DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Consolidated Financial Statements and Supplementary Schedules

June 30, 2022 and 2021

(With Independent Auditors' Report Thereon)

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

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KPMG LLP
Suite 800
500 W 5th St
Winston-Salem, NC 27101

Independent Auditors' Report

Board of Directors
Duke University Health System, Inc. and Affiliates:

Opinion

We have audited the consolidated financial statements of Duke University Health System, Inc. and Affiliates (the Health System), which comprise the consolidated balance sheets as of June 30, 2022 and June 30, 2021, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Health System as of June 30, 2022 and June 30, 2021, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Health System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with U.S. generally accepted accounting principles, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for a reasonable period of time.

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

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information in schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Winston-Salem, North Carolina
October 4, 2022

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Consolidated Balance Sheets

June 30, 2022 and 2021

(In thousands)

Assets	2022	2021
Current assets:		
Cash and cash equivalents	$ 161,284	98,528
Patient accounts receivable	550,509	510,291
Other receivables	31,164	47,265
Inventories of drugs and supplies	143,050	140,533
Short-term investments	444,351	770,256
Assets limited as to use	17,045	13,167
Other current assets	46,037	36,799
Total current assets	1,393,440	1,616,839
Assets limited as to use	105,863	92,307
Investments	4,437,035	4,691,913
Property and equipment, net	2,274,057	2,259,635
Prepaid pension asset	83,654	—
Right-of-use operating lease assets	346,641	356,856
Other noncurrent assets	59,750	57,633
Total assets	$ 8,700,440	9,075,183
Liabilities and Net Assets		
Current liabilities:		
Accounts payable	$ 233,469	198,460
Accrued salaries, wages, and vacation payable	269,906	259,565
Current portion of estimated third-party payor settlements, net	42,388	198,039
Current portion of postretirement and postemployment benefit obligations	8,850	8,682
Current portion of indebtedness	30,963	27,120
Current portion of finance lease liabilities	9,864	9,779
Current portion of operating lease liabilities	28,202	31,311
Other current liabilities	82,563	110,075
Total current liabilities	706,205	843,031
Estimated third-party payor settlements, net of current portion	—	31,064
Postretirement and postemployment benefit obligations, net of current portion	74,759	301,437
Indebtedness, net of current portion	1,491,073	1,525,381
Finance lease liabilities, net of current portion	160,635	166,251
Operating lease liabilities, net of current portion	344,280	340,762
Derivative instruments	37,749	73,800
Other noncurrent liabilities	83,916	114,889
Total liabilities	2,898,617	3,396,615
Net assets:		
Without donor restrictions	5,744,395	5,603,869
With donor restrictions	57,428	74,699
Total net assets	5,801,823	5,678,568
Total liabilities and net assets	$ 8,700,440	9,075,183

See accompanying notes to consolidated financial statements.

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Consolidated Statements of Operations

Years ended June 30, 2022 and 2021

(In thousands)

	2022	2021
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 4,196,547	3,967,396
Other revenue	286,482	302,102
Total revenues, gains, and other support	4,483,029	4,269,498
Expenses:		
Salaries, wages, and benefits	2,215,310	2,029,617
Medical supplies	1,196,544	1,147,452
Interest	37,584	24,081
Depreciation and amortization	209,069	176,919
Other operating expenses	838,051	770,720
Total expenses	4,496,558	4,148,789
Operating (loss) income	(13,529)	120,709
Nonoperating (loss) income:		
Investment (loss) income	(88,170)	1,642,016
Nonoperating components of net periodic benefit cost	27,108	1,297
Other	(4,531)	(4,805)
Total nonoperating (loss) income	(65,593)	1,638,508
(Deficit) excess of revenues over expenses	(79,122)	1,759,217
Change in funded status of defined benefit plans	341,027	563,080
Net assets released from restrictions for purchase of property and equipment	16,460	547
Transfers to the University, net	(137,839)	(142,998)
Increase in net assets without donor restrictions	$ 140,526	2,179,846

See accompanying notes to consolidated financial statements.

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2022 and 2021

(In thousands)

	2022	2021
Net assets without donor restrictions:		
(Deficit) excess of revenues over expenses	$ (79,122)	1,759,217
Change in funded status of defined benefit plans	341,027	563,080
Net assets released from restrictions for purchase of property and equipment	16,460	547
Transfers to the University, net	(137,839)	(142,998)
Increase in net assets without donor restrictions	140,526	2,179,846
Net assets with donor restrictions:		
Contributions for restricted purposes	5,160	12,795
Transfers to the University, net	(61)	(390)
Net assets released from restrictions used for operations	(3,467)	(11,261)
Net assets released from restrictions for purchase of property and equipment	(16,460)	(547)
Net realized and unrealized (losses) gains	(2,443)	14,542
(Decrease) increase in net assets with donor restrictions	(17,271)	15,139
Increase in net assets	123,255	2,194,985
Net assets, beginning of year	5,678,568	3,483,583
Net assets, end of year	$ 5,801,823	5,678,568

See accompanying notes to consolidated financial statements.

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2022 and 2021

(In thousands)

	2022	2021
Cash flows from operating activities:		
Increase in net assets	$ 123,255	2,194,985
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	209,069	176,919
Amortization of debt issuance costs and premium	(3,345)	(3,615)
Investment loss (income)	90,355	(1,656,152)
Net loss on other investments and disposals of property and equipment	5,508	5,215
Nonperiodic changes in defined benefit plans	(341,027)	(563,080)
Transfers to the University, net	137,900	143,388
Donor-restricted contributions for long-term investment and capital projects and associated investment income	(181)	(539)
Changes in operating assets and liabilities:		
Patient accounts receivable	(40,218)	(80,200)
Other receivables	16,280	(6,352)
Inventories of drugs and supplies	(2,513)	(14,117)
Right-of-use operating lease assets, net of operating lease liabilities	10,624	5,570
Prepaid pension asset	(83,654)	—
Other assets	(3,767)	(2,743)
Accounts payable	30,919	(10,244)
Accrued salaries, wages, and vacation payable	10,289	29,512
Estimated third-party payor settlements payable	(186,715)	(77,072)
Postretirement and postemployment benefit obligation	114,517	66,908
Other liabilities	(60,233)	76,786
Net cash provided by operating activities	27,063	285,169
Cash flows from investing activities:		
Capital expenditures	(218,846)	(386,834)
Decrease (increase) in assets limited as to use	429	(698)
Sales of investments	2,045,494	2,188,894
Purchases of investments	(1,607,605)	(1,972,522)
Increase in other assets	(9,380)	(3,097)
Net cash provided by (used in) investing activities	210,092	(174,257)

(Continued)

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2022 and 2021

(In thousands)

		2022	2021
Cash flows from financing activities:			
Payments on indebