
** Investment rate of return includes inflation assumption and is net 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, 2019 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, 2020 (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, 2020 is 1.2%.

Discount Rate: The discount rate used to measure the total pension liability was calculated at 7.00% for the December 31, 2019 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, 2020 calculated using the discount rate of 7.00%, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower (6.00%) or 1-percentage point higher (8.00%) than the current rate:

Net Pension Liability		
1% Decrease (6.00%)	Current Discount Rate (7.00%)	1% Increase (8.00%)
$ 664,294,885	$ 369,100,874	$ 121,494,187

Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions: For the year ended June 30, 2021, the Hospitals recognized pension expense of $107,300,934. At June 30, 2021, 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	$ 23,544,046	$ 0
Changes of Assumptions	12,792,301	
Net Difference Between Projected and Actual Earnings on Plan Investments	39,946,627	
Change in Proportion and Differences Between Employer's Contributions and Proportionate Share of Contributions	6,566,070	
Contributions Subsequent to the Measurement Date	69,329,906	
Total	**$ 152,178,950**	$ 0

The amount 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 ending June 30, 2022. 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 Ending June 30:	Amount
2022	$ 31,603,901
2023	21,613,640
2024	17,762,355
2025	11,869,148
Total	$ 82,849,044

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. Faculty and staff 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, 2021, 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 $696,732,291, of which $128,243,482 was covered under ORP. Total employee and employer contributions for pension benefits for the year were $7,694,609 and $8,771,854, 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 2020 *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. For purposes of measuring the net OPEB liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of each plan, and additions to/deductions from each plans' fiduciary net position have been determined on the same basis as they are reported by the 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 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 2020 *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 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 North Carolina General Assembly first taking office on or after February 1, 2007, future coverage as retired employees and retired members of the North Carolina 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 North Carolina

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.

Section 35.21 (c) & (d) of Session Law 2017-57 repeals retiree medical benefits for employees first hired on or after January 1, 2021. The legislation amends Chapter 135, Article 3B of the General Statutes to require that retirees must earn contributory retirement service in the Teachers' and State Employees' Retirement System (or in an allowed local system unit), the Consolidated Judicial Retirement System, or the Legislative Retirement System prior to January 1, 2021, and not withdraw that service, in order to be eligible for retiree medical benefits under the amended law. Consequently, members first hired on and after January 1, 2021 will not be eligible to receive retiree medical benefits.

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 North Carolina General Assembly in the Appropriations Bill. The Hospitals' contractually-required contribution rate for the year ended June 30, 2021 was 6.68% of covered payroll. The Hospitals' contributions to the RHBF were $39,901,155 for the year ended June 30, 2021.

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 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 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 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 North Carolina General Assembly and coincide with the State's fiscal year. The Hospitals' contractually-required contribution rate for the year ended June 30, 2021 was 0.09% of covered payroll. The Hospitals' contributions to DIPNC were $537,591 for the year ended June 30, 2021.

C. Net OPEB Liability (Asset)

Net OPEB Liability: At June 30, 2021, the Hospitals reported a liability of $968,217,608 for its proportionate share of the collective net OPEB liability for RHBF. The net OPEB liability was measured as of June 30, 2020. The total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of December 31, 2019, and update procedures were used to roll forward the total OPEB liability to June 30, 2020. 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, 2020, the Hospitals' proportion was 3.49%, which was an increase of 0.13 from its proportion measured as of June 30, 2019, which was 3.36%.

Net OPEB Asset: At June 30, 2021, the Hospitals reported an asset of $1,732,999 for its proportionate share of the collective net OPEB asset for DIPNC. The net OPEB asset was measured as of June 30, 2020. The total OPEB liability used to calculate the net OPEB asset was determined by an actuarial valuation as of December 31, 2019, and update procedures were used to roll forward the total OPEB liability to June 30, 2020. 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, 2020, the Hospitals' proportion was 3.52%, which was an increase of 0.18 from its proportion measured as of June 30, 2019, which was 3.34%.

Actuarial Assumptions: The total OPEB liabilities for RHBF and DIPNC were determined by actuarial valuations as of December 31, 2019, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified. The total OPEB liabilities were then rolled forward to June 30, 2020 utilizing update procedures incorporating the actuarial assumptions.

	Retiree Health Benefit Fund	Disability Income Plan of N. C.
Valuation Date	12/31/2019	12/31/2019
Inflation	3%	3%
Salary Increases*	3.5% - 8.1%	3.5% - 8.1%
Investment Rate of Return**	7%	3.75%
Healthcare Cost Trend Rate - Medical	6.5% grading down to 5% by 2024	6.5% grading down to 5% by 2024
Healthcare Cost Trend Rate - Prescription Drug	9.5% grading down to 5% by 2029	9.5% grading down to 5% by 2029
Healthcare Cost Trend Rate - Medicare Advantage	5%	N/A
Healthcare Cost Trend Rate - Administrative	3%	3%

* 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, 2020.

Best estimates of real rates of return for each major asset class included in RHBF's target asset allocation as of June 30, 2020 (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, 2020 is 1.2%.

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, 2019 valuations were generally based on the results of an actuarial experience study prepared as of December 31, 2014, as amended for updates to certain assumptions (such as the long-term investment return, medical claims, and medical trend rate assumptions) implemented based on annual reviews that have occurred since that experience study.

Discount Rate: The discount rate used to measure the total OPEB liability for RHBF was 2.21%. 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 2.21% was used as the discount rate used to measure the total OPEB liability. The 2.21% rate is based on the Bond Buyer 20-year General Obligation Index as of June 30, 2020.

The discount rate used to measure the total OPEB liability 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 liability.

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 (1.21%)	Current Discount Rate (2.21%)	1% Increase (3.21%)
RHBF	$ 1,148,255,019	$ 968,217,608	$ 823,183,007
	1% Decrease (2.75%)	Current Discount Rate (3.75%)	1% Increase (4.75%)
DIPNC	$ (1,496,691)	$ (1,732,999)	$ (1,962,439)

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:

	Net OPEB Liability (Asset)		
	1% Decrease (Medical - 4.% - 5.5%, Pharmacy - 4% - 8.5%, Med. Advantage - 4%, Administrative - 2%)	Current Healthcare Cost Trend Rates (Medical - 5% - 6.5%, Pharmacy - 5% - 9.5%, Med. Advantage - 5%, Administrative - 3%)	1% Increase (Medical - 6% - 7.5%, Pharmacy - 6% - 10.5%, Med. Advantage - 6%, Administrative - 4%)
RHBF	$ 780,565,398	$ 968,217,608	$ 1,219,060,165
	1% Decrease (Medical - 4% - 5.5%, Pharmacy - 4% - 8.5%, Administrative - 2%)	Current Healthcare Cost Trend Rates (Medical - 5% - 6.5%, Pharmacy - 5% - 9.5%, Administrative - 3%)	1% Increase (Medical - 6% - 7.5%, Pharmacy - 6% - 10.5%, Administrative - 4%)
DIPNC	$ (1,735,853)	$ (1,732,999)	$ (1,730,498)

OPEB Expense: For the fiscal year ended June 30, 2021, the Hospitals recognized OPEB expense as follows:

OPEB Plan	Amount
RHBF	$ (1,937,644)
DIPNC	1,179,349
Total OPEB Expense	$ (758,295)

Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB: At June 30, 2021, 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	$ 866,236	$ 1,268,812	$ 2,135,048
Changes of Assumptions	43,353,616	134,026	43,487,642
Net Difference Between Projected and Actual Earnings on Plan Investments	2,018,492		2,018,492
Changes in Proportion and Differences Between Employer's Contributions and Proportionate Share of Contributions	120,379,431		120,379,431
Contributions Subsequent to the Measurement Date	39,901,155	537,591	40,438,746
Total	$ 206,518,930	$ 1,940,429	$ 208,459,359

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

	RHBF	DIPNC	Total
Differences Between Actual and Expected Experience	$ 39,491,740	$ 0	$ 39,491,740
Changes of Assumptions	389,923,799	136,890	390,060,689
Net Difference Between Projected and Actual Earnings on Plan Investments		289,973	289,973
Changes in Proportion and Differences Between Employer's Contributions and Proportionate Share of Contributions	6,390,716	335,045	6,725,761
Total	$ 435,806,255	$ 761,908	$ 436,568,163

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 ending June 30, 2022. 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 Ending June 30:	RHBF	DIPNC
2022	$ (110,414,821)	$ 327,542
2023	(110,309,822)	184,832
2024	(28,796,529)	66,464
2025	5,330,538	141,830
2026	(24,997,846)	(25,313)
Thereafter		(54,425)
Total	$ (269,188,480)	$ 640,930

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 and employee contributions. 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 who enroll in the Teachers' and State Employees' Retirement System. This Death Benefit Plan is administered by the

State Treasurer and funded via employer contributions. The employer contribution rate was 0.13% 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 for up to twelve months. The Board of Trustees of the DIPNC may extend the short-term disability benefits for up to an additional twelve months. During the extended period of short-term disability benefits, payments are made directly by the DIPNC to the beneficiary. 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.

The limit of coverage for property and contents is limited to the value reported to the Fund as per the declaration page. In addition to property coverage, the Hospitals added Business Interruption and Extra Expense coverage with a limit of $500,000,000, 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 the deductible increase from $250 to $500 for collision on vehicles less than $75,000. 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 $2,000,000 per claim and $5,000,000 in the aggregate per fiscal year 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 *Annual Comprehensive 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) and Employment Practices Liability (EPL) insurance up to $10,000,000 aggregate with retention of $1,000,000 for DNO, $1,000,000 for EPL, and First Excess insurance with limits of $10,000,000 and Second Excess insurance with limits of $5,000,000;
- Lawyers Professional Liability insurance with limits of $5,000,000 aggregate and $25,000 retention;

- Master Crime insurance up to $500,000 per occurrence with a deductible of $2,500;

- Comprehensive General Liability insurance up to $1,000,000 per occurrence, $50,000 Damage to Rented Premises, $5,000 Medical Payment, $1,000,000 Personal and Advertising Injury, $2,000,000 aggregate with a self-insured retention of $25,000 per occurrence and Excess Liability insurance with limits of $5,000,000 per occurrence and aggregate, with a self-insured retention of $25,000 per occurrence;

- 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 $400,000 for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies Medicare Program (DMEPOS);

- Network Security and Privacy Liability limit of $10,000,000 aggregate, with $1,000,000 self-insured retention per claim, including claims expenses, excess layers of $20,000,000 aggregate limit.

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, 2020, through June 30, 2021, 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, 2021, 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, 2021, the Hospitals' assets in the Trust Fund totaled $25,111,663 while Hospitals' liabilities totaled $8,398,126 resulting in net position of $16,713,537.

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, 5221 Paramount Pkwy, Suite 230, Morrisville, NC 27560.

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 $265,629,898 and on other purchases were $62,842,420 at June 30, 2021.

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 - THE CORONAVIRUS PANDEMIC EMERGENCY

In response to the coronavirus pandemic emergency, the federal government provided grants to the State and the Hospitals through various coronavirus program funds appropriated by (1) The Coronavirus Aid, Relief, and Economic Security Act (CARES), (2) The Coronavirus Response and Relief Supplemental Appropriations within the Federal Consolidated Appropriations Act of 2021 (CRRSA), and (3) The American Rescue Plan Act of 2021 (ARP).

The grant revenues from the various coronavirus program funds are contingent upon meeting the terms and conditions of the grant and signed agreements with the funding agencies, incurring qualifying expenditures, and are reported in the following nonoperating revenue captions of the financial statements:

State Aid - Coronavirus - This caption includes $3,000,000 of grant funds received directly by the State from the U.S. Department of Treasury, Coronavirus Relief Fund (CRF), and appropriated by the State to the Hospitals.

Federal Aid - COVID-19 - This caption includes $11,664,146 of Provider Relief Fund distributions received directly from the U.S. Department of Health and Human Services to reimburse the Hospitals for health care-related expenses or lost revenues not otherwise reimbursed that are directly attributable to COVID-19.

The CARES Act also made other forms of financial assistance available to healthcare providers, including Medicare and Medicaid payment adjustments and an expansion of the Medicare Accelerated and Advanced Payment Program, which makes available accelerated payments of Medicare funds in order to increase cash flow to healthcare providers. Advanced Payments are recorded in the following caption of the financial statements:

Advanced Payments - During the previous fiscal year, the Hospitals received advanced payments of $165,818,250 under the Medicare Accelerated and Advanced Payment program. Recoupment of these advanced payments started in May 2021 and will be spread over a 17-month period with a balloon payment in month 18 for any remaining balance. The recoupment in the first 11 months is 25% of the total Medicare payment and 50% for the final 6 months. As of June 30, 2021, the Hospitals has seen recoupment of $16,822,375 leaving an advance payment balance of $148,995,875.

NOTE 17 - 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.

The Hospitals was assessed $64,097,103 to fund initiatives supported by the System Fund and $48,710,773 to fund System affiliates. The Hospitals has receivables from and payables to the System Fund of $67,310,210 and $55,285,257, respectively, as of June 30, 2021.

University of North Carolina Health Care Shared Administrative Services Fund (Shared Administrative Services Fund) - The Shared Administrative Services Fund within UNC Health Care represents those activities that benefit all of the owned entities such as legal, marketing, human resources, finance, strategic planning, contract pharmacy, risk management, and information technology services. The annual flow of funds involves budgeting the Shared Administrative Services required to support UNC Health Care's operations over the course of the next year and then billing the applicable entities for their allocated share. Managed entities are provided services on a contractual basis.

In 2014, UNC Health Care implemented a new electronic health record and patient accounting system that was funded, in part, by the Hospitals. The funding provided served as a prepayment for the Hospitals' portion of the user fees for the new system. As of June 30, 2021, the outstanding prepaid balance was $23,573,805. The remaining balance will be amortized over five years using the straight-line method. In addition, there are outstanding prepaid balances of $83,110,580 for shared services user fees and rent that will be amortized over 5 to 18 years. The Hospitals has receivables from and payables to the Shared Administrative Services Fund of $33,870,539 and $80,447,405, respectively, as of June 30, 2021.

University of North Carolina Health Care Real Estate Fund (NC Health Properties) - NC Health Properties within UNC Health Care was created to segregate and track real estate holdings in the name of UNC Health Care System and Health System Properties, LLC. This fund will act as a service center to accumulate costs associated with real estate holdings across various UNC Health Care entities which will have rental or use agreements with NC Health Properties.

The Hospitals has funded construction of property held by NC Health Properties in the amount of $69,370,055 in exchange for a prepaid asset for future rental payments that will be amortized over 17 years. Amortization of this prepaid item during the year ending June 30, 2021 was $1,392,382 leaving a balance of $67,977,673 for future years.

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 1,337 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 UNC Hospitals and the outpatient clinics on the UNC campus, there is a growing range of services provided at clinics in the community. There are 22 clinical departments and three administrative units 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 $29,196,040 and the Hospitals paying $56,743,007 to UNCFP during the year ended June 30, 2021. The Hospitals has receivables from and payables to UNCFP of $13,951,076 and $29,844,136, respectively, as of June 30, 2021.

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 $29,882,965 from Rex and the Hospitals paying $12,411,548 to Rex during the year ended June 30, 2021. The Hospitals has receivables from and payables to Rex of $8,004,290 and $964,421, respectively, as of June 30, 2021.

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 $2,124,477 and the Hospitals paying $206,135 to Chatham Hospital, Inc. during the fiscal year for those services. The Hospitals has receivables from and payables to Chatham Hospital, Inc. of $487,833 and $35,355, respectively, as of June 30, 2021.

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 115 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 $20,409,283 for supplies and services during the fiscal year, and the Hospitals paid $31,272,354 to UNC Physicians Network during the year ended June 30, 2021. The Hospitals has receivables from and payables to UNC Physicians Network, LLC of $13,135,206 and $274,411, respectively, as of June 30, 2021.

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 $5,563,622 for services received during fiscal year 2021 and the Hospitals paid $104,976 to Pardee Memorial Hospital for supplies and services during the fiscal year. The Hospitals has receivables from Pardee Memorial Hospital of $533,802 as of June 30, 2021.

UNC Rockingham Health Care - UNC Rockingham Health Care is a nonprofit community hospital located in Eden, North Carolina that offers inpatient, outpatient, surgical and emergency care, and diagnostic and treatment services. In January 2018, the System became the sole member of UNC Rockingham Health Care.

UNC Rockingham Health Care paid the Hospitals $735,907 for services received during fiscal year 2021 and the Hospitals paid UNC Rockingham Health Care $1,547,423 for supplies and services during the fiscal year. The Hospitals has receivables from and payables to UNC Rockingham Health Care of $1,067,369 and $594,686, respectively, as of June 30, 2021.

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 $2,624,224 for services during fiscal year 2021. The Hospitals paid Caldwell Memorial Hospital $2,474,034 for supplies and services during the fiscal year. The Hospitals has receivables from and payables to Caldwell Memorial Hospital of $89,868 and $484,685, respectively, as of June 30, 2021.

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 $2,146,266 for services received during fiscal year 2021. The Hospitals paid Nash Health Care Systems $525,474 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 $3,847,734 for services received during fiscal year 2021. The Hospitals paid Johnston Health Services Corporation $674,243 for supplies and services received during fiscal year 2021.

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 $1,354,420 for services received during fiscal year 2021. The Hospitals paid Wayne Health Corporation $18,487 for supplies and services during the fiscal year.

Lenoir Memorial Hospital, Inc. - Lenoir Memorial Hospital, Inc. is a private, not-for-profit hospital located in Kinston, North Carolina that operates Lenoir Memorial Hospital and several physician practices. It serves patients primarily from Lenoir and neighboring counties. Lenoir Memorial Hospital, Inc. signed a management services agreement with 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 $826,629 for services received during fiscal year 2021 and the Hospitals paid Lenoir Memorial Hospital, Inc. $3,623 for supplies and services during the fiscal year.

Onslow County Hospital Authority - The Onslow County Hospital Authority (Authority), is the sole member of Onslow Memorial Hospital, Inc., Onslow Ambulatory Services, Inc., and Onslow Memorial Hospital Foundation, all of which are nonprofits and are collectively component units of Onslow County, located in Jacksonville, North Carolina. These component units provide a variety of health care, diagnostic, therapeutic, support, administrative, and financial services on behalf of the citizens of Onslow County and the surrounding areas. These component units are blended in the Authority's reporting entity because of their operational or financial relationships with the Authority. On January 1, 2019, the Authority entered into a management services arrangement with UNC Health Care to provide management and operational expertise in order to assist healthcare providers with the provision of inpatient and outpatient services.

The Hospitals paid Onslow County Hospital Authority $298,202 for supplies and services during fiscal year 2021. Activity between the Authority and both the Hospitals and UNC Health Care is expected to increase in the future as opportunities for collaboration continue to develop.

NOTE 18 - INVESTMENT IN AFFILIATES

The Hospitals has investments in affiliates and joint ventures accounted for on the equity method. Investments in affiliates were $27,313,777 at June 30, 2021. 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:

	2021 (Unaudited)
Total Affiliate Activity	
Current Assets	$ 34,453,305
Noncurrent Assets	28,052,171
Current Liabilities	8,403,605
Noncurrent Liabilities	1,547,813
Shareholders' Equity	52,554,058
Revenue	32,682,549
Net Gain	5,634,758
Hospitals' Share of Activity	
Realized Affiliate Gain - Ongoing Operations	$ 3,392,084

NOTE 19 - CHANGES IN FINANCIAL ACCOUNTING AND REPORTING

For the fiscal year ended June 30, 2021, the Hospitals implemented the following pronouncements issued by the Governmental Accounting Standards Board (GASB):

GASB Statement No. 84, Fiduciary Activities

GASB Statement No. 93, Replacement of Interbank Offered Rates

GASB Statement No. 97, Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans

GASB Statement No. 98, The Annual Comprehensive Financial Report

GASB Statement No. 84 improves guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. This Statement establishes criteria for identifying fiduciary activities of all state and local governments. The focus of the criteria generally is on (1) whether a government is controlling the assets of the fiduciary activity, and (2) the beneficiaries with whom a fiduciary relationship exists. Separate criteria are included to identify fiduciary component units and postemployment benefit arrangements that are fiduciary activities. Governments with activities meeting the criteria should present a statement of fiduciary net position and a statement of changes in fiduciary net position. An exception to that requirement is provided for a business-type activity that normally expects to hold custodial assets for 90-days or less.

GASB Statement No. 93 addresses accounting and financial reporting implications that result from the replacement of an Interbank Offered Rate (IBOR).

GASB Statement No. 97's primary objectives are to (1) increase consistency and comparability related to the reporting of fiduciary component units in circumstances in which a potential component unit does not have a governing board and the primary government performs the duties that a governing board typically would perform; (2) mitigate costs associated with the reporting of certain defined contribution pension plans, defined contribution other postemployment benefit (OPEB) plans, and employee benefit plans other than pension plans or OPEB plans (other employee benefit plans) as fiduciary component units in fiduciary fund financial statements; and (3) enhance the relevance, consistency, and comparability of the accounting and financial reporting for Internal Revenue Code (IRC) Section 457 deferred compensation plans (Section 457 plans) that meet the definition of a pension plan and for benefits provided through those plans.

GASB Statement No. 98 establishes the term annual comprehensive financial report and its acronym ACFR. That new term and acronym replace instances of comprehensive annual financial report and its acronym in generally accepted accounting principles for state and local governments.

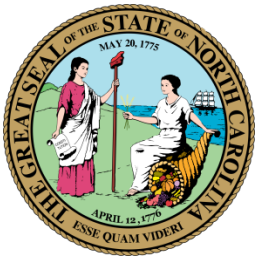
NOTE 20 - NET POSITION RESTATEMENT

As of July 1, 2020, net position as previously reported was restated as follows:

	Amount
July 1, 2020 Net Position as Previously Reported	$ 481,425,746
Restatement:	
Transfer Health System Properties, LLC to the UNC Health Care System	(32,753,328)
July 1, 2020 Net Position as Restated	$ 448,672,418

There was a change in the Hospitals' financial reporting entity and its inclusion of the blended component unit for Health System Properties, LLC (HSP LLC). In previous years, although it was legally separate with the University of North Carolina Health Care System (UNC HCS) as its sole member, HSP LLC was reported as if it were part of the Hospitals. Beginning with the fiscal year ending June 30, 2021, HSP LLC is no longer blended as part of the Hospitals' combined financial report.

HSP LLC was established to purchase, develop and/or lease real property. In prior years, HSP LLC's activities were solely for the benefit of the Hospitals, but with the continued growth of UNC HCS, property is now being managed for entities across the UNC HCS and UNC HCS has created a service center for segregating and tracking the real estate holdings titled in the name of UNC HCS and HSP LLC. The name of this fund is University of North Carolina Health Care Real Estate Fund. See Note 17 for further information related to this new fund.



REQUIRED SUPPLEMENTARY INFORMATION

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of the Proportionate Share of the Net Pension Liability
Cost-Sharing, Multiple-Employer, Defined Benefit Pension Plan
*Last Eight Fiscal Years**

Exhibit B-1

Teachers' and State Employees' Retirement System	**2021**	**2020**	**2019**	**2018**
Proportionate Share Percentage of Collective Net Pension Liability	3.05%	2.97%	2.95%	2.96%
Proportionate Share of TSERS Collective Net Pension Liability	$ 369,100,874	$ 308,079,994	$ 293,449,695	$ 234,902,642
Covered Payroll	$ 467,020,398	$ 445,929,821	$ 424,224,102	$ 410,190,797
Proportionate Share of the Net Pension Liability as a Percentage of Covered Payroll	79.03%	69.09%	69.17%	57.27%
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability	85.98%	87.56%	87.61%	89.51%

	2017	**2016**	**2015**	**2014**
Proportionate Share Percentage of Collective Net Pension Liability	2.87%	2.93%	3.02%	2.90%
Proportionate Share of TSERS Collective Net Pension Liability	$ 263,884,731	$ 107,911,125	$ 35,436,808	$ 176,263,060
Covered Payroll	$ 409,497,038	$ 378,212,144	$ 376,934,884	$ 374,616,224
Proportionate Share of the Net Pension Liability as a Percentage of Covered Payroll	64.44%	28.53%	9.40%	47.05%
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability	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.

* The amounts presented for each fiscal year were determined as of the prior fiscal year ending June 30.

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of Hospitals Contributions
Cost-Sharing, Multiple-Employer, Defined Benefit Pension Plan
Last Ten Fiscal Years ***Exhibit B-2***

Teachers' and State Employees' Retirement System	**2021**	**2020**	**2019**	**2018**	**2017**
Contractually Required Contribution	$ 69,329,906	$ 60,572,546	$ 54,804,775	$ 45,731,358	$ 40,937,042
Contributions in Relation to the Contractually Determined Contribution	69,329,906	60,572,546	54,804,775	45,731,358	40,937,042
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 469,079,198	$ 467,020,398	$ 445,929,821	$ 424,224,102	$ 410,190,797
Contributions as a Percentage of Covered Payroll	14.78%	12.97%	12.29%	10.78%	9.98%

	2016	**2015**	**2014**	**2013**	**2012**
Contractually Required Contribution	$ 37,468,979	$ 34,606,412	$ 32,755,821	$ 31,205,523	$ 27,731,613
Contributions in Relation to the Contractually Determined Contribution	37,468,979	34,606,412	32,755,821	31,205,523	27,731,613
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 409,497,038	$ 378,212,144	$ 376,934,884	$ 374,616,224	$ 372,736,737
Contributions as a Percentage of Covered Payroll	9.15%	9.15%	8.69%	8.33%	7.44%

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
Cost-Sharing, Multiple-Employer, Defined Benefit Pension Plan
For the Fiscal Year Ended June 30, 2021

Changes of Benefit Terms:

	Cost of Living Increase									
Teachers' and State Employees' Retirement System	**2019**	**2018**	**2017**	**2016**	**2015**	**2014**	**2013**	**2012**	**2011**	**2010**
	N/A	N/A	1.00%	N/A	N/A	N/A	1.00%	N/A	N/A	N/A

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 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 the Teachers' and State Employees' Retirement System was lowered from 7.20% to 7.00% for the December 31, 2017 valuation. For the December 31, 2019 valuation, the discount rate was 7.00%.

The Boards of Trustees also adopted a new asset valuation method for the Teachers' and State Employees' Retirement System. For determining plan funding requirements, the plan now uses 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 2020 *Comprehensive Annual Financial Report*.

N/A - Not Applicable

University of North Carolina Hospitals at Chapel Hill
Required Supplementary Information
Schedule of the Proportionate Share of the Net OPEB Liability or Asset
Cost-Sharing, Multiple-Employer, Defined Benefit OPEB Plans
*Last Five Fiscal Years**

Exhibit B-3

Retiree Health Benefit Fund	**2021**	**2020**	**2019**	**2018**	**2017**
Proportionate Share Percentage of Collective Net OPEB Liability	3.49%	3.36%	3.10%	3.07%	3.17%
Proportionate Share of Collective Net OPEB Liability	$ 968,217,608	$ 1,062,552,688	$ 882,281,160	$ 1,007,758,079	$ 1,379,551,642
Covered Payroll	$ 591,265,695	$ 558,877,461	$ 518,813,045	$ 471,296,422	$ 461,240,243
Proportionate Share of the Net OPEB Liability as a Percentage of Covered Payroll	163.75%	190.12%	170.06%	213.83%	299.10%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	6.92%	4.40%	4.40%	3.52%	2.41%
Disability Income Plan of North Carolina					
Proportionate Share Percentage of Collective Net OPEB Asset	3.52%	3.34%	3.23%	3.19%	2.99%
Proportionate Share of Collective Net OPEB Asset	$ 1,732,999	$ 1,440,312	$ 980,591	$ 1,948,442	$ 1,856,726
Covered Payroll	$ 591,265,695	$ 558,877,461	$ 518,813,045	$ 471,296,422	$ 461,240,243
Proportionate Share of the Net OPEB Asset as a Percentage of Covered Payroll	0.29%	0.26%	0.19%	0.41%	0.40%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	115.57%	113.00%	108.47%	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* , as amended.

* The amounts presented for each fiscal year were determined as of the prior fiscal year ending June 30.

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	**2021**	**2020**	**2019**	**2018**	**2017**
Contractually Required Contribution	$ 39,901,155	$ 38,254,890	$ 35,041,628	$ 31,388,189	$ 27,382,322
Contributions in Relation to the Contractually Determined Contribution	39,901,155	38,254,890	35,041,628	31,388,189	27,382,322
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 597,322,680	$ 591,265,695	$ 558,877,461	$ 518,813,045	$ 471,296,422
Contributions as a Percentage of Covered Payroll	6.68%	6.47%	6.27%	6.05%	5.81%

