System Collaboration: A Statewide Network of Care

The University of North Carolina Health Care System
2015 ANNUAL REPORT
# Table of Contents

## INTRODUCTION
- Delivering Complete Care to Communities Across the State 2
- Making Sustainable Improvements Through Carolina Value 4
- Expanding and Innovating Care in North Carolina 9
- The Soul of Research 14
- Community Benefit Report 2015 19

## FINANCIALS AND STATISTICS
- Letter of Transmittal 24
- UNC Health Care System Reporting Structure 27
- The Board of Directors 28
- Management’s Discussion and Analysis 29
- Pro Forma Statement of Net Position 32
- Pro Forma Statement of Revenues, Expenses and Changes in Net Position 33
- Pro Forma Statement of Cash Flows 34
- UNC Faculty Physicians Statement of Net Assets (Unaudited) 35
- UNC Faculty Physicians Statement of Revenues, Expenses and Changes in Net Position (Unaudited) 36
- UNC Faculty Physicians Statement of Cash Flows (Unaudited) 37
- Pro Forma Selected Statistics and Ratios 38
- Notes to Financials 39
During the past year, UNC Health Care continued growing as a system. Each entity in our system brings unique strengths and characteristics, making us stronger as a whole. We celebrate that uniqueness while remaining committed to what binds us together: a relentless focus on quality patient care.

By combining expertise and empathy—both of which are required for what we consider complete care—we offer breakthrough medicine. We make our care personal, tailoring it to patients in all of our distinct communities. This provides North Carolinians with care that makes them better, and that is the kind of care they deserve.

However, while still adjusting to health care reform, we must remain focused on positioning UNC Health Care for future success. The status quo simply is not enough. We have begun implementing several innovative solutions to improve the way that we do business. Although our work is far from over, we are making significant progress.

Thanks to the hard work of my colleagues throughout the system, I am proud to say that UNC Health Care reported $3.2 billion in revenue and nearly $119 million in operating profit. This is a significant improvement from the previous year.

This year’s Annual Report includes a number of initiatives that demonstrate how we are collaborating across the system to deliver complete care to the people of North Carolina.

SUSTAINABILITY NOW AND IN THE FUTURE
Doing More with Less
The changes in health care have made it abundantly clear that we need to embrace solutions that lead to sustainability now and into the future. We are embracing initiatives that marry two key components: efficiency and quality. This will enable us to do more with less while remaining intensely focused on delivering the best care possible.

Launched in 2014 in partnership with national consulting firm Huron Healthcare, Carolina Value is our largest initiative to date. Carolina Value spans all UNC Health Care entities and the UNC School of Medicine. The initiative involves the system’s nearly 20,000 system employees who are working together as one team to create a solid health system and medical school for the present and the future.

We are using Carolina Value to examine all aspects of the system to determine where we excel—and where we can do better. Carolina Value will run through 2017, but the initiative has already begun to yield impressive results. For instance, UNC REX is saving $750,000 on early, basic revenue cycle changes. A committee working on non-labor issues identified nearly $60 million in opportunities to reduce costs and increase revenue. We are decreasing average patient length of stay and discharging patients faster.

This initial success is encouraging. Our success demonstrates that Carolina Value is about much more than increasing revenues. It’s about improving the way we conduct business so that we can continue advancing care for the people of North Carolina.

Improving Patient Satisfaction
Now that the federal Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) program is publicly reporting patient satisfaction data, we are even more focused on patient satisfaction.

Whether in the hospital, in the emergency department or in ambulatory care, we strive to give our patients a consistent and high level of care. We formally call this effort Carolina Care. The initiative that was started at UNC Hospitals in Chapel Hill and created measurable successes is now being implemented across the UNC Health Care system. This will allow patients to expect the same care experience at all of our entities.

Built on five core components, Carolina Care is a set of behaviors designed to show how we care about our patients throughout the full spectrum of care. As part of this initiative, nurses now spend three to five minutes with each patient during each shift to talk about how the patient is coping with his or her condition. In addition, in the event of a patient complaint, staff members now have a standard protocol in place to discern what happened, offer an apology and find a solution.

The expansion of Carolina Care is occurring over the next 18 months. But patients are already noticing the positive changes. Since
every day.

quality care to the people of North Carolina are a further testament to our combined
UNC Health Care. The awards listed below accomplish the many other
accomplishments of each entity within
UNC Health Care. The awards listed below are a further testament to our combined
time this year with Magnet recognition
from the American Nurses Credentialing Center (ANCC). Magnet recognition is
the ANCC’s highest national credential in recognition of quality care, nursing
efficiency and innovations in professional
practice.
• UNC REX Healthcare was also redesignated a Magnet hospital in 2015
by the ANCC. In 2006, REX became the first Triangle-area hospital to achieve
Magnet designation, and in 2011, REX was the first to be redesignated. UNC
REDX is one of only 2 percent of hospitals nationwide to achieve this recognition for
a third consecutive time.
• Chatham Hospital is one of only three in North Carolina to receive five stars in the
first-ever Hospital Compare Star Ratings from the Centers for Medicare and
Medicaid Services.
• Pardee Hospital, Caldwell Memorial Hospital and UNC REX were each
honored with an “A” hospital safety score in 2014 by The Leapfrog Group. This is
evidence of our commitment to provide better, safer care to our patients.
• High Point Regional Health qualified for the American Heart Association’s
Mission: Lifeline Gold Performance Achievement Award in 2012, 2013, 2014
and 2015. The award recognizes High Point Regional Health’s commitment
and success in implementing a higher standard of care for heart attack patients
that effectively improves the survival and care of ST elevation myocardial
infarction patients.
• The Joint Commission recognized Johnston Health as a 2013 Top Performer
on Key Quality Measures* for its excellence in accountability measure performance
for heart attack, heart failure, pneumonia
and surgical care. It was one of only 1,224
hospitals in the United States to achieve the
distinction of 2013 Top Performer.
• Nash UNC Health Care received the
American College of Cardiology’s NCDR
ACTION Registry-GWTG Silver Performance Achievement Award for 2015. Nash is one of only 91 hospitals
nationwide to receive the honor.
• UNC Hospitals was designated a U.S.
News & World Report Best Hospitals top-50 facility for cancer (No. 32), ear, nose
and throat (No. 18), gynecology (No.
25), pulmonology (No. 34) and urology
(No. 49).
• The UNC School of Medicine was ranked
No. 2 in the country for primary care by
U.S. News & World Report and tied at No. 22 for research.
• Aziz Sancar, a biochemist and a member
of the Lineberger Comprehensive Cancer Center at UNC, was a recipient of the
Nobel Prize in Chemistry for his work
on mapping cellular mechanisms that
underlie DNA repair. With his mapping
mechanism, Dr. Sancar makes it possible
for scientists to pick one of 6 billion base
pairs in the human genome and know
how it is repaired.

LOOKING FORWARD
I am confident that the entities and
individuals making up the UNC Health Care system prepare us for even greater
success in the years to come. Together,
we are in a position to set an example for
excellent research, teaching and care for
systems across the nation.

On behalf of UNC Health Care, thank you
for your support. You make it possible for us
to meet our mission and to serve the people
of North Carolina.

Sincerely,

William L. Roper
Chief Executive Officer
The University of North Carolina Health Care System

A. Dale Jenkins
Chair, Board of Directors
November 2015–Present
The University of North Carolina Health Care System
Effecting real change means more than making improvements. It means making improvements sustainable.

In an environment as complex and dynamic as health care, such a goal is far easier established than realized. However, UNC Health Care is using teamwork and rivers of data to do just that for the system and the hundreds of thousands of patients it serves—through an initiative called Carolina Value.

Spanning all UNC Health Care entities and the UNC School of Medicine, Carolina Value is an unprecedented effort to improve the health of the people of North Carolina. Nearly 20,000 system employees are working together to create an optimal health care system and medical school for the present and many years to come.

Launched in 2014 in partnership with Huron Healthcare, a national consulting firm dedicated to the health care industry, Carolina Value is an ongoing initiative that brings together more than 700 dedicated staff members and 4,000 data points to strengthen and streamline more than a dozen areas within the organization.

“Carolina Value is directed toward improving the system’s ability to care for patients and the patient experience,” said Carolina Value Senior Vice President Cam Enarson, MD, MBA. “We want to think about the important outcomes that we’re seeking to achieve and how we can collect data to achieve these goals—and find more areas for improvement.”
New ways of creating, capturing and analyzing data fuel Carolina Value and help make improvements sustainable over the long term. It is a sweeping and intricate undertaking, but the overriding goal is simple: better health and better care, now and in the future.

“We are changing the way we do things today,” said Matt Smith, director of Carolina Value. “We are the state health care system, and everything ties back to our clinical, research and teaching missions for caring for the people of North Carolina.”

GUIDED BY DATA
Patients and medical professionals understand that the nation’s overall health care costs are too high and, if unchecked, could become untenable over time. What can large systems like UNC Health Care do to make sure they operate as cost-effectively as possible, while maximizing resources for patient care?

As a result of nationwide reforms, more people are gaining health insurance and, by extension, access to care. How can providers best anticipate and accommodate this ongoing increase in patients?

At the same time, state and federal payments and incentives for health care are gradually moving toward a model that compensates for achieving specific health goals for large groups of people, rather than reimbursing for individual tests and procedures.

These factors help illustrate why the time is now for Carolina Value. Cost-effective operations, better access to care, and a sharper focus on keeping patients healthy before they get sick are important objectives.

“We want to make it easier for patients to get into our system,” said Mary Tonges, PhD, RN, who recently retired as senior vice president and chief nursing officer for UNC Hospitals. “We want a collaborative partnership between those who care for a patient in every setting, including inpatient hospitalization and outpatient clinic visits.”

How, exactly, is Carolina Value helping UNC Health Care accomplish these goals?

Leaders, consultants and staffers are letting data lead the way.

Whether in the operating room or the conference room, these groups employ four core techniques to improve performance:

“Blocking and tackling,” or refining existing procedures; seeking and evaluating best practices from other institutions; “good to great,” which involves looking at how every UNC Health Care team can better work together; and enhanced tools and analytics, which makes an overall commitment to capturing and using data as extensively and effectively as feasible.

“We want this to be something we can continue to sustain,” Dr. Enarson said. “There is careful attention paid to making sure the metrics we’re collecting are tied to the outcomes we desire. It’s a routine system of collecting and reviewing data on how we’re caring for patients, and all the associated metrics.”

NEW FRONTIERS OF CARE
A large part of Carolina Value begins in the ER, the OR and the everyday exam room. Clinical improvements are a significant part of the initiative.

Evidence shows that health care is at its best when it is a team sport. According to Allen Daugird, MD, MBA, chief value officer and president of the UNC Physicians Network and UNC Faculty Physicians, a “redesigned workflow” will improve efficiency, with all team members working to the top of their license.

“In the new model, the nursing staff are empowered to give more patient care through standing protocols and orders in the electronic medical record and takes social histories,” said Dr. Daugird, who is the Carolina Value sponsor of the Physician Services Solution team. “They see what prescriptions need to be filled and tee that up for the physician. When a physician comes in, more has been done.”

Under such an approach, case managers work alongside patients to maintain optimal health both inside and outside the walls of the hospital or clinic.

“Case managers look at patients with diabetes, for example, and see which ones are past due for a visit,” Dr. Daugird said. “They can actively reach out to them, see how they’re doing, and schedule an appointment.”

One measurement process already developed through Carolina Value is the Communication and Patient Planning (CAPP) meeting.
These interdisciplinary team meetings take place each day in each unit across the system and center on each patient’s individual care plan. The ultimate results of CAPP are safer and higher-quality care, better coordination among care team members, improved patient and family satisfaction, and reduced length of stay. CAPP meetings are being rolled out across UNC Health Care.

“It will keep patients out of expensive, complex settings if they do not really need to be there,” Dr. T onges said. “It is a move toward population health, with improved health and decreased hospital admissions.”

Similar plans occur on an even deeper level for patients with complex medical situations and who have, for various reasons, experienced extended hospital stays. In these cases, meetings center on identifying and alleviating challenges that may be prolonging a stay.

“In complex patient care meetings, the team talks about patients who have been here for an extended period of time and what it would take to get them discharged,” Dr. T onges explained.

Carolina Value has the power to effect sustainable clinical transformations far outside the hospital. Ultimately, leaders anticipate that change will reach into the day-to-day operations of physician offices in the system.

“We want to figure out how quickly we’ll be able to see patients when they call in,” Dr. Daugird said. “If it’s a new patient, maybe the goal is seeing them within 14 days. If it’s an existing patient, the goal could be within two days. This will increase the level of service we provide to patients across the system.”

**OPTIMAL PEOPLE FOR OPTIMAL PERFORMANCE**

Until recently, Sharon Kimball served as chief nursing officer at Caldwell Memorial Hospital, a UNC Health Care member hospital located in Lenoir, North Carolina. But when she first became aware of Carolina Value, her career quickly changed directions as she took on a project management role with Carolina Value.

“I recognized that there are major changes happening in health care,” Kimball recalled. “Change is going to have to happen if we’re going to continue to succeed. I bought into the Carolina Value approach. Everything is focused on what was right for the patient, and what was right for the residents in North Carolina, and how we take care of them.”

Kimball is not alone in her motivation. In collaboration with Huron, the people of UNC Health Care are leading the initiative, and to hear them tell it, they are ready for the opportunity.

“This accelerates the evolution of the UNC Health Care system,” said Ernie Bovio, president and CEO of High Point Regional Hospital. “We are very ready for this. We are ready to become more integrated, and we are all very enthusiastic and motivated to begin the process.”

In a way, Carolina Value is a vehicle through which UNC Health Care can examine itself, including the many professionals and operations that make it work each day. Several employee teams affiliated with Carolina Value are exploring different aspects of work life at UNC Health Care, from compensation to day-to-day work loads.

As an example of how Carolina Value is optimizing the work of both individuals and groups, a team of compliance documentation specialists—nurses that use their clinical expertise to review medical
record documentation and translate or clarify that information for coders—has worked together to make major strides in improving clinical documentation at the Johnston Health system. This already high-performing team reached a new level after a combined eight weeks of training and mentoring associated with Carolina Value. Thanks to a more targeted and thorough review process, compliance documentation specialists far exceeded specific goals around clarifying medical records, which in turn now saves the system between $100,000 and $140,000 per month.

Changes like these are unfolding on the ground and in the C-Suite. The actions that Carolina Value has set in motion will refresh the way the system is led and managed, and how employees get things done. Part of this is an examination of how UNC Health Care’s governance structure might best be positioned to help and sustain the system and its missions.

“There will be appropriate governance and oversight structure as a part of Carolina Value, and teams meeting on a regular basis,” Dr. Enarson said. “That will help us sustain our results.”

Other efforts include comprehensive reviews of human-resources policies for a range of system professionals, in order to determine whether there are new or better ways to help the people of UNC Health Care help the people of North Carolina.

“We’re looking at how staff spend their time and find ways to be more productive,” said Dr. Tonges. “We’re taking away old things or finding more efficiencies. It’s a full workflow study of who does what and how we can do it better.”

**ONE GOAL, ONE SYSTEM**

Part of UNC Health Care’s current strength flows from its ongoing growth, which includes the additions of entities like High Point Regional and Hillsborough hospitals, among other additions and expansions.

“We have grown significantly as a health care system,” explained Dr. Daugird. “The corollary of that growth on the physician side is we now have 2,000 employed physicians and another 500 employed by others. We need to have some consistency in our policies.”

New measures from Carolina Value will leverage this strength in new ways, facilitating better knowledge transfer and shared services among its people and institutions.

“It’s about how we cooperate across the system,” Smith said, “There’s a great need to be agile in order to be great.”

As the quality and safety of care become larger points of focus across the nation, emphasis grows on finding ways to share clinical innovations among colleagues. Carolina Value will help facilitate these exchanges.
“The goal is an inventory of our quality improvement work and coming up with an operational or governance structure to better coordinate it,” Dr. Daugird said. “We have done a lot of good work as a system around quality improvement, but it has been siloed.”

Integration is another popular concept at UNC Health Care and beyond. What, exactly, it entails varies based on needs and circumstances, but in a health care context it essentially involves unifying disparate operations so that they function, to the greatest extent possible, as a seamless and coherent whole.

“Integration can take many forms,” said Steve Burriss, president of UNC REX Healthcare, a not-for-profit private health care organization in the UNC Health Care system. “The complexion of REX is changing a lot as we go from a community hospital to a tertiary center. With that come new levels of sophistication and very sick patients. Integration gives us access to more trained experts across the system.”

To take full advantage of the opportunities integration presents, all entities across the UNC Health Care system are closely involved in all 13 Carolina Value solution teams, so that all voices are well represented.

Integration transcends the clinical realm. Every day, large systems like UNC Health Care perform an enormous range of functions, some of which can be shared to maximize efficiency and minimize costs.

Changes in the system’s supply chain could realize major savings. These savings could occur when entities combine their contracts for specific products—latex gloves, for example—that the entire system needs. With an eye toward sustainability, system leaders will eventually engineer a newer distribution system that will create further savings.

“Our size, scale and geography give us an advantage,” noted Bovio. “Because of Carolina Value, we are, potentially, not duplicating efforts in places like legal or support functions. We’re learning from each other, sharing best practices, whether it’s clinical or business functions. There is lots of benefit from that perspective.”

Reducing costs and finding new efficiencies in the revenue cycle—encompassing functions like billing and coding—means a healthier system, and that, ultimately, means healthier patients. According to Burriss, savings from the revenue cycle could improve revenue yield by 2 to 3 percent.

“Health care is a low-margin business,” Burriss said. “Anything that can increase that margin is huge.”

Another key concept for Carolina Value is transparency. Clear standards for employees and goals for operations will help foster accountability around specific outcomes.

The UNC School of Medicine is closely involved in many aspects of Carolina Value and has its own dedicated solution team as part of the initiative. While medical education and clinical operations are primary areas of emphasis for the school, another, perhaps more surprising, area of focus is its business functions, particularly as they relate to the school’s research endeavors.

“The school has ways of generating revenue,” said Paul Godley, MD, PhD, the school’s vice dean for finance and administration and sponsor of the School of Medicine solution team. “We are looking at how more efficiency can bring new discoveries to the licensing phase. My vision would be that we redesign school of medicine operations to operate more efficiently, transferring our own discovery into intellectual property.”

THE FUTURE: ALREADY ARRIVING
Direct oversight of Carolina Value is expected to transition from Huron experts to UNC Health Care teams and experts some time within the next year, but early implementation of some measures is already yielding meaningful results.

For example, UNC REX is saving $750,000 on early, basic revenue cycle changes, according to Burriss.

Nash Healthcare in Rocky Mount experienced three consecutive months of lower average lengths of stay for patients, thanks to CAPP rounds and other patient-focused initiatives, added Smith.

Carolina Value organizers are making sure these meaningful results continue by building these changes into the heart of UNC Health Care’s operations. The changes will be transparent, and as with everything in Carolina Value, they will be designed to last.

“It is less about the present than it is about the future,” Dr. Enarson said. “This is not just a one-time activity. We are putting in place policies and procedures to ensure sustainability. There are 70 teams and hundreds of people in all of our locations engaged in this, and we want to keep them engaged. It is truly a system initiative.”

THE BUSINESS OF GREAT HEALTH CARE
Health care is a unique business, but it is a business nonetheless. Being the best in patient care also means being the best behind the scenes. Integration is a big part of this, but Carolina Value will provide plenty of opportunities in a number of ways.

“From the health care system perspective, Carolina Value can give us enhanced ability to manage the billing and collecting components of our work,” Dr. Enarson said. “Enhanced staffing productivity management, enhanced contracting related to supplies, enhanced coding.”
UNC Health Care is always in motion, seeking new and better ways to serve the state and its people, strengthen its team and harness emerging technologies. A range of new and ongoing projects demonstrates the system’s commitment to its core mission of providing unparalleled patient care to communities across North Carolina.

**EPIC@UNC GOES SYSTEM-WIDE**

Since its inception, the goal of Epic@UNC has remained constant—one patient ID, one problem list, one medication list and one bill for every patient at every UNC Health Care location.

The current push for this initiative, led by UNC Health Care and the medical software group Epic, is extending the platform across the entire UNC Health Care system. Already up and running at three hospitals (Chatham, REX and UNC Medical Center) and more than 300 clinics, Epic@UNC is being implemented at many additional locations.

“Integrating clinical data is the valuable piece of this,” said UNC Health Care IT Director Angie Groves Odham. “The data follows patients wherever they go, from the clinic to the hospital and back.”
Epic@UNC is set to begin operating at High Point Regional Hospital and Johnston Health in Smithfield by May 2016, then Caldwell Memorial Hospital and Pardee Hospital in Hendersonville a month later. IT leaders also are developing Beaker, the Epic@UNC Lab System, and Cupid, the Epic@UNC Cardiology System, which will revolutionize laboratory and cardiology orders, respectively, at UNC Health Care.

“Physicians now have more data in their hands because of Epic@UNC,” Odham said. “They’ve said that the new data has sometimes changed their plans, and without it, they would have gone down a different path of treatment.”

As expansion continues, Epic@UNC will continue to fundamentally change how patients connect with care providers. The linchpin of this change is My UNC Chart, an online patient portal.

“Patients have a lot of information through the portal,” Odham explained. “They can communicate with the provider, see lab results, get their clinical summaries, schedule an appointment, pay their bill, etc. The patient feedback is they love having all this data at their fingertips.”

CAROLINA CARE®: IMPROVING PATIENT SATISFACTION ACROSS THE SYSTEM

Health care reform, including value-based purchasing and transparency, is drawing more focus on the patient experience across the country, and UNC Health Care is leading the way by bringing its proven Carolina Care® initiative to the entire UNC Health Care system.

Carolina Care® was developed at UNC Hospitals and is grounded in the Swanson Theory of Caring. It initially performed so well...
that it was quickly adapted to the ambulatory care environments, including the Emergency Department.

UNC Health Care has grown significantly since Carolina Care® began, and the initiative has been implemented systemwide to ensure a consistent patient experience throughout the state.

“Carolina Care® is designed to show patients we care as much about them as we do for them,” explained Mary Tonges, PhD, RN, NEA-BC, FAAN, who recently retired from UNC Health Care as senior vice president and chief nursing officer. “Patients have said, ‘I was here years ago, and something is different, and it is fabulous.’”

Carolina Care® consists of five main components that guide and impact the patient experience. It includes a system of rounding to assess patient needs; key points for patient interactions; addressing complaints in ways that acknowledge the patients’ concerns without placing blame; empowering all caregivers to respond to a patient call light regardless of room assignments; and including patients in shift report as caregivers transition and individualize a patient’s plan of care.

Many people think nurses provide most of the front-line care for hospitalized patients, but staff members in many departments play a role in the patient’s experience. For Carolina Care®, Environmental Services, Facilities, and Nutrition and Food Services join nursing as key members of the Carolina Care® team.

“We partner most closely with the departments that have the most effect on our ability to deliver care,” Dr. Tonges said. “I’m very grateful that our staff has the commitment to make things so good for our patients and their families.”

Carolina Care® teams meet every week to review patient satisfaction data. If feedback is less positive in a particular area, underlying issues are reviewed and action plans are initiated to find ways to make a sustainable change.

“It’s really about the partnerships and people from all areas working together,” said Suzanne Herman, system executive director of customer experience at UNC Health Care. “It’s data-driven, branded and trademarked, and we know it works.”

Mastering the patient experience is more critical now that hospitals are required to participate in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) program, which is a component of the Centers for Medicare and Medicaid Services’ Hospital Value-Based Purchasing program. Patient satisfaction data are publicly reported and impact a portion of funds for hospitals.

“How that Carolina Care® exists throughout the system, it is being fully integrated into the culture of each entity,” said Herman. “They are really taking it and making it their own while keeping the core principles, which is one of the best parts of this initiative.”

THE UNC HEALTH CARE BRAND: ONE WHOLE, UNIQUE PARTS
Expertise and empathy: Being part of a team but retaining a unique identity.

Connecting those disparate but important areas is what the UNC Health Care brand Initiative is all about. “UNC Health Care is unique in its ability to provide this important balance,” said UNC Health Care Strategic Marketing Director Daniel P. Stevens, DMD, PhD, MBA.

Given UNC Health Care’s ongoing expansion, leaders set out to create a brand identity that unified the system’s entities and established them as members of a statewide network of top medical experts without sacrificing the qualities that distinguish each organization.

As the marketing department began developing the system brand campaign, the question they wanted to answer was, “How do we introduce ourselves and communicate these new resources to our constituents across the state in a meaningful and impactful way?”

The initiative began with widespread research, based mainly on extensive conversations with patients and caregivers.

“We learned that people respect UNC Health Care and that they see it as a leading national academic medical center,” Stevens said, “but people also want to know and understand how that fits into the context of their town and their community.”

With that feedback in mind, system leaders developed the campaign and unveiled the new brand in October 2015. Known as “Your Hospital,” the brand and related outreach campaign include advertisements that describe how, as a part of UNC Health Care, each facility offers high-quality care that is delivered with empathy, while acknowledging and honoring the unique attributes of each location. Consistent with this framework, hospital entities maintain their names and logos within a system framework so they are also recognized as part of the UNC Health Care system.

According to Stevens, the ultimate outcome is “living the brand.”

“We talk about expertise in standardized ways, but ways that are specific to a town,” Stevens said. “It is customized for the community.”

TELEMEDICINE: A NEW TECHNOLOGICAL FRONTIER

There is a wealth of expertise in an academic medical system as highly regarded as UNC Health Care, but how do you share that expertise when doctor and patient are separated by hundreds of miles? One answer is telemedicine.

Defined as the diagnosis or treatment of patients using remote technology, telemedicine allows doctors and patients to interact over long distances via video-conferencing equipment, software, smartphones and tablets, among other tools.
UNC Health Care is adopting this new resource to improve care in specialized areas across the state.

In July, the system announced that The Duke Endowment foundation—matched by one-to-one dollars from UNC Health Care—will cover the full cost of telemedicine equipment for UNC Health Care affiliate hospitals for two years. This will offer immediate benefits for patients in a variety of challenging circumstances.

For example, more than 10,000 North Carolinians suffer a serious burn injury each year, but fewer than 60 percent are admitted to a dedicated burn center. Thanks to telemedicine, patients with severe burns who are admitted to Johnston Health in Smithfield can receive real-time examinations from on-call specialists in Chapel Hill.

Additionally, the UNC Cancer Network uses its telemedicine network to provide a host of free oncology services to doctors and patients throughout the state.

The Maternal-Fetal Telemedicine program offers remote care, ranging from ultrasound interpretation and reports to care and consultations for pregnant women with diabetes to preconception, prenatal and perinatal consultations for women with various complications.

**KEEPING A FULL POPULATION HEALTHY**

Population health means caring for a large group of individuals and improving that group’s health and quality of life with every interaction, not just when a problem arises.

One approach to population health gaining traction around the country is the patient-centered medical home, an advanced model of primary care that emphasizes coordination and communication among patients and providers. Earlier this year, UNC Health Care and the North Carolina campus of technology company Cisco Systems became partners in a new primary care center for Cisco’s 5,000 employees and their family members in North Carolina. The site is operated by UNC Health Care physicians and staff, with technology powered by Cisco Systems.

The LifeConnections Health Center on Cisco’s campus includes a large fitness center, and eye care, chiropractics, massage, acupuncture, counseling and health coaching services are available to keep people healthy and prevent problems before they start.

That is just one way that UNC Health Care is diving into population health. Earlier this year, system leaders partnered with Alignment Healthcare for a full population health management program. The partnership kicked off by offering a new Medicare Advantage HMO plan for senior citizens in Wake County.

“By partnering with Alignment, community physicians and insurance providers, we are creating a new model for care that will improve health care for Wake County seniors and provide peace of mind to families knowing their loved ones are receiving high-quality care,” said Allen Daugird, MD, president of UNC Physicians Network and UNC Health Care’s chief value officer. “This program offers a new type of health plan that will improve patient outcomes, increase quality of care and reduce costs by tapping into UNC Health Care’s broad network of providers and depth of clinical expertise.”

UNC Health Care—including UNC Physicians Network, UNC Faculty Physicians and REX-employed specialists, REX Hospital,
and UNC Hospitals—is the foundation of the provider network. Select, high-quality community providers also are in the network to ensure access close to home.

According to Dr. Daugird, this partnership may be just the beginning. “Everyone benefits with this plan, and we have a more healthy community as a result. Over time, we hope to replicate this plan to care for other populations across the state, thus furthering our mission of caring for all North Carolinians.”

**CLINICALLY INTEGRATED NETWORK**

Doctors and patients within the UNC Health Care system are about to gain a new ally in coordinating care: a clinically integrated network called UNC Health Alliance.

UNC Health Alliance is a close partnership and collaboration between independent, community physicians and UNC Health Care, created to build an integrated system of care that is outcomes-driven, patient-centered and affordable for the continuum of care.

Physicians who participate in UNC Health Alliance will continue to provide care for and support their local communities and now, as members of the Health Alliance, can do so with the additional resources of UNC Health Care.

The network, which functions in a manner similar to models being adopted by health systems across the country, is a physician-led organization designed to improve the health of the population, enhance the care experience for patients and providers, and reduce total costs of care. The organization fosters a culture of collaboration between UNC Health Care and community providers and will develop contractual relationships with payers and employer groups who recognize value in an integrated network that provides high-quality, cost-effective, patient-centered care.

**UNC CANCER CARE AT CALDWELL**

In May, McCreary Cancer Center became a service of UNC Hospitals and a part of UNC Cancer Care. Staffed by faculty physicians of the UNC School of Medicine, the Center offers easy access to top-quality cancer care for residents in and around Caldwell County.

Services offered at the McCreary Cancer Center include:
- Medical oncology
- Radiation oncology
- Chemotherapy and blood product infusion
- Laboratory

Approximately 135,000 visits occur at UNC Cancer Care clinics each year. In 2015, *U.S. News & World Report* recognized UNC Hospitals as one of the nation’s top 40 hospitals for cancer care.

**HILLSBOROUGH HOSPITAL OPENS**

UNC Hospitals welcomed the public to its Hillsborough campus on June 20, 2015. The campus is home to diagnostic, emergency and treatment facilities.

After the 265,000-square-foot, 68-bed hospital's open house in June, the emergency department opened July 6, followed by six operating rooms, two procedure rooms and full inpatient services in August.

About 400 employees work at the hospital. Specialty services include joint and elective spinal surgeries, non-cancerous gynecological treatment and ophthalmology.

**REX HEART HOSPITAL UPDATE**

The North Carolina Heart and Vascular Hospital will be an eight-story, 114-bed tower consolidating REX’s heart and stroke services into one location on its Raleigh campus.

Backed by UNC Health Care and staffed by Wake County’s top physicians, the hospital will act as the central hub of one of the Southeast region’s premier heart and vascular programs. The entity is being created to join the most cutting-edge technologies with the most skilled and compassionate care providers. The facility is scheduled to open in early 2017.

**CHATHAM HOSPICE BREAKS GROUND**

The SECU Jim & Betsy Bryan Hospice Home of UNC Health Care is scheduled to open in 2016. The home will provide an end-of-life care option not previously available to residents in and around Chatham County.

Located on two acres of land in Pittsboro, the 11,000-square-foot facility will house a kitchen, dining room, meditation space, family visiting areas and 10 private rooms with individual outdoor patios.

The inpatient and residential services will be founded on the UNC Hospice program’s existing expertise in hospice and palliative care. Patients and families will receive support from a team of nurses, social workers, pastoral and grief counselors, and trained UNC Health Care volunteers.

The State Employees Credit Union (SECU) Foundation committed $1 million to The Medical Foundation of North Carolina to help finance the home’s construction.

“It allows us to provide patients and their families coordinated, compassionate end-of-life care in a peaceful setting,” said William L. Roper, MD, MPH, CEO of UNC Health Care. “We are so pleased that the SECU Foundation recognizes the importance of this public service to the people of Chatham County and has agreed to partner with us.”
A PRIZE FOR AZIZ
After 40 years spent studying how DNA repair occurs in human cells, Aziz Sancar, MD, PhD, was recognized with the highest honor in science—The Nobel Prize. His work, which intricately explains why all of us do not get skin cancer every single day because of ultraviolet radiation, has been used to create new therapeutic approaches to treat cancer. In 2015 his work culminated in a first in his field—a map of DNA repair across the entire human genome.

“Now we can say to a fellow scientist, ‘Tell us the gene you’re interested in or any spot on the genome, and we’ll tell you how it is repaired,’” said Dr. Sancar, professor of biochemistry and biophysics at the UNC School of Medicine and member of the UNC Lineberger Comprehensive Cancer Center. “Out of 6 billion base pairs, pick out a spot, and we’ll tell you how it is repaired.”

The findings offer scientists a potential way to find and target the proteins that help cancer cells circumnavigate therapy. The benefit of this new method could be more effective and better tolerated classes of cancer therapeutics.

Dr. Sancar, a native of Turkey, came to UNC in 1982 when Mary Ellen Jones, PhD, recruited him. It was at UNC that he conducted the research that earned him the Nobel Prize in chemistry. He is the second Nobel laureate at UNC. The first was Oliver Smithies, PhD, in 2007.

AN IMMUNOTHERAPY BREAKTHROUGH
Two years ago, Carlos and Tina Sandi faced the fear of losing a child to cancer. Their son Phineas was diagnosed with acute lymphoblastic leukemia at age 4. The Sandi family sought treatment at UNC Health Care under the care of Philip Roehrs, MD, in the hematology-oncology division.
“Even after several rounds of chemo, Phineas still had evidence of disease,” said Dr. Roehrs, who is also a member of UNC Lineberger. “For Phineas to get to the next stage in his care—a bone marrow transplant—we needed him to be cancer-free, but the standard of care was just not working.”

The medical team searched for other options, including a groundbreaking treatment called T-cell immunotherapy. Dr. Roehrs found a clinical trial at the National Institutes of Health designed to use the power of the body’s own immune system to fight cancer with genetically engineered T-cells that recognize and attack the cancer cells.

Phineas completed the NIH trial and was in full remission within 28 days.

Following the trial, Phineas underwent his bone marrow transplant at UNC and went home on Christmas Day, 2013. Today, he is back to doing things a 6-year-old should be doing—vacationing in Disney World, meeting new friends in kindergarten and taking a road trip with his family during spring break.

“The team that cared for Phineas is simply amazing,” said Tina Sandi. “There was a tremendous amount of communication between UNC and the NIH throughout the trial, and Dr. Roehrs really advocated for our son.”

Because of medical successes like this one, UNC is able to make this experimental form of immunotherapy available in North Carolina with the launch of a new clinical research program.

“What was once available in only a handful of cancer centers will now be available to patients in North Carolina,” said Jon Serody, MD, associate director of translational science at UNC Lineberger.

UNC Lineberger recruited two faculty members from the Baylor College of Medicine to help launch T-cell therapy clinical trials. Gianpietro Dotti, MD, and Barbara Savoldo, MD, PhD, have studied these types of trials at Baylor since 1998. The initial trial for Hodgkin lymphoma will be followed by acute lymphoblastic leukemia and additional cancers as the program expands.

UNC will also open a new “clean” facility where the T-cells will be developed. Once validated by the FDA, the facility will pave the way for these trials to open in 2016, along with the addition of two new facility leaders, facility director Paul Eldridge, PhD, and associate director Kathryn McKay, MS.

“We are thrilled that immunotherapy is coming to North Carolina,” said Carlos Sandi. “We’re thrilled about the capabilities UNC has, about the wonderful people here, about how much of an impact this institution has and will continue to have on the people of our state.”

THE GENETICS OF AUTISM

Two years ago, Mark J. Zylka’s, PhD, research was named one of the top autism breakthroughs of the year. This past year he had another one. He led an elegant study of an enzyme called UBE3A, which is typically turned off and on in neurons during brain development. Dr. Zylka, associate professor of cell biology and physiology, found that a genetic mutation destroys this regulatory switch. This means the UBE3A enzyme cannot be turned off. As a result, UBE3A becomes hyperactive and drives abnormal brain development and autism.

“Genetic studies are showing that there will be about 1,000 genes linked to autism,” said Dr. Zylka, who is also a member of the UNC Neuroscience Center. “This means you could mutate any one of them and get the disorder. We found how one of these mutations works.”

Because this one autism-linked UBE3A mutation was part of the Simons Simplex Collection—and Dr. Zylka previously had been funded through a Simons Foundation grant—he had access to the human patient cells that were used to find this one mutation. His team saw that one child’s regulatory switch was broken, causing UBE3A to be perpetually switched on.

“When this child’s mutation was introduced into an animal model, we saw all these spines form on the neurons,” said Dr. Zylka, who is also a member of the Carolina Institute for Developmental Disabilities. “This was a big deal because too many dendritic spines have been linked to autism. We think it may be possible to tamp down UBE3A in some patients to restore normal levels of the enzyme. In fact, we tested known compounds and showed that two of them substantially reduced UBE3A activity in neurons.”

Future work will include creating a new therapeutic approach based on this discovery.

EBOLA ON THE RUN

William A. Fischer II, MD, and David Wohl, MD, served as key leaders for a clinical trial in Liberia that involved taking plasma from Ebola survivors and giving it to patients who are actively sick in an effort to help them combat this disease.

The trial was run by ClinicalRM of Hinckley, Ohio, and is being funded through a grant from the Bill & Melinda Gates Foundation.

“At a time when there is no specific therapy for Ebola, this trial is truly unique; it serves to empower survivors to fight back through the donation of plasma that could potentially save someone’s life,” said Dr. Fischer, an assistant professor in the Division of Pulmonary and Critical Care Medicine. Dr. Fischer previously treated Ebola patients in Guinea in May and June of 2014 as part of a team from Doctors Without Borders.
“As part of the trial, we have been able to enhance a range of lab capabilities within the hospital system allowing for real-time electrolyte analysis,” said Dr. Wohl, an associate professor in the Division of Infectious Diseases. “Monitoring and responding to electrolyte abnormalities is a huge benefit in the effort to care for and support people battling Ebola, and it greatly enhances the health care team’s ability to make informed and rapid treatment decisions.”

On the basic science side, researchers at the UNC School of Medicine and the UNC Gillings School of Global Public Health developed the first genetic strain of mice that can be infected with Ebola and display symptoms similar to those that humans experience. This work will significantly improve basic research on Ebola treatments and vaccines, which are desperately needed to curb the worldwide public health threat and economic toll of the disease.

A SMARTER WAY TO TREAT DIABETES
Zhen Gu, PhD, a professor in the joint UNC/NC State Biomedical Engineering Department, devised a technology that could make painful insulin injections a thing of the past. He created a “smart insulin patch” that can detect increases in blood sugar levels and secrete doses of insulin into the bloodstream whenever needed.

The patch—a thin square no bigger than a penny—is covered with more than 100 tiny needles, each about the size of an eyelash. These “microneedles” are packed with microscopic storage units for insulin and glucose-sensing enzymes that rapidly release their cargo when blood sugar levels get too high.

Dr. Gu’s team found that the new, painless patch could lower blood glucose in a mouse model of type 1 diabetes for up to 9 hours. More preclinical tests and subsequent clinical trials in humans will be required before the patch can be administered to patients, but the approach shows great promise.

“We have designed a patch for diabetes that works fast, is easy to use, and is made from nontoxic, biocompatible materials,” said Dr. Gu, who also holds appointments in the UNC Eshelman School of Pharmacy and the UNC Diabetes Care Center. “The whole system can be personalized to account for a diabetic’s weight and sensitivity to insulin,” he added, “so we could make the smart patch even smarter.”

Dr. Gu’s work earned him a spot on the MIT Technology Review’s list of top investigators under the age of 35.

PINNING DOWN CF’S GENETIC PATHWAYS
At the state-of-the-art Marsico Hall—funded by the state of North Carolina—cystic fibrosis researchers at the UNC School of Medicine and the Marsico Lung Institute have identified genetic pathways—or clusters of genes—that play major roles in why one person with CF might never experience the worst kinds of symptoms while another person will battle severe airway infection for a lifetime.

The finding opens avenues of research toward new personalized or precision treatments to lessen pulmonary symptoms and increase life expectancy for people with cystic fibrosis.

“Right now, there are drugs being developed to fix the function of the CFTR protein that is disrupted in all CF patients; but even then, some patients will respond very well to therapy and some will not,” said Michael Knowles, MD, professor of pulmonary and critical care medicine. “Why is that? We think it is the genetic background—the genes that interact with the CFTR gene.”
Knowles’ team found that when these groups of genes are highly expressed, patients with CF have less severe symptoms. When these genes are expressed in lower amounts, patients experience a more severe form of the disease and are more likely to be hospitalized.

Wanda O’Neal, PhD, associate professor of medicine who had six siblings die due to CF, said, “Now that we’ve found these “genetic pathways,” we need to dig into the biology to see how specific genes within the pathways influence disease severity. This could help us not only predict which patients will respond to a given therapy, but it may also provide drug targets to lessen the severity of disease for all patients.”

**A BRAIN INITIATIVE FIRST**
Led by Bryan Roth, MD, PhD, researchers at UNC and the NIH devised a noninvasive research technique that allows them to switch off a specific behavior in mice and then switch it back on. The method involves neurons—specifically, two different cell surface receptors that trigger specific chemical signals in the brain. These signals control brain function and complex behaviors.

When this complex signaling system goes awry, the results can lead to a plethora of diseases, including schizophrenia, depression, Alzheimer’s disease, Parkinson’s disease, eating disorders, and epilepsy. Cell surface receptors also play roles in cancers, diabetes, digestive conditions, and other diseases. This new research technique could be modified to study them, as well.

This is the first technology to stem from the initial set of NIH BRAIN Initiative grants to create new cutting-edge research tools to improve our understanding of the brain.

“This new chemogenetic tool will show us how brain circuits can be more effectively targeted to treat human disease,” said Roth, the Michael Hooker Distinguished Professor of Protein Therapeutics and Translational Proteomics at the UNC School of Medicine. “The problem facing medical science is that although most approved drugs target these brain receptors, it remains unclear how to selectively modulate specific kinds of receptors to effectively treat disease.”

Roth’s research directly addresses this issue.

**ON THE UPSWING**
These projects mark the pinnacle of each field, and they are not alone in the pantheon of cutting-edge research done at the UNC School of Medicine. Most of these projects and the majority of other research at the school are funded through the National Institutes of Health, which granted more than $261 million to the school in the fiscal year 2015. In total, including funding through other government agencies such as the National Science Foundation and private organizations such as the Cystic Fibrosis Foundation, grants to the UNC School of Medicine for FY15 topped $402 million.

UNC, which remains one of the top-funded and well-respected research universities in the world, uses this money to fund specific research projects and to pay for the many necessary materials used in experiments and projects, as well as the hiring of graduate students, postdoctoral researchers, and research professors. However, infrastructure costs such as refurbishing, upgrading, and building lab space and other facilities, as well as salaries for faculty, are incurred by the state of North Carolina. Retaining and recruiting faculty, which remains a top priority at the school, is dependent on funding through the state.

It was a banner year in research at the UNC School of Medicine, which continues to spin out companies to help fuel the economy in the Triangle and throughout the state, and it would not have been possible without funding from the state and the federal governments, as well as private organizations.
Community Benefit Report 2015

88 Smoke alarms installed in 1 day by Safe Kids Orange/Chatham County

650 Meals provided at the Chapel Hill-Carrboro Community Dinner
1
Clinic for the homeless supported at Community House

100
Attended the Hillsborough Chamber of Commerce annual meeting at Hillsborough Hospital

10,000
Items collected for Stuff the Bus

“Sometimes it’s important to step out of the hospital environment. We’ve worked hard here to build a sense of sanctuary.”

—Shelley Day, executive director of the RMH of Chapel Hill
Partnering with the Community

When a child becomes seriously ill, it can be difficult to feel normal or find a place to take a quiet moment to recharge. Days or weeks at the hospital can leave family members physically and emotionally drained.

Many families who travel from all over the state and country for the expert care at N.C. Children’s Hospital can find support at the Ronald McDonald House (RMH) of Chapel Hill. The RMH not only provides a place to stay for families with seriously ill children but is designed to create a community of support among volunteers and other families facing similar difficulties.

“Sometimes it’s important to step out of the hospital environment,” says Shelley Day, executive director of the RMH of Chapel Hill. “We’ve worked hard here to build a sense of sanctuary.”

UNC Health Care and the RMH work together to serve the community and patients. Within N.C. Children’s Hospital, the Ronald McDonald Family Room offers all families of pediatric patients a place of respite and includes a kitchen, wireless Internet access and comfortable seating overlooking an outdoor play space. At the same time, employees from UNC Health Care volunteer at the nearby RMH to offer support to the patients and families staying there.

“The Ronald McDonald House has a critically important relationship with the Children’s Hospital,” said Dr. Wesley Burks, physician in chief at the N.C. Children’s Hospital. “It provides accommodations in a warm and friendly atmosphere. The number of critically ill children is growing over time. It’s important to serve the next generation of children who come to the hospital.”

Since opening in 1988, the RMH has served more than 36,000 families from all 100 North Carolina counties, 39 other states and 21 countries. About 99 percent of the families that stay at the RMH...
are in Chapel Hill to be treated at N.C. Children's Hospital, which is located just over a mile from the House. However, more than 800 families were turned away in 2014 because there wasn’t room for them. That will not be the case in the future. With support from UNC Health Care, the RMH opened a new expansion last fall that doubles its capacity, making room for many more patients and families, as well as innovative support programs.

The $7.6 million expansion adds 24,000 square feet to the RMH, including an additional 24 guest rooms, bringing the total to 53. Gathering spaces, meeting rooms, play rooms, a welcome center and dining rooms round out the indoor amenities. Outside, the five new buildings surround a 1-acre courtyard that features play areas for children and quiet places for parents to relax.

The expansion also adds a groundbreaking pediatric palliative care program, called “Loving Hands,” a first of its kind in North Carolina and the global Ronald McDonald House network.

The RMH provides a home away from home for thousands of families in need. After 10 years of planning and more than a year of construction, the expansion will allow it to help many more families.

The SECU Family House is a hospitality house located a little more than a mile from UNC Hospitals. First opened in 2008, the house offers hotel-style accommodations to patients that have to travel long distances to receive care at UNC Hospitals, but its staff works hard to provide the sense of comfort that comes from feeling at home.

UNC Health Care supports the SECU Family House and the Ronald McDonald House of Chapel Hill both financially and through volunteers. These partnerships provide additional assistance to the patients and families who entrust their medical care to UNC Health Care.
Financials and Statistics

CHAPEL HILL, NORTH CAROLINA
For the years ending June 30, 2015, and June 30, 2014
Letter of Transmittal

FEBRUARY 16, 2016

To the Governor, the State Auditor, members of the General Assembly, members of the UNC Board of Governors, UNC Chapel Hill Board of Trustees, members of the UNC Health Care System Board of Directors, supporters of the University of North Carolina Health Care System, and William L. Roper, CEO.

INTRODUCTION
This Annual Report includes a compilation of the operating results and financial position of the University of North Carolina Health Care System (UNC Health Care) as established by N.C.G.S. 116-37. The financial reports as presented represent a summary of data generated by the various entities under the control of the Board of Directors of UNC Health Care.

The University of North Carolina Hospitals (UNC Hospitals), UNC REX Healthcare, Inc. (REX), Chatham Hospital, Inc. (Chatham), High Point Regional Health (High Point), Caldwell Memorial (Caldwell) and UNC Physicians Network (UNCPN) prepare and publish their own separate audit reports on an annual basis. University of North Carolina Faculty Physicians (UNCFP), the clinical patient care programs of the University of North Carolina School of Medicine, is included in the audit report for the University of North Carolina at Chapel Hill (UNC-CH). Additional information regarding the organization structure can be found in the Notes to Financials section of the Annual Report.

The Annual Report is compiled to provide useful information about the entity’s operations and programs and to ensure its accountability to the citizens of North Carolina. While UNC Health Care’s management believes this information to be accurate, it should be noted that these documents are unaudited and not intended to be used for any financial decisions.

The Financials and Statistics section presents Management’s Discussion and Analysis and pro forma financial statements for UNC Health Care and UCFP. This section includes selected statistical and financial ratio information. Management’s Discussion and Analysis provides a review of the financial operations, and the Notes to Financials section provides additional explanations for the reader.
FINANCIAL INFORMATION

Internal Control Structure

UNC Health Care's management establishes and maintains an internal control structure to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Management applies the internal control standards to meet each of the internal control objectives and to assess internal control effectiveness. When evaluating the effectiveness of internal control over financial reporting and compliance with financial-related laws and regulations, management follows the assessment process to assure the state of North Carolina and the public that UNC Health Care is committed to safeguarding its assets and is providing reliable financial information.

One objective of an internal control structure is to provide management with reasonable, although not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition. Another objective is to ensure that transactions are executed in accordance with appropriate authorization and recorded properly in the financial records to permit the preparation of financial statements in accordance with generally accepted accounting principles. Annually, management provides assurances on internal control in its Performance and Accountability Report, including a separate assurance on internal control over financial reporting along with a report on identified material weaknesses and corrective actions.

As a recipient of federal and state funds, UNC Health Care is responsible for ensuring compliance with all applicable laws and regulations. A combination of state and UNC Health Care policies and procedures, integrated with a system of internal controls, provides for this compliance. The accounts and operations of UNC Hospitals and UNCFP (as a part of UNC-CH) are subject to an annual examination by the Office of the State Auditor. REX, Chatham, High Point, Caldwell and UNCPN are audited annually by independent third-party CPA firms. All seven entities are an integral part of the state’s reporting entity represented in the state’s Comprehensive Annual Financial Report and the state’s Single Audit Report. The audit procedures are conducted in accordance with auditing standards generally accepted in the United States of America and Government Auditing Standards issued by the Comptroller General of the United States.

Budgetary Controls

On an annual basis, UNC Health Care’s Board of Directors approves budgets for UNC Hospitals, UNCFP, REX, Chatham, High Point, Caldwell and UNCPN. The budget for UNCFP is also subject to approval by UNC-CH. Each entity of UNC Health Care produces monthly reports that compare budget and actual operating results. Department heads are expected to review the reports and identify significant variances from their budgets. If necessary, action plans are implemented that will improve negative variances. In addition to the monthly reports, an encumbrance system is maintained by UNC Hospitals and UNCFP to track open purchase orders and commitments made to vendors.

N.C.G.S. 116-37 granted UNC Health Care flexibility for management of UNC Hospitals in regard to its policies for personnel and salary management; purchasing of goods, services and property; and property construction. On an annual basis, UNC Health Care submits a report on its activity under this flexibility. The report is sent to the Educational Planning, Policies, and Programs Committee of the UNC Board of Governors and to the Joint Legislative Commission on Governmental Operations on or before Sept. 30 each year.

UNC Health Care is subject to the provisions of the Executive Budget Act, except for trust funds identified in N.C.G.S. 116-36.1 and 116-37.2. These two statutes primarily apply to the receipts generated by patient billings and other revenues from the operations of UNC Hospitals and UNCFP. UNC Hospitals submits monthly reports to the Office of State Budget and Management that reflect its overall operations. UNC Health Care receives no appropriation from the state. In the past, appropriated funds from the General Fund covered a portion of operating expenses, including the portion of expenses attributable to the cost of providing (i) care to indigent patients and (ii) graduate medical education.
**Debt Administration**

In May 2015, REX issued two series of bonds for costs associated with its Heart and Vascular Hospital. The Series 2015A was for $50M of fixed-rate bonds and the Series 2015B was for $100M of variable-rate bonds. Through June 30, 2015, REX had drawn down $11M of the Series 2015B bonds. None of the other UNC Health Care entities entered into new long-term debt-financing arrangements. UNC Hospitals issues debt through the UNC Board of Governors. REX, Chatham and High Point issue debt through the North Carolina Medical Care Commission.

Standard & Poor's and Moody's ratings services classify UNC Hospitals' bonds as AA and Aa3, respectively. Standard & Poor's, Moody's and Fitch classify REX's bonds as AA-, A2, and AA-, respectively. Standard & Poor's and Moody's classify Chatham's bonds as AA- and A3.

**Cash and Investment Management**

UNC Health Care continues to work with the Office of the State Treasurer and the University of North Carolina Management Company (UNCMC) to maximize the investment earnings for UNC Hospitals based on changes in the General Statutes that were made during the 2005, 2008 and 2011 sessions of the General Assembly. In addition, UNC-CH has allowed UNCFP to invest a portion of their funds in an intermediate fund beginning in fiscal year 2008. Investment earnings subsidize operating income and enable UNC Health Care to provide more services to the citizens of the state of North Carolina. The cash management policy includes all areas of receipts and disbursements so that investment earnings are maximized and vendor relations are maintained.

**Risk Management**

Exposures to loss are handled by a combination of methods, including participation in state-administered insurance programs, purchase of commercial insurance and self-retention of certain risks. The key to managing risk is to ensure that programs are in place that educate and guide employees to the best practices for our industry. We have a responsibility to safeguard our patients so that no additional harm comes to them while under our care. We are similarly committed to ensure a safe workplace for our employees.

In addition to the typical litigation risks with which we are faced, we have to recognize the risk and rewards associated with the health care industry. Continual evaluation of existing programs and new service development is the only way to maintain or increase our competitive advantage.

**ACKNOWLEDGEMENTS**

Preparation for this Annual Report in a timely manner would not have been possible without the coordinated efforts of the various financial staffs within UNC Health Care, with special assistance from the CEO’s office and the Communications, Marketing & External Affairs office.

John P. Lewis  
Chief Financial Officer  
The University of North Carolina Health Care System
UNC Health Care System Board of Directors

A. Dale Jenkins  
(Chair)  
CEO, Medical Mutual Holdings, Inc.  
Raleigh, NC

Anne H. Bernhardt  
Vice Chair, Bernhardt Furniture Company  
Lenoir, NC

Timothy Burnett  
President, Bessemer Improvement Company  
Greensboro, NC

Wesley Burks, MD  
Physician-in-Chief, NC Children’s Hospital  
Chapel Hill, NC

G. Hadley Callaway, MD  
Raleigh Orthopaedic Clinic  
Raleigh, NC

William H. Cameron  
President, Cameron Management, Inc.  
Wilmington, NC

Michael A. Crabb III  
Managing Director  
B.C. Ziegler and Company  
Nashville, TN

Susan B. Culp  
Past Chair, High Point Regional Health System  
High Point, NC

Allen J. Daugird, MD, MBA  
President, UNC Faculty Physicians  
President, UNC Physicians Network  
Chapel Hill, NC

Matthew Fajack  
CFO, The University of North Carolina at Chapel Hill  
Chapel Hill, NC

The Rev. Lisa G. Fischbeck  
Vicar, The Episcopal Church of the Advocate  
Chapel Hill, NC

Carol Folt, PhD  
Chancellor, The University of North Carolina at Chapel Hill  
Chapel Hill, NC

Ernest J. Goodson, DDS  
Orthodontist  
Fayetteville, NC

M. Andrew Greganti, MD  
Vice Chair, Department of Medicine  
Chapel Hill, NC

Barbara Jessie-Black  
Executive Director, PTA Thrift Shop, Inc.  
Carrboro, NC

William G. Lapsley  
President and Principal Engineer, William G. Lapsley & Associates, PA.  
Hendersonville, NC

Charles D. Owen III  
President, Fletcher Development Group, Inc.  
Fletcher, NC

Gary Park  
President, UNC Hospitals  
Chapel Hill, NC

Roger Perry  
President, East-West Partners  
Chapel Hill, NC

William L. Roper, MD, MPH  
Dean, UNC School of Medicine  
Vice Chancellor for Medical Affairs  
CEO, UNC Health Care System  
Chapel Hill, NC

J. Troy Smith Jr.  
Ward and Smith, PA  
New Bern, NC

Margaret Spellings  
President, The University of North Carolina  
Chapel Hill, NC

Greg Wessling  
Business Advisor, A&G Associates and Partners, LLC  
Davidson, NC

Edward Willingham  
President, First Citizens Bank  
Raleigh, NC
Management’s Discussion and Analysis

INTRODUCTION

Management’s Discussion and Analysis provides an overview of the financial position and activities of the University of North Carolina Health Care System (UNC Health Care) for the fiscal years ending June 30, 2015, and June 30, 2014. The financial statements included for UNC Health Care—Statement of Net Position; Statement of Revenues, Expenses and Changes in Net Position; and Statement of Cash Flows—are labeled “pro forma” to demonstrate that they are an aggregation of assets and liabilities and results of financial activities and not the result of an overall audit of UNC Health Care by an independent auditor and, as a result, should not be relied on as such.

UNC Health Care was established Nov. 1, 1998, by N.C.G.S. 116-37. The original legislation included only the University of North Carolina Hospitals (UNC Hospitals) and the clinical patient care programs of the University of North Carolina at Chapel Hill (UNC-CH). UNC Health Care is governed by a Board of Directors and is administered as an affiliated enterprise of the University of North Carolina. UNC Health Care and UNC-CH are sister entities. UNC Faculty Physicians (UNCFP) represents the clinical patient care programs of the UNC School of Medicine. UNC REX Healthcare, Inc. (REX), Chatham Hospital, Inc. (Chatham), High Point Regional Health (High Point), Caldwell Memorial Hospital (Caldwell), UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPNGP) have been added to the organization since its inception.

Effective Feb. 1, 2014, UNC Health Care and Johnston Memorial Hospital Authority (JMHA) entered into a Master Agreement to form Johnston Health Services Corporation (JHSC), a joint venture to provide health care services 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 UNC Health Care. UNC Health Care manages the day-to-day operations of JHSC.

As illustrated in the reporting structure on page 27, UNC Health Care owns and/or controls the net assets and financial operations of UNC Hospitals, REX, Chatham, High Point, Caldwell, UNCPN and UNCPNGP. In contrast, UNC-CH owns and controls the net assets and financial operations of UNCFP. The UNC Health Care Board of Directors governs and oversees physician credentialing, quality and patient safety, and resident training, and acts to advise and review the financial activities of UNCFP. Final direct control of the monetary operations of UNCFP remains within UNC-CH. The physicians who provide patient care at UNC Hospitals and in UNC-CH clinics are employees of UNC-CH. Most non-physician employees who assist in providing patient care and the associated administrative, billing and collection services are employees of UNC Health Care.

For purposes of these financial statements, UNCFP serves as a financial proxy for the “clinical patient care programs of the School of Medicine.” The financial statements for the entities directly controlled by UNC Health Care (UNC Hospitals, REX, Chatham, High Point, Caldwell, UNCPN and UNCPNGP) are separately audited on an annual basis and have received unqualified opinions for their prior year reports. The financial activities of UNCFP are included in the financial statements and audit report of UNC-CH. Since an unqualified audit opinion on the aggregation of financial information for these entities cannot be efficiently obtained, we have used the term “pro forma” to describe fairly the full financial scope and worth of UNC Health Care.

In the interest of being concise, we have included pro forma consolidated financial statements for UNC Health Care, which includes UNC Hospitals, REX, Chatham, High Point, Caldwell, UNCPN, UNCPNGP and UNCFP. Since UNCFP’s financial activities are not separately disclosed elsewhere, we also are presenting UNCFP’s Statement of Net Position, Statement of Revenues, Expenses and Changes in Net Position; and Statement of Cash Flows for the fiscal years ending June 30, 2015 and 2014.

USING THE FINANCIAL STATEMENTS

UNC Health Care’s financial statements provide information regarding its financial position and results of operations as of June 30, 2015, and 2014 and the years then ended. The Statement of Net Position; the Statement of Revenues, Expenses and Changes in Net Position; and the Statement of Cash Flows comprise the basic financial statements required by the Governmental Accounting Standards Board (GASB).

In accordance with GASB, the pro forma financial statements are presented and follow reporting concepts consistent with those required of a private business enterprise. The financial statement balances reported are presented in a classified format to aid the reader in understanding the nature of the operations. The Notes to the Financials provide information relative to the significant accounting principles applied in the financial statements and further detail concerning the organization and its operations. These disclosures provide information to better understand details, risk and uncertainty associated with the amounts reported and are considered an integral part of the financial statements.

The pro forma Statement of Net Position provides information relative to the assets (resources), deferred outflows of resources, liabilities (claims to resources), deferred inflows of resources, and net position (equity). Assets and liabilities on this Statement are categorized as either current or noncurrent. Current assets are those that are available to pay for expenses in the next fiscal year, and it is anticipated that they will be used to pay for current liabilities. Current liabilities are those payable in the next fiscal year. Management estimates are necessary in some instances to determine current or noncurrent categorization. The pro forma Statement of Net Position provides information relative to the financial strength of the organization and its ability to meet current and long-term obligations.
The pro forma Statement of Revenues, Expenses and Changes in Net Position provides information relative to the results of the organization's operations, non-operating activities and other activities affecting net assets. Non-operating activities include noncapital gifts and grants, investment income (net of investment expenses), unrealized gains and losses on investments, and loss realized on the disposition of capital assets. Under GASB, bond interest expense is considered a non-operating activity; but for these pro forma statements it is presented as operating. The pro forma Statement of Revenues and Expenses provides information relative to the management of the organization's operations and its ability to maintain its financial stability.

The pro forma Statement of Cash Flows provides information relative to the cash receipts, cash disbursements, and net changes in cash resulting from operating activities, non-capital financing activities, capital and related financing activities, and investing activities. The Statement provides a reconciliation of beginning cash balances to ending cash balances and is representative of the activity reported on the pro forma Statement of Revenues, Expenses and Changes in Net Assets as adjusted for changes in the beginning and ending balances of noncash accounts on the pro forma Statement of Net Assets.

The Notes to the Financials provide information relative to the significant accounting principles applied in the financial statements, authority for and associated risk of deposits and investments, information on long-term liabilities, accounts receivable, accounts payable, revenues and expenses, pension plans and other post-employment benefits, insurance against losses, commitments and contingencies, accounting changes, and a discussion of adjustments to prior periods and events subsequent to the enterprise's financial statement period when appropriate. These disclosures provide information to better understand details, risks, and uncertainty associated with the amounts reported and are considered an integral part of the financial statements.

**COMPARISON OF TWO-YEAR DATA FOR 2015 TO 2014**

Data for 2015 and 2014 are presented in this report and discussed in the following sections. Discussion in the following sections is pertinent to fiscal year 2015 results and changes relative to ending balances in fiscal year 2014.

**Analysis of Overall Financial Position and Results of Operations**

**STATEMENT OF NET POSITION**

Total assets increased overall by $359.2 million or 10.5 percent during fiscal year 2015. Current assets increased $148.1 million primarily due to favorable cash flow from operations that resulted in an increase in cash and cash equivalents. Noncurrent assets increased $211.1 million due to capital investments for the construction of UNC Health Care Hillsborough Campus and the North Carolina Heart & Vascular Hospital at REX. The UNC Health Care Hillsborough Campus serves as a fully functioning acute care satellite hospital of UNC Hospitals that opened in July 2015. The North Carolina Heart & Vascular Hospital at REX is slated for opening in January 2017. Liabilities increased $234.1 million or 15.5 percent during fiscal year 2015. Accounts payable and other increased due to the aforementioned construction projects. Long-term notes and bonds payable increased $64.7 million as REX issued tax-exempt revenue bonds to fund a portion of the construction of the North Carolina Heart & Vascular Hospital. Accrued salaries increased with FTE growth, salary growth and an increase in the employee incentive accrual.

**STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION**

UNC Health Care generated operating income of $109.2 million (3.4% operating margin) in fiscal year 2015, representing an improvement of $140.4 million over fiscal year 2014. This improvement is attributed to the elimination of nonrecurring operating expenses related to the implementation of the Epic electronic medical record system in fiscal 2014, continued growth in volume, and management of operating expense. Net Operating Revenue increased by $333.0 million (11.6%), primarily attributable to volume growth and increased payments from negotiated payor contracts. Operating expenses grew at a 6.7 percent rate. The impact of increasing volumes on operating expenses was partially offset by the impact of nonrecurring operating expenses incurred in fiscal 2014 related to the Epic implementation and a favorable impact to pension expense under the new GASB pension accounting standard. Aggressive cost containment efforts continue in non-growth areas. In order to remain financially strong, to reinvest in new facilities, and to retain the most highly trained work force, UNC Health Care’s goal is to average an annual operating margin of at least 4 percent.

Nonoperating gains were positive at $16.0 million but decreased $62.2 million from fiscal year 2014 attributable to lower investment returns in fiscal year 2015 following historically high returns in fiscal year 2014. Net income was $125.2 million, a 3.9 percent margin.

**Discussion of Capital Asset and Long-Term Debt Activity**

**CAPITAL ASSETS**

In addition to the investment in Epic, which included $84.2 million of costs capitalized during fiscal year 2015, UNC Health Care continued to improve and modernize its facilities during the past year.

UNC Hospitals expended $83.6 million on the acquisition and construction of buildings, infrastructure and renovations. An additional $27.8 million was paid during the year for capital equipment throughout the facilities and $7.5 million on software. Total capital investment was $118.9 million for the year. Commitments of $28.5 million were outstanding on construction contracts at June 30, 2015.

REX continued growth seen in prior fiscal years. Capital investments in fiscal year 2015 were $51.3 million consisting primarily of costs incurred in connection with the construction of the new North Carolina Heart & Vascular Hospital, and medical technology and renovations.

**LONG-TERM DEBT ACTIVITY**

UNC Health Care has no borrowing authority. UNC Hospitals, REX, High Point and Chatham have issued revenue bonds in the past and may issue additional debt in the future should the need arise to finance construction projects and if the market rates are favorable. UNCFP issues its bonds through UNC-CH. As such, its revenues and assets are a part of the bond covenants of UNC-CH. UNC Hospitals, High Point and Chatham did not enter into new debt-financing arrangements during the past fiscal year.

During fiscal year 2015, REX obtained financing for a portion of the construction costs of the North Carolina Health & Vascular Hospital.

REX issued $50 million Series 2015A Healthcare Facilities Revenue Bonds in May 2015. The Series 2015A Bonds bear interest at rates ranging from 3.5% and 5.0% and mature annually at amounts ranging from $2.7 million to $4.6 million between 2032 and 2045.

Standard & Poor’s and Moody’s ratings services classify UNC Hospitals’ bonds as AA and Aa3, respectively. Standard & Poor’s and Fitch reaffirmed REX’s bonds as AA- and Moody’s downgraded REX’s credit rating to A2. Additional information about debt activity can be found in the Notes to Financials.

Discussion of Conditions that May Have a Significant Effect on Net Assets or Revenues and Expenses

UNC Health Care derives the vast majority of its operating revenues from patient care services. Strong operating performance has enabled UNC Health Care to make investments in support of the clinical, education and research programs of UNC Faculty Physicians, the UNC School of Medicine and other network entities. These investments have yielded positive results as measured by growth in needed services, expansion of the medical school class and increased research funding.

The health care sector continues to face tumultuous change. Pressure on health care providers has come in the form of expectations to provide greater value at a lower cost, to have fully interoperable electronic health records, to care for the uninsured, to integrate care for individual patients, and to improve wellness across populations.

UNC Health Care has sought to remain a leader in evolving to meet the demands of the changing environment. We are making infrastructure investments to modernize our patient care. The inpatient census at the academic medical center in Chapel Hill is regularly near maximum capacity. To address this need, UNC Health Care developed and opened the Hillsborough Campus, an extension of UNC Medical Center. Acute care services began early in fiscal year 2016. Further, many of our facilities, especially in procedural areas, were designed for the way care was delivered five decades ago. Accordingly, the construction of the North Carolina Heart & Vascular Hospital on the REX campus is underway, and we are in the process of developing a replacement perioperative tower on the Chapel Hill campus. These facilities are being designed to optimize efficiency and the patient experience.

UNC Health Care is engaged in a review of all operations through a program known as Carolina Value. This program is being developed and executed to enable UNC Health Care to be more integrated operationally and clinically. The intended goal is to improve the health of the people of North Carolina, provide exceptional patient care and service, become more efficient and work together as one team across UNC Health Care, exploiting best practices through our talented staff members.

During fiscal year 2014, UNC Health Care implemented an integrated medical record across all of our Triangle service area. UNC Health Care long operated with electronic medical records. However, the system used at the academic medical center was unique from the system at Chatham Hospital, the system at REX Hospital, or the several systems used in our community physician practices and new affiliates. These systems did not “talk” well with one another, and any form of data transfer between them was limited and cumbersome. Therefore, we established a vision for one patient to have one record everywhere within UNC Health Care. UNC Health Care implemented the Epic medical record at UNC Medical Center, REX, Chatham and the UNCPN physician practices in fiscal year 2014 and at the Caldwell and High Point physician practices in fiscal year 2015. The phased rollout will continue across our remaining entities in fiscal year 2016. This is a pervasive endeavor requiring organizational focus and resources.

Third-party payors, including governmental sponsored programs, continue to migrate from fee-for-service to fee-for-value. Traditional payment mechanisms have paid providers for each intervention. As a result, providers have been paid more for providing more care, not necessarily for providing better care. UNC Health Care is researching ways to respond to a new model that shifts risk and accountability to UNC Health Care. UNC Health Care is positioning 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. These programs include an operational and strategic partnership with Alignment Healthcare for population management. This partnership kicked off with the offering of a new Medicare Advantage HMO plan for seniors in Wake County, North Carolina, in the fall of 2014. This is but one example among several that we are pursuing as we embrace the long-term view that to increase the value of our clinical services, we must accept—and be rewarded for accepting—increased accountability and risk.

We are engaging with new partners as the provider community consolidates. Of the more than 100 hospitals in North Carolina, today fewer than 25 remain unaffiliated with larger systems. Nationally and in North Carolina, the increasing demands on providers, both physician groups and hospitals, has caused many to seek partners in larger systems. Several of these—High Point Regional Health System, Caldwell Memorial Hospital and Johnston Health Services Corporation have joined UNC Health Care. With our help, these hospitals will be able to provide more of the care needed in local communities; they will be able to access our state-of-the-art information systems (e.g. Epic) that are otherwise unaffordable, and they will become more efficient by leveraging UNC Health Care’s scale.

We are responding to the State’s needs and the needs of underserved populations. UNC Health Care has proudly cared for underserved patients as a safety net provider. In recent years, the cost we incur for those unable to pay for their care has exceeded $300 million. We also serve North Carolina in other ways such as providing much of the specialty and hospital care for the Department of Public Safety. We have found multiple cost-saving measures that will preserve taxpayer resources. In early 2013, we also extended our psychiatric services in Wake County. We have opened new inpatient acute psychiatric beds but also operate two levels of step-down care that can be a model for better care that integrates psychiatric services with the patients’ other medical needs.

UNC Health Care System agreed to provide, enhance and expand all services offered in the past at Wake County’s WakeBrook facility. Pursuant to agreements with Wake County and Alliance Behavioral Health, the System began with the operation of WakeBrook Crisis and Assessment services on February 1, 2013. WakeBrook is now fully operational, providing the behavioral health and medical services including Crisis and Assessment, Residential Treatment, a Detoxification Unit, Onsite Medical Care, Primary Care and an Assertive Community Treatment Team. WakeBrook was included in UNC Hospitals’ accreditation survey by The Joint Commission in December 2013. UNC Health Care committed to invest $40 million in behavioral health services in Wake County, including the operation of 28 inpatient beds, during the next five to 10 years.

Successfully managing in the future requires tighter integration of administrative functions across the entities of UNC Health Care, caring for patients in lower-cost delivery settings, and comprising sufficient scale to spread the cost of major investments across a broad base. UNC Health Care continues to plan for these changes through a health system-wide planning and implementation process.
## Pro Forma Statement of Net Position

*For the Years Ended June 30, 2015, and June 30, 2014*

<table>
<thead>
<tr>
<th>Account</th>
<th>2015</th>
<th>2014*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Investments</td>
<td>$373,174,000</td>
<td>$203,118,000</td>
</tr>
<tr>
<td>Patient Accounts Receivable - Net</td>
<td>384,129,000</td>
<td>372,621,000</td>
</tr>
<tr>
<td>Inventories</td>
<td>61,495,000</td>
<td>53,009,000</td>
</tr>
<tr>
<td>Other Assets and Receivables</td>
<td>307,254,000</td>
<td>332,637,000</td>
</tr>
<tr>
<td>Assets Whose Use Is Limited or Restricted</td>
<td>55,563,000</td>
<td>82,009,000</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>45,173,000</td>
<td>35,343,000</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>1,226,788,000</td>
<td>1,078,737,000</td>
</tr>
<tr>
<td><strong>NONCURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant and Equipment - Net</td>
<td>1,472,538,000</td>
<td>1,344,731,000</td>
</tr>
<tr>
<td>Assets Whose Use Is Limited or Restricted</td>
<td>915,889,000</td>
<td>895,694,000</td>
</tr>
<tr>
<td>Other Assets</td>
<td>158,282,000</td>
<td>95,181,000</td>
</tr>
<tr>
<td>Total Noncurrent Assets</td>
<td>2,546,709,000</td>
<td>2,335,606,000</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>3,773,497,000</td>
<td>3,414,343,000</td>
</tr>
<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts and Other Payables</td>
<td>345,979,000</td>
<td>249,207,000</td>
</tr>
<tr>
<td>Accrued Salaries and Benefits</td>
<td>150,583,000</td>
<td>128,493,000</td>
</tr>
<tr>
<td>Estimated Third-Party Settlements</td>
<td>163,575,000</td>
<td>169,227,000</td>
</tr>
<tr>
<td>Notes and Bonds Payable</td>
<td>27,207,000</td>
<td>56,347,000</td>
</tr>
<tr>
<td>Interest Payable</td>
<td>4,150,000</td>
<td>4,203,000</td>
</tr>
<tr>
<td>Other</td>
<td>24,258,000</td>
<td>23,364,000</td>
</tr>
<tr>
<td>Total Current Liabilities</td>
<td>715,752,000</td>
<td>630,841,000</td>
</tr>
<tr>
<td><strong>NONCURRENT LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes and Bonds Payable</td>
<td>487,290,000</td>
<td>422,568,000</td>
</tr>
<tr>
<td>Compensated Absences</td>
<td>107,328,000</td>
<td>69,186,000</td>
</tr>
<tr>
<td>Other Noncurrent Liabilities</td>
<td>436,932,000</td>
<td>390,742,000</td>
</tr>
<tr>
<td>Total Noncurrent Liabilities</td>
<td>1,031,550,000</td>
<td>882,496,000</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>1,747,302,000</td>
<td>1,513,337,000</td>
</tr>
<tr>
<td><strong>NET POSITION</strong></td>
<td><strong>$2,026,195,000</strong></td>
<td><strong>$1,901,006,000</strong></td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
<td><strong>$3,773,497,000</strong></td>
<td><strong>$3,414,343,000</strong></td>
</tr>
</tbody>
</table>

*2014 as restated*
THE UNIVERSITY OF NORTH CAROLINA HEALTH CARE SYSTEM

Pro Forma Statement of Revenues, Expenses and Changes in Net Position

For the Years Ended June 30, 2015, and June 30, 2014

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>$3,002,227,000</td>
<td>$2,689,374,000</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>193,390,000</td>
<td>173,227,000</td>
</tr>
<tr>
<td><strong>Net Operating Revenue</strong></td>
<td><strong>3,195,617,000</strong></td>
<td><strong>2,862,601,000</strong></td>
</tr>
<tr>
<td><strong>OPERATING EXPENSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Fringe Benefits</td>
<td>1,792,468,000</td>
<td>1,670,239,000</td>
</tr>
<tr>
<td>Medical and Surgical Supplies</td>
<td>570,896,000</td>
<td>479,040,000</td>
</tr>
<tr>
<td>Contracted Services</td>
<td>346,120,000</td>
<td>385,736,000</td>
</tr>
<tr>
<td>Other Supplies and Services</td>
<td>160,687,000</td>
<td>158,756,000</td>
</tr>
<tr>
<td>Communications and Utilities</td>
<td>45,946,000</td>
<td>43,554,000</td>
</tr>
<tr>
<td>Medical Malpractice Costs</td>
<td>4,068,000</td>
<td>6,906,000</td>
</tr>
<tr>
<td>Depreciation</td>
<td>137,750,000</td>
<td>118,868,000</td>
</tr>
<tr>
<td>Bond and Other Interest Expense</td>
<td>14,607,000</td>
<td>18,630,000</td>
</tr>
<tr>
<td>Medical School Trust Fund (MSTF)</td>
<td>13,843,000</td>
<td>12,063,000</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td><strong>3,086,385,000</strong></td>
<td><strong>2,893,792,000</strong></td>
</tr>
<tr>
<td><strong>OPERATING INCOME (LOSS)</strong></td>
<td><strong>109,232,000</strong></td>
<td><strong>(31,191,000)</strong></td>
</tr>
<tr>
<td><strong>NONOPERATING GAINS (LOSSES)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest and Investment Activity</td>
<td>45,012,000</td>
<td>120,101,000</td>
</tr>
<tr>
<td>Nonoperating Income (Expense)</td>
<td>(3,586,000)</td>
<td>461,000</td>
</tr>
<tr>
<td>Grants</td>
<td>(25,469,000)</td>
<td>(42,358,000)</td>
</tr>
<tr>
<td><strong>Total Nonoperating Gains</strong></td>
<td><strong>15,957,000</strong></td>
<td><strong>78,204,000</strong></td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td><strong>$125,189,000</strong></td>
<td><strong>$47,013,000</strong></td>
</tr>
</tbody>
</table>

*2014 as restated
### Pro Forma Statement of Cash Flows
**For the Years Ended June 30, 2015, and June 30, 2014**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH FLOWS FROM OPERATING ACTIVITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received from Patients and Third Parties</td>
<td>$2,985,067,000</td>
<td>$2,728,689,000</td>
</tr>
<tr>
<td>Payments to Employees and Fringe Benefits</td>
<td>(1,738,244,000)</td>
<td>(1,693,537,000)</td>
</tr>
<tr>
<td>Payments to Vendors and Suppliers</td>
<td>(1,046,281,000)</td>
<td>(1,020,228,000)</td>
</tr>
<tr>
<td>Payments for Medical Malpractice</td>
<td>(4,306,000)</td>
<td>(8,422,000)</td>
</tr>
<tr>
<td>Other Receipts</td>
<td>181,014,000</td>
<td>100,622,000</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td><strong>377,250,000</strong></td>
<td><strong>107,124,000</strong></td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care System Grants Paid to UNC</td>
<td>(25,469,000)</td>
<td>(35,582,000)</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td><strong>(25,469,000)</strong></td>
<td><strong>(35,582,000)</strong></td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from Issuance of Long-Term Debt</td>
<td>61,402,000</td>
<td>-</td>
</tr>
<tr>
<td>Principal and Arbitrage Paid on Outstanding Debt</td>
<td>(27,819,000)</td>
<td>(29,198,000)</td>
</tr>
<tr>
<td>Interest and Fees Paid on Debt</td>
<td>(12,099,000)</td>
<td>(19,313,000)</td>
</tr>
<tr>
<td>Acquisition and Construction of Capital Assets</td>
<td>(226,140,000)</td>
<td>(236,097,000)</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td><strong>(204,656,000)</strong></td>
<td><strong>(284,608,000)</strong></td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM INVESTING ACTIVITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment Income and Other Activity</td>
<td>45,012,000</td>
<td>120,101,000</td>
</tr>
<tr>
<td>Purchase and Sale of Investments, Net of Fees</td>
<td>6,251,000</td>
<td>(34,034,000)</td>
</tr>
<tr>
<td>Investments in and Loans to Affiliated Enterprises - Net</td>
<td>(28,332,000)</td>
<td>(31,026,000)</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td><strong>22,931,000</strong></td>
<td><strong>55,041,000</strong></td>
</tr>
<tr>
<td><strong>NET INCREASE (DECREASE)</strong></td>
<td><strong>$170,056,000</strong></td>
<td><strong>$(158,025,000)</strong></td>
</tr>
<tr>
<td><strong>BEGINNING CASH AND CASH EQUIVALENTS</strong></td>
<td><strong>$203,118,000</strong></td>
<td><strong>$361,143,000</strong></td>
</tr>
<tr>
<td><strong>ENDING CASH AND CASH EQUIVALENTS</strong></td>
<td><strong>$373,174,000</strong></td>
<td><strong>$203,118,000</strong></td>
</tr>
</tbody>
</table>

*2014 as restated
## Statement of Net Position (Unaudited)

*For the Years Ended June 30, 2015, and June 30, 2014*

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Investments</td>
<td>$61,723,000</td>
<td>$83,955,000</td>
</tr>
<tr>
<td>Patient Accounts Receivable - Net</td>
<td>51,302,000</td>
<td>50,869,000</td>
</tr>
<tr>
<td>Estimated Third-Party Settlements</td>
<td>40,393,000</td>
<td>27,938,000</td>
</tr>
<tr>
<td>Other Assets and Receivables</td>
<td>43,126,000</td>
<td>25,657,000</td>
</tr>
<tr>
<td>Assets Whose Use Is Limited or Restricted</td>
<td>6,686,000</td>
<td>6,457,000</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>11,410,000</td>
<td>8,371,000</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>214,640,000</strong></td>
<td><strong>203,247,000</strong></td>
</tr>
<tr>
<td><strong>NONCURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant and Equipment - Net</td>
<td>3,042,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Noncurrent Assets</strong></td>
<td><strong>3,042,000</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>217,682,000</strong></td>
<td><strong>203,247,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts and Other Payables</td>
<td>44,496,000</td>
<td>33,601,000</td>
</tr>
<tr>
<td>Accrued Salaries and Benefits</td>
<td>18,065,000</td>
<td>8,799,000</td>
</tr>
<tr>
<td>Estimated Third-Party Settlements</td>
<td>8,083,000</td>
<td>7,774,000</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>811,000</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>70,644,000</strong></td>
<td><strong>50,985,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NONCURRENT LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensated Absences</td>
<td>37,058,000</td>
<td>29,995,000</td>
</tr>
<tr>
<td><strong>Total Noncurrent Liabilities</strong></td>
<td><strong>37,058,000</strong></td>
<td><strong>29,995,000</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>107,702,000</strong></td>
<td><strong>80,980,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NET POSITION</strong></td>
<td><strong>$109,980,000</strong></td>
<td><strong>$122,267,000</strong></td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
<td><strong>$217,682,000</strong></td>
<td><strong>$203,247,000</strong></td>
</tr>
</tbody>
</table>
**Statement of Revenues, Expenses and Changes in Net Position (Unaudited)**

*For the Years Ended June 30, 2015, and June 30, 2014*

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>$343,429,000</td>
<td>$314,008,000</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>84,609,000</td>
<td>80,398,000</td>
</tr>
<tr>
<td><strong>Net Operating Revenue</strong></td>
<td><strong>428,038,000</strong></td>
<td><strong>394,406,000</strong></td>
</tr>
<tr>
<td><strong>OPERATING EXPENSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Fringe Benefits</td>
<td>389,398,000</td>
<td>346,109,000</td>
</tr>
<tr>
<td>Medical and Surgical Supplies</td>
<td>15,272,000</td>
<td>15,714,000</td>
</tr>
<tr>
<td>Contracted Services</td>
<td>59,735,000</td>
<td>56,542,000</td>
</tr>
<tr>
<td>Other Supplies and Services</td>
<td>16,696,000</td>
<td>19,925,000</td>
</tr>
<tr>
<td>Communications and Utilities</td>
<td>2,758,000</td>
<td>2,876,000</td>
</tr>
<tr>
<td>Medical Malpractice Costs</td>
<td>966,000</td>
<td>1,777,000</td>
</tr>
<tr>
<td>Medical School Trust Fund (MSTF)</td>
<td>13,843,000</td>
<td>12,063,000</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td><strong>498,668,000</strong></td>
<td><strong>455,006,000</strong></td>
</tr>
<tr>
<td><strong>OPERATING INCOME (LOSS)</strong></td>
<td>(70,630,000)</td>
<td>(60,600,000)</td>
</tr>
<tr>
<td><strong>NONOPERATING GAINS (LOSSES)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest and Investment Income</td>
<td>1,340,000</td>
<td>2,181,000</td>
</tr>
<tr>
<td>Transfers to HCS Enterprise Fund</td>
<td>(16,234,000)</td>
<td>(17,265,000)</td>
</tr>
<tr>
<td>Transfers from HCS Enterprise Fund</td>
<td>73,237,000</td>
<td>69,883,000</td>
</tr>
<tr>
<td><strong>Total Nonoperating Gains (Losses)</strong></td>
<td><strong>58,343,000</strong></td>
<td><strong>54,799,000</strong></td>
</tr>
<tr>
<td><strong>CHANGE IN NET POSITION</strong></td>
<td>$(12,287,000)</td>
<td>$(5,801,000)</td>
</tr>
</tbody>
</table>
Statement of Cash Flows (Unaudited)
For the Years Ended June 30, 2015, and June 30, 2014

<table>
<thead>
<tr>
<th>CASH FLOWS FROM OPERATING ACTIVITIES</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received from Patients and Third Parties</td>
<td>$330,852,000</td>
<td>$290,810,000</td>
</tr>
<tr>
<td>Payments to Employees and Fringe Benefits</td>
<td>(373,071,000)</td>
<td>(342,169,000)</td>
</tr>
<tr>
<td>Payments to Vendors and Suppliers</td>
<td>(91,852,000)</td>
<td>(95,352,000)</td>
</tr>
<tr>
<td>Payments for Medical Malpractice</td>
<td>(1,412,000)</td>
<td>(1,800,000)</td>
</tr>
<tr>
<td>Operating Capital Grants</td>
<td>60,421,000</td>
<td>69,927,000</td>
</tr>
<tr>
<td>Other Receipts</td>
<td>70,766,000</td>
<td>68,336,000</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td>(4,296,000)</td>
<td>(10,248,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquisition and Construction of Capital Assets</td>
<td>(3,042,000)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td>(3,042,000)</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOWS FROM INVESTING ACTIVITIES</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Income and Other Activity</td>
<td>1,340,000</td>
<td>2,181,000</td>
</tr>
<tr>
<td>Investments in and Loans to Affiliated Enterprises - Net</td>
<td>(16,234,000)</td>
<td>(17,265,000)</td>
</tr>
<tr>
<td><strong>Net Cash Provided (Used)</strong></td>
<td>(14,894,000)</td>
<td>(15,084,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NET INCREASE (DECREASE)</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$(22,232,000)</td>
<td>$(25,332,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEGINNING CASH AND CASH EQUIVALENTS</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$83,955,000</td>
<td>$109,287,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENDING CASH AND CASH EQUIVALENTS</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$61,723,000</td>
<td>$83,955,000</td>
</tr>
</tbody>
</table>
The University of North Carolina Health Care System

Pro Forma Selected Statistics and Ratios

For the Years Ended June 30, 2015, and June 30, 2014

<table>
<thead>
<tr>
<th></th>
<th>REX SITES</th>
<th>CHATHAM SITES</th>
<th>HPRH SITES</th>
<th>CALDWELL SITES</th>
<th>UNC SITES</th>
<th>UNCPN SITES</th>
<th>2015 UNC HEALTH CARE TOTAL</th>
<th>2014* UNC HEALTH CARE TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT SERVICE STATISTICS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Days</td>
<td>124,278</td>
<td>4,993</td>
<td>67,813</td>
<td>17,685</td>
<td>263,137</td>
<td></td>
<td>477,906</td>
<td>481,340</td>
</tr>
<tr>
<td>Inpatient Discharges</td>
<td>26,114</td>
<td>690</td>
<td>15,693</td>
<td>3,667</td>
<td>35,058</td>
<td></td>
<td>81,222</td>
<td>82,190</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>4.2</td>
<td>3.0</td>
<td>4.2</td>
<td>4.8</td>
<td>6.3</td>
<td></td>
<td>5.9</td>
<td>5.8</td>
</tr>
<tr>
<td>Inpatient Operating Room Cases</td>
<td>10,258</td>
<td>32</td>
<td>2,506</td>
<td>1,099</td>
<td>12,729</td>
<td></td>
<td>26,624</td>
<td>27,467</td>
</tr>
<tr>
<td>Outpatient Operating Room Cases</td>
<td>21,930</td>
<td>715</td>
<td>2,456</td>
<td>4,376</td>
<td>16,934</td>
<td></td>
<td>46,411</td>
<td>46,229</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>54,219</td>
<td>16,112</td>
<td>63,475</td>
<td>29,007</td>
<td>69,273</td>
<td></td>
<td>232,086</td>
<td>237,864</td>
</tr>
<tr>
<td>Clinic Visits</td>
<td>490,986</td>
<td>-</td>
<td>248,193</td>
<td>-</td>
<td>1,003,579</td>
<td></td>
<td>578,028</td>
<td>1,764,086</td>
</tr>
<tr>
<td>Births/Deliveries</td>
<td>5,484</td>
<td>-</td>
<td>1,551</td>
<td>391</td>
<td>3,679</td>
<td></td>
<td>11,105</td>
<td>11,152</td>
</tr>
<tr>
<td><strong>FINANCIAL RATIOS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin Percentage</td>
<td>3.42%</td>
<td>-1.08%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days in Net Accounts Receivable</td>
<td>46.70</td>
<td>50.57</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days of Cash on Hand (includes investments)</td>
<td>155.88</td>
<td>159.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Payment Period (days)</td>
<td>112.39</td>
<td>89.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Debt to Equity</td>
<td>19.39%</td>
<td>16.28%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Debt Service Coverage</td>
<td>6.95</td>
<td>4.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2014 as restated
NOTES TO FINANCIALS

NOTE 1 // SIGNIFICANT ACCOUNTING POLICIES

A. ORGANIZATION – The University of North Carolina Health Care System (UNC Health Care) was established November 1, 1998, by N.C.G.S. 116-37. It is governed and administered as an affiliated enterprise of The University of North Carolina system with its stated purpose to provide patient care, facilitate the education of physicians and other health care providers, conduct research collaboratively with the health sciences schools of The University of North Carolina at Chapel Hill (UNC-CH) and render other services designed to promote the health and well-being of the citizens of North Carolina.

The original legislation included the University of North Carolina Hospitals at Chapel Hill (UNC Hospitals) and the clinical patient care programs established or maintained by the School of Medicine of The University of North Carolina at Chapel Hill, including University of North Carolina Physicians and Associates (UNC P&A). As of January 1, 2013, UNC Physicians & Associates changed its name to UNC Faculty Physicians (UNCFP) to better identify the relationship with the UNC School of Medicine. UNC Health Care is under the governance of the Board of Directors of UNC Health Care. UNC REX Healthcare, Inc. (REX), Chatham Hospital, Inc. (Chatham), High Point Regional Health (High Point), Caldwell Memorial Hospital (Caldwell), UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPNGP) have been added to the organization since its inception.

The University of North Carolina Hospitals – The University of North Carolina Hospitals at Chapel Hill (UNC Hospitals) is the only state-owned teaching hospital in North Carolina. With a licensed base of 830 beds, this facility serves as an acute care teaching hospital for The University of North Carolina at Chapel Hill. UNC Hospitals consists of North Carolina Memorial Hospital, North Carolina Children’s Hospital, North Carolina Neurosciences Hospital, North Carolina Women’s Hospital and North Carolina Cancer Hospital. As a state agency, UNC Hospitals is required to conform to financial requirements established by various statutory and constitutional provisions. While UNC Hospitals is exempt from both federal and state income taxes, a small portion of its revenue is subject to the unrelated business income tax.

BLENDED COMPONENT UNITS – Although legally separate, Health System Properties, LLC (the LLC), a component unit of UNC Hospitals, is reported as if it were part of the Hospitals.

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

The University of North Carolina Faculty Physicians – Formerly known as UNC Physicians & Associates, University of North Carolina Faculty Physicians (UNCFP) is the clinical service component of the UNC School of Medicine. At the heart of UNCFP are the approximately 1,100 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 19 clinical departments, two affiliated departments and two administrative units that collectively form UNCFP.

The University of North Carolina Physicians Network – The University of North Carolina Physicians Network (UNCPN) is the parent holding company of High Point Regional Health Foundation, High Point Health Care Ventures, Inc., and High Point Regional Health Services, Inc.

While UNCFP is affiliated with UNC Health Care, the net assets of UNCFP are held in a UNC-CH trust fund. The operating income and expenses for UNCFP are managed via UNC-CH’s accounting infrastructure; and, as such, its operational results are included in the annual audit for UNC-CH.

UNC REX Healthcare, Inc. – UNC REX Healthcare, Inc. (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 the corporation and appoints eight of the 13 seats on REX’s Board of Trustees and reviews and approves REX’s annual operating and capital budgets.

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 System appoints nine of the 15 members on the Chatham Hospital, Inc. Board and reviews and approves its annual operating and capital budgets.

UNC Physicians Network and UNC Physicians Network Group Practice – UNC Physicians Network and UNC Physicians Network Group Practice are wholly owned subsidiaries of the System but are private employers that own and operate more than 30 community physician practices throughout the Triangle region of North Carolina (Raleigh, Durham and Chapel Hill).

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.

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

The System became the sole corporate member of HPRH on March 31, 2013. HPRH is the parent holding company of High Point Regional Health Foundation, High Point Health Care Ventures, Inc., and High Point Regional Health Services, Inc.
**B. BASIS OF PRESENTATION** – The accompanying financial statements present all activities under the direction of the UNC Health Care Board of Directors. The financial statements for UNC Health Care are presented as a compilation of the various statements generated by its separate entities. UNC Hospitals, REX, Chatham, and UNCPN issue their own audited financial statements while UNCFP is included as a part of the audited statements for UNC-CH.

In compiling the financial statements for UNC Health Care, significant intercompany transactions and balances between the related parties have been eliminated. In addition, while the general statutes refer to only the clinical operations of the School of Medicine, which are reported through UNCFP, this annual report includes the assets, liabilities and net assets of UNCFP, which are included in the audited financial statements for UNC-CH.

**C. BASIS OF ACCOUNTING** – The financial statements of the various entities have been prepared using the accrual basis of accounting for UNC Hospitals, REX, Chatham, and UNCPN and the modified accrual basis of accounting for UNCFP. Under the accrual basis, revenues are recognized when earned; and expenses are recorded when an obligation has been incurred. When preparing the financial statements, management makes estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from the estimates. For UNCFP, their monthly financials are maintained on a cash basis; and then at year-end, adjustments are made to accrue all known material amounts for revenue and expense.

**D. CURRENT AND NONCURRENT DESIGNATION** – Assets are classified as current when they are expected to be collected within the next 12 months or consumed for a current expense in the case of cash or prepaid items. Liabilities are classified as current when they are expected to be collected within the next 12 months.

**E. OPERATING AND NON-OPERATING ACTIVITIES** – Revenues and expenses are classified as operating or non-operating in the accompanying Statements 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 principal ongoing operations. Operating revenues include activities that have characteristics of exchange transactions, such as charges for inpatient and outpatient services as well as for external customers who purchase medical services or supplies. Operating expenses are all expense transactions incurred other than those related to capital and noncapital financing or investing activities.

Non-operating revenues include activities that have the characteristics of non-exchange transactions. Revenues from non-exchange transactions “and donations” that represent subsidies or gifts, as well as investment income “and gain (loss) on disposal of capital assets,” are considered non-operating since these are investing, capital or noncapital financing activities.

**F. CASH AND CASH EQUIVALENTS** – This classification includes all highly liquid investments with an original maturity of three months or less when purchased, including deposits held by the State Treasurer in the short-term investment fund (STIF). The STIF account 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.

UNC-CH manages the funds of UNCFP as authorized by the University of North Carolina Board of Governors pursuant to N.C.G.S. 116-36.2 and Section 600.2.4 of the Policy Manual of the University of North Carolina. Special funds and funds received for services rendered by health care professionals pursuant to N.C.G.S 116-36.1(h) are invested in the same manner as the State Treasurer is required to invest. Investments of various funds may be pooled unless prohibited by statute or by terms of the gift or contract. UNC-CH utilizes investment pools to manage investments and distribute investment income. Shares in the temporary pool trade at a fixed value of $1 per share.

**G. INVESTMENTS** – This classification includes marketable debt and equity securities with readily determinable fair values, including assets whose use is limited and is measured at fair value. Investment income or loss (including realized and unrealized gains and losses on investments, interest and dividends) is included in non-operating income (loss). The calculation of realized gains and losses is independent of a calculation of the net change in the fair value of investments.

**H. PATIENT ACCOUNTS RECEIVABLE, NET** – Net patient accounts receivable consist of unbilled (in-house patients, inpatients discharged but not final billed and outpatients not final billed) and billed amounts. Payment of these charges comes primarily from managed care payors, Medicare, Medicaid and, to a lesser extent, the patient. The amounts recorded in the financial statements are net of indigent care, contractual allowances and allowances for bad debt to determine the net realizable value of the accounts receivable balance.

Reserves for these deductions are recorded based on the historical collection percentage realized for each payor and projections for future collection rates. Flexible payment arrangements with selected payors have been established to optimize collection of past-due accounts, and any amounts payable beyond one year are classified as noncurrent assets.

**I. ESTIMATED THIRD-PARTY SETTLEMENTS** – Estimated third-party amounts represent settlements with Medicare, TRICARE and Medicaid programs that may result in a receivable or a payable. Reimbursement for cost-based items is paid at a tentative interim rate with final settlement determined after submission of annual cost reports and audits thereof by fiscal intermediaries. Final settlements under the Medicare and Medicaid programs are based on regulations established by the respective programs and as interpreted by fiscal intermediaries. The classification of patients under the Medicare and Medicaid programs as well as the appropriateness of their admission is subject to review. Several years of cost reports are currently under review. Beginning in 2012, UNC Health Care’s physician and hospital entities receive supplemental reimbursement for Medicaid via the Upper Payment Limit methodology.

**J. INVENTORIES** – Inventories consist of medical and surgical supplies, pharmaceuticals, prosthetics and other supplies that are used to provide patient care by service departments. Inventories are stated at the lower of cost or market on the FIFO (first-in, first-out) basis.

**K. OTHER ASSETS AND RECEIVABLES** – Other assets and receivables relate to items such as sales tax refunds due from the North Carolina Department of Revenue, amounts due from state agencies, and billings to outside companies for ancillary testing.
L. ASSETS WHOSE USE IS LIMITED OR RESTRICTED – Current assets whose use is limited or restricted include the debt service funds established with the trustee in accordance with the bond indenture agreements and donor restrictions. The debt service funds will be used to pay bond interest and principal as it becomes due.

Noncurrent assets whose use is limited or restricted include the bond proceeds for construction projects, the funds required by the bond indenture agreements, funds in the maintenance reserve fund that will be used to acquire or construct future property, plant or equipment, and the money on deposit with the Liability Insurance Trust Fund.

M. PROPERTY, PLANT AND EQUIPMENT – Property, plant and equipment are stated at cost or fair value at date of acquisition. The value of assets constructed includes all material direct and indirect construction costs. Interest costs incurred during the period of construction are capitalized.

Assets under capital lease are stated at the present value of the minimum lease payments at the inception of the lease.

Depreciation is computed using the straight-line method over the estimated useful lives of the assets, generally three to 20 years for equipment, 10 to 40 years for buildings and fixed equipment and five to 25 years for general infrastructure and building improvements. Assets under capital leases and leasehold improvements are depreciated over the related lease term, generally periods ranging from five to seven years.

N. OTHER NON-CURRENT ASSETS – Other noncurrent assets include amounts for long-term payment arrangements for patient accounts receivable, bond issuance costs net of amortization and investments in affiliates.

O. NOTES AND BONDS PAYABLE – Notes and bonds payable represent debt issued for the construction of buildings and the acquisition of equipment. The current amount is the portion of bonds due within one year, and the balance is reflected as noncurrent.

The bonds carry interest rates ranging from 0.02 percent to 7.00 percent. The various bond series have fixed, variable or synthetic rates with final maturity in fiscal year 2034. Bonds payable are reported net of unamortized discount, premium and deferred loss on refundings. Amortization of these amounts is done using either the effective interest method or the straight-line method. The notes payable carry various interest rates ranging from 0.0 percent to 11.02 percent with a final maturity in fiscal year 2029.

P. OTHER CURRENT LIABILITIES – Other current liabilities represent funds held for others and amounts due to patients or third parties for credit balances.

Q. COMPENSATED ABSENCES – Compensated absences represent the liability for employees with accumulated leave balances earned through various leave programs. These amounts would be payable if an employee terminated employment. Employees earn leave at varying rates depending upon their years of service and the leave plan in which they participate.

R. NET ASSETS – Net assets represent the difference between assets and liabilities. Due to the complexities of consolidating these entities, only a combined number is shown for net assets.

S. NET PATIENT SERVICE REVENUE – Patient service revenue is recorded at established rates when services are provided with contractual adjustments, estimated bad debt expenses and services qualifying as charity care deducted to arrive at net patient service revenue. Contractual adjustments arise under reimbursement agreements with Medicare, Medicaid, certain insurance carriers, health maintenance organizations and preferred provider organizations, which provide for payments that are generally less than established billing rates. The difference between established rates and the estimated amount collectable is recognized as revenue deductions on an accrual basis.

Charity care represents health care services that were provided free of charge or at rates that are less than the established rates to individuals who meet the criteria of UNC Health Care's charity care and uninsured policy. For UNC Hospitals and UNCFP, uninsured patients receive a 40 percent discount for medically necessary treatment. Charity care provided is not considered to be revenue, since no effort is made to collect accounts that fall under this policy.

Medicare reimburses 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 diagnostic-related groups (DRGs) applicable to each patient discharge rather than on the basis of the Hospitals' allowable charges. Psychiatric and Rehabilitation inpatient services are reimbursed under separate programs.

A prospective payment system for outpatient services was implemented Aug. 1, 2000, and is based on ambulatory payment classifications. It applies to most hospital outpatient services other than ambulance, rehabilitation services, clinical diagnostic laboratory services, dialysis for end-stage renal disease, non-implantable durable medical equipment, prosthetic devices and orthotics.

Medicaid reimburses inpatient services on an interim basis under a Prospective Payment System. Medicaid uses the Medicare DRG system with some modifications. Medicaid reimburses outpatient services on an interim basis at an agreed upon percent of charges but is settled based on 90% of documented cost for all services except hearing aids, durable medical equipment (DME), outpatient pharmacy laboratory, ambulance services and home health.

Hospital payments for Medicare and Medicaid services are made based on a tentative reimbursement rate with final settlement determined after submission of the appropriate cost reports by the entities within UNC Health Care. Medicaid reimburses physician services at a rate of approximately 80% of allowable Medicare rates. Some UNC Health Care physicians receive supplemental payments under the Upper Payment Limit Program in addition to the interim payments as a replacement to filing a Medicaid Cost report for periods after June 30, 2010.

T. MEDICAL AND SURGICAL SUPPLIES – Medical and surgical supplies represent the items used to provide patient care. This includes instruments, special medical devices and pharmaceuticals.

U. MEDICAL MALPRACTICE COSTS – Medical malpractice costs represent the actuarially determined contributions required for self-insured funding or commercial premiums for third-party coverage. The coverage is intended to include both reported claims and claims that have been incurred but not yet reported.

V. MEDICAL SCHOOL TRUST FUND – Medical School Trust Fund (MSTF) expenses represent an assessment of 4.6 percent of net patient service revenue. The MSTF funds are at the Dean's discretion for the support of projects such as program development and recruitment incentives for new department chairs.

W. 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 operations of UNC Health Care.
X. CONCENTRATIONS OF CREDIT RISK – UNC Health Care provides services to a relatively compact area surrounding the Research Triangle Park without collateral or other proof of ability to pay. Concentration of credit risk with respect to patient accounts receivable are limited due to large numbers of patients served and formalized agreements with third-party payors. Significant accounts receivable are dependent upon the performance of certain governmental programs, primarily Medicare and North Carolina Medicaid for their collectability. Management does not believe there are significant credit risks associated with these governmental programs.

NOTE 2 // ESTIMATED THIRD-PARTY SETTLEMENTS

For Medicare and Medicaid, reported amounts reflect the net difference between the filed cost report settlements and amounts reserved for possible future audit findings. TRICARE/Champus is a federal insurance program for eligible active duty and retired military personnel and their dependents. TRICARE/Champus makes payments on an interim basis. Upon completion of the Medicare Cost Report, TRICARE will reimburse certain portions of direct medical and paramedical education and capital costs from the Medicare Cost Report.

NOTE 3 // CAPITAL ASSETS

A summary of capital assets as of June 30 was:

<table>
<thead>
<tr>
<th></th>
<th>FY2015</th>
<th>FY2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land and Improvements</td>
<td>130,413,740</td>
<td>122,575,797</td>
</tr>
<tr>
<td>Buildings and Improvements</td>
<td>1,296,737,213</td>
<td>1,239,076,243</td>
</tr>
<tr>
<td>Equipment</td>
<td>1,044,657,837</td>
<td>1,030,451,235</td>
</tr>
<tr>
<td>Computer Software</td>
<td>176,629,567</td>
<td>141,292,689</td>
</tr>
<tr>
<td>Goodwill</td>
<td>7,704,529</td>
<td>7,704,529</td>
</tr>
<tr>
<td>Construction in Progress</td>
<td>292,980,231</td>
<td>187,672,168</td>
</tr>
<tr>
<td><strong>Gross PP&amp;E</strong></td>
<td><strong>2,949,123,117</strong></td>
<td><strong>2,728,772,661</strong></td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(1,476,585,859)</td>
<td>(1,384,041,185)</td>
</tr>
<tr>
<td><strong>Net PP&amp;E</strong></td>
<td><strong>$1,472,537,258</strong></td>
<td><strong>$1,344,731,476</strong></td>
</tr>
</tbody>
</table>
NOTE 4 // LONG-TERM DEBT

A summary of outstanding bond debt and related issuance costs as of June 30 was:

<table>
<thead>
<tr>
<th>Bond Series</th>
<th>FY2015</th>
<th>FY2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chatham Series 2007 Bonds</td>
<td>25,750,000</td>
<td>26,525,000</td>
</tr>
<tr>
<td>REX Series 2010A Bonds</td>
<td>105,385,000</td>
<td>110,365,000</td>
</tr>
<tr>
<td>REX Series 2015A Bonds</td>
<td>50,000,000</td>
<td>0</td>
</tr>
<tr>
<td>REX Series 2015B Bonds</td>
<td>11,000,000</td>
<td>0</td>
</tr>
<tr>
<td>UNCH Series 2001 Bonds</td>
<td>92,000,000</td>
<td>93,600,000</td>
</tr>
<tr>
<td>UNCH Series 2003 Bonds</td>
<td>91,665,000</td>
<td>92,295,000</td>
</tr>
<tr>
<td>UNCH Series 2005 Bonds</td>
<td>0</td>
<td>4,075,000</td>
</tr>
<tr>
<td>UNCH Series 2009 Bonds</td>
<td>29,505,000</td>
<td>32,200,000</td>
</tr>
<tr>
<td>UNCH Series 2010 Bonds</td>
<td>41,280,000</td>
<td>43,290,000</td>
</tr>
</tbody>
</table>

**FACE VALUE OF BONDS OUTSTANDING**

<table>
<thead>
<tr>
<th></th>
<th>FY2015</th>
<th>FY2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>446,585,000</td>
<td>402,350,000</td>
</tr>
</tbody>
</table>

**Deferred Costs – Premium on Issuance**

4,133,479

**Arbitrage Rebate Payable**

325,026

**NET VALUE OUTSTANDING**

450,885,243

406,808,505

**Current Portion of Bonds**

46,270,000

**Current Portion of Notes**

3,405,174

**Other Current Debt**

6,672,362

**TOTAL CURRENT BONDS AND NOTES**

56,347,536

**Noncurrent Portion of Bonds**

360,538,505

**Noncurrent Portion of Notes**

36,074,836

**Other Noncurrent Debt**

25,954,227

**TOTAL NONCURRENT BONDS AND NOTES**

422,567,568

**Deferred Costs - Loss on Refunding**

17,720,000

**Hedging Liability**

46,270,000

**DEFERRED BOND ACTIVITY**

3,875,209

3,405,174

450,885,243

406,808,505

**As currently constituted, UNC Health Care has no authority to issue debt. Only the individual entities within UNC Health Care have assets and revenue that can be pledged as collateral for the debt.**

Annual requirements to pay principal and interest (including swap arrangements) on the bonds outstanding at June 30, 2015 are:

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>PRINCIPAL</th>
<th>INTEREST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>17,720,000</td>
<td>14,675,600</td>
<td>32,395,609</td>
</tr>
<tr>
<td>2017</td>
<td>18,375,000</td>
<td>14,821,650</td>
<td>33,196,650</td>
</tr>
<tr>
<td>2018</td>
<td>19,180,000</td>
<td>14,094,213</td>
<td>33,274,213</td>
</tr>
<tr>
<td>2019</td>
<td>19,880,000</td>
<td>13,335,752</td>
<td>33,215,752</td>
</tr>
<tr>
<td>2020</td>
<td>20,615,000</td>
<td>12,596,966</td>
<td>33,211,966</td>
</tr>
<tr>
<td>2021-2025</td>
<td>115,990,000</td>
<td>48,553,242</td>
<td>164,543,242</td>
</tr>
<tr>
<td>2026-2030</td>
<td>139,550,000</td>
<td>26,756,069</td>
<td>166,306,069</td>
</tr>
<tr>
<td>2031-2045</td>
<td>95,275,000</td>
<td>19,655,149</td>
<td>114,930,149</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>446,585,000</strong></td>
<td><strong>164,488,650</strong></td>
<td><strong>611,073,650</strong></td>
</tr>
</tbody>
</table>

Annual requirements to pay principal and interest on the outstanding notes and capital leases payable at June 30, 2015 are:

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>PRINCIPAL</th>
<th>INTEREST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>9,486,522</td>
<td>1,053,376</td>
<td>10,539,898</td>
</tr>
<tr>
<td>2017</td>
<td>7,436,208</td>
<td>872,020</td>
<td>8,308,228</td>
</tr>
<tr>
<td>2018</td>
<td>7,350,106</td>
<td>827,121</td>
<td>8,177,227</td>
</tr>
<tr>
<td>2019</td>
<td>5,603,170</td>
<td>630,101</td>
<td>6,233,271</td>
</tr>
<tr>
<td>2020</td>
<td>7,181,801</td>
<td>525,708</td>
<td>7,707,509</td>
</tr>
<tr>
<td>2021-2025</td>
<td>26,424,264</td>
<td>405,882</td>
<td>26,830,146</td>
</tr>
<tr>
<td>2026-2030</td>
<td>128,913</td>
<td>2,866</td>
<td>131,779</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$63,610,984</strong></td>
<td><strong>$4,317,074</strong></td>
<td><strong>$67,928,058</strong></td>
</tr>
</tbody>
</table>
NOTE 5 // PENSION PLANS

UNC Health Care has a variety of retirement plans available to its permanent full-time employees. The majority of employees of UNC Hospitals and UNCFP are members of the Teachers’ and State Employees’ Retirement System (TSERS) as a condition of employment. TSERS is a cost-sharing multiple-employer defined benefit pension plan established by the State to provide pension benefits for employees of the State, its component units and local boards of education. The plan is administered by the North Carolina State Treasurer. Graduate medical residents, temporary employees and permanent part-time employees with appointments of less than 30 hours per week are not covered by the plan.

The Optional Retirement Program (the Program) is a defined contribution retirement plan that provides retirement benefits with options for payments to beneficiaries in the event of the participant’s death. Administrators and eligible faculty of the University may join the Program instead of the Teachers’ and State Employees’ Retirement System. The Board of Governors of The University of North Carolina is responsible for the administration of the Program. Participants in the Program are immediately vested in the value of employee contributions. The value of employer contributions is vested after five years of participation in the Program. Participants become eligible to receive distributions when they terminate employment or retire.

REX sponsors a single-employer defined benefit retirement plan available to eligible employees. The benefit formula is based on the highest five consecutive years of an employee’s compensation during the 10 plan years preceding retirement. There are no employee contributions to the plan.

Funding amounts for all of the plans are based upon actuarial calculations.

In addition to the employer plans, UNC Health Care employees may elect to participate in any number of deferred compensation and Supplemental Retirement Income Plans. These include 401(k) plans, 403(b) plans and 457 plans. All costs of administering and funding the plans are the responsibility of the participants. REX employees may contribute to a tax-deferred annuity plan through which REX matches one-half of each participant’s voluntary contributions on a graduated scale based on length of service, not to exceed 5 percent of the participant’s annual salary.

NOTE 6 // OTHER EMPLOYMENT BENEFITS

UNC Hospitals and UNCFP participate in state-administered programs that provide health insurance and life insurance to current and eligible former employees. Funding for the health care benefit is financed on a pay-as-you-go basis based upon actuarial reports. UNC Hospitals and UNCFP assume no liability for retiree health care benefits provided by the programs other than their required contributions.

UNC Hospitals and UNCFP participate in the Disability Income Plan of North Carolina (DIPNC). DIPNC provides short-term and long-term disability benefits to eligible members of the Teachers’ and State Employees’ Retirement System. UNC Hospitals and UNCFP assume no liability for long-term disability benefits under the Plan other than their contribution.

REX offers a full menu of employment benefits to its employees through various third-party carriers. These include medical insurance, dental coverage, short-term and long-term disability benefits and life insurance coverage.

More information about these plans can be found in the individual audit reports for the various entities.

NOTE 7 // RISK MANAGEMENT

UNC Health Care is exposed to various risks of loss related to torts; theft of, damage to and the destruction of assets; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and various employee plans for health, dental and accident. These exposures to loss are handled by 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.

Liability Insurance Trust Fund – UNC Hospitals and UNCFP participate in the Liability Insurance Trust Fund (the Fund), a claims-paying public entity risk pool for professional liability protection. The Fund acts as a servicer of 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 Fund.

Additional disclosures relative to the funding status and obligations of the Fund are set forth in the audited financial statements of the Liability Insurance Trust Fund for the Years Ended June 30, 2015, and June 30, 2014. Copies of this report may be obtained from The University of North Carolina Liability Insurance Trust Fund, 211 Friday Center Drive, Haywood Building - Room 2029, Chapel Hill, NC, 27517.

NOTE 8 // ESCROW FOR CERTIFIED PUBLIC EXPENDITURES (CPEs)

With the help of the North Carolina Hospital Association, UNC Health Care has entered into an agreement with other Public Hospitals in North Carolina to receive the benefit of additional Certified Public Expenditures (CPEs). By making additional CPEs available, the Public Hospitals risk possible Disproportionate Share of Hospital (DSH) overpayments that would require repayment to state or federal agencies. In order to mitigate the Public Hospitals’ risk, UNC Health Care established a reserve fund to be held in escrow. This fund will reimburse participating Public Hospitals for any repayments that should result from this program. The UNC Health Care Enterprise Fund transferred $14,844,132 for 2012 CPE and $10,732,004 for 2013 CPE to the Escrow Agent, First-Citizens Bank & Trust Company.

NOTE 9 // RELATED PARTY TRANSACTIONS

The Medical Foundation of North Carolina, Inc. – UNC Hospitals and UNCFP are participants in The Medical Foundation of North Carolina, Inc., a nonprofit foundation for the University of North Carolina at Chapel Hill and UNC Hospitals, which solicits gifts and grants for both entities. The Board of Directors of the Medical Foundation administers the funds of the Foundation. Transactions are recorded only by the Foundation. If the Foundation were to purchase any equipment for UNC Hospitals, then the amount would be recorded at the time of receipt on UNC Hospitals’ financial statements.

UNC Health Care System Enterprise Fund – The Board of Directors of UNC Health Care authorized and approved the creation of the UNC Health Care System Enterprise Fund (The System Fund) to support UNC Health Care’s mission and vision to be the nation’s leading public academic health care system. Pursuant to a memorandum of understanding effective July 1, 2005, UNC Hospitals, UNCFP, REX and UNC-CH School of Medicine agreed to finance the Enterprise Fund. The System Fund enables fund transfers among entities in the health system in support of the Board’s vision to be the nation’s leading public academic health care system.

The System Fund assesses, holds and allocates funds across the entities of UNC Health Care. Initially formed as the Enterprise Fund to facilitate investments in support of the clinical, academic and research missions of UNC Health Care and the UNC School of Medicine, the Enterprise Fund today exists as a sub-account within The System
Fund. Since its formation, The System Fund has been used to enable additional types of transfers between entities of UNC Health Care. As such, the Enterprise Fund, Outreach Fund, Patient Safety Fund, Recruitment Fund, and Shared Administrative Services Fund each function as sub-accounts of The System Fund.

**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. HCHCS 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 UNC Health Care to conduct and effectively manage the day-to-day operations of Margaret R. Pardee Memorial Hospital and HCHC’s affiliated operations over a term of 10 years. On Sept. 4, 2013, this agreement was extended to a term of 25 years.

**Johnston Health Services Corporation**—Effective February 1, 2014, Johnston Memorial Hospital Authority (JMHA) and UNC Health Care entered into a Master Agreement to form Johnston Health Services Corporation (JHSC), a joint venture created to achieve the long-term vision of providing high quality health care to the residents of Johnston County, North Carolina. Oversight and governance of the joint venture is controlled by a Board of Directors, consisting of appointees from both JMHA and UNC Health Care. UNC Health Care manages the day-to-day operations of JHSC under the terms of a Management Services Agreement entered into and effective November 1, 2013. UNC Health Care has a 35.25 percent membership interest in JHSC.

**Nash Health Care Systems**—Nash Health Care Systems is a non-profit hospital authority composed 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 UNC Health Care to conduct and manage its operations effective April 1, 2014.

**The John REX Endowment**—The John REX Endowment (Endowment) operates as a 501(c)(3) corporation and is independent of the Board of Directors of UNC Health Care. Its purpose is to advance the health and well-being of the residents of the greater Triangle area, with specific funds set aside for indigent care and to make grants to support health services, education, prevention and research. In discharging its purposes, priority consideration will be given to any funding requests from REX, UNC Health Care and their affiliates. The funding source for the Endowment is the $100 million transfer that came from UNC Health Care in April 2000.

---

**NOTE 10 // COMMUNITY BENEFITS**

In addition to providing care without charge or at amounts less than established rates to certain patients identified as qualifying for charity care, UNC Health Care also recognizes its responsibility to provide health care services and programs for the benefit of the community at no cost or at reduced rates. UNC Health Care sponsors many community health initiatives, including kidney screenings, cardiovascular and pulmonary awareness, and diabetes education programs that ultimately result in the overall improved health of our community. UNC Health Care also provides contributions, cash and in-kind, to various charitable and community organizations. The costs of these programs are included in operating expenses in the accompanying pro forma statements of revenues and expenses.

UNC Health Care and its entities participate in the North Carolina Hospital Association’s (NCHA) Advocacy Needs Data Initiative (ANDI) to quantify their Community Benefit. The data for calculating the FY15 Community Benefit remains fluid and will be included in NCHA’s ANDI report in spring 2016.