	2016	**2015**	**2014**	**2013**	**2012**
Contractually Required Contribution	$ 25,829,454	$ 22,833,847	$ 21,842,082	$ 20,520,650	$ 18,636,837
Contributions in Relation to the Contractually Determined Contribution	25,829,454	22,833,847	21,842,082	20,520,650	18,636,837
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 461,240,243	$ 415,917,072	$ 404,482,994	$ 387,182,066	$ 372,736,737
Contributions as a Percentage of Covered Payroll	5.60%	5.49%	5.40%	5.30%	5.00%

Disability Income Plan of North Carolina	**2021**	**2020**	**2019**	**2018**	**2017**
Contractually Required Contribution	$ 537,591	$ 591,266	$ 782,429	$ 726,338	$ 1,790,927
Contributions in Relation to the Contractually Determined Contribution	537,591	591,266	782,429	726,338	1,790,927
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 597,322,680	$ 591,265,695	$ 558,877,461	$ 518,813,045	$ 471,296,422
Contributions as a Percentage of Covered Payroll	0.09%	0.10%	0.14%	0.14%	0.38%

	2016	**2015**	**2014**	**2013**	**2012**
Contractually Required Contribution	$ 1,891,085	$ 1,705,260	$ 1,779,725	$ 1,703,601	$ 1,938,231
Contributions in Relation to the Contractually Determined Contribution	1,891,085	1,705,260	1,779,725	1,703,601	1,938,231
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 461,240,243	$ 415,917,072	$ 404,482,994	$ 387,182,066	$ 372,736,737
Contributions as a Percentage of Covered Payroll	0.41%	0.41%	0.44%	0.44%	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.

University of North Carolina Hospitals at Chapel Hill
Notes to Required Supplementary Information
Schedule of Hospitals Contributions
Cost-Sharing, Multiple-Employer, Defined Benefit OPEB Plans
For the Fiscal Year Ended June 30, 2021

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

Effective January 1, 2019, benefit terms related to copays, out-of-pockets maximums, and deductibles were changes for one of four options of the RHBF. Out of pocket maximums increased while certain specialist copays decreased related to option benefits.

Effective January 1, 2020, benefit terms related to copays, out-of-pockets maximums, and deductibles were changes for the 70/30 PPO option of the RHBF. Only the copays were adjusted for 80/20 PPO option of the RHBF.

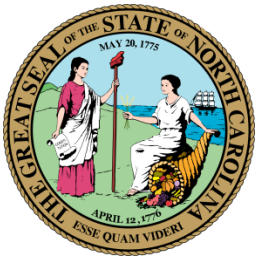
Additionally, the December 31, 2017 Disability Income Plan of North Carolina (DIPNC) actuarial valuation includes a liability for the State's potential reimbursement of health insurance premiums paid by employers during the second six months of the short-term disability benefit period.

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 Hospitals 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 RHBF. The actuarially determined contribution rates in the Schedule of Hospitals 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 DIPNC. 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 RHBF and the DIPNC. 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.

For the actuarial valuation measured as of June 30, 2020, the discount rate for the RHBF was updated to 2.21%. In the prior year, disability rates were adjusted to the non-grandfathered assumptions used in the Teachers' and State Employees' Retirement System actuarial valuation to better align with the anticipated incidence of disability. Medical and prescription drug claim costs were changed based on most recent experience, and medical and prescription drug trend rates were changed to the current schedule. Enrollment assumptions were updated to model expected migrations among RHBF plan options over the next four years. For the DIPNC actuarial valuation as of December 31, 2018, for individuals who may become disabled in the future, the Social Security disability income benefit (which is an offset for the DIPNC benefit) was updated to be based on assumed Social Security calculation parameters in the year of disability. The assumed costs related to the Patient Protection and Affordable Care Act regarding the Health Insurance Provider Fee for the fully insured plans and Excise Tax were removed when those pieces were repealed December 2019.

The Notes to Required Supplementary Information reflect the most recent available information included in the State of North Carolina's 2020 *Comprehensive Annual Financial Report*.



INDEPENDENT AUDITOR'S REPORT

STATE OF NORTH CAROLINA
Office of the State Auditor

Beth A. Wood, CPA
State Auditor

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INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT 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, 2021, and the related notes to the financial statements, which collectively comprise the Hospitals' basic financial statements, and have issued our report thereon dated October 27, 2021.

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 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, 2021, 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) as a basis for designing 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 financial statements. 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 27, 2021

ORDERING INFORMATION

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This audit required 1,565 hours at an approximate cost of $165,890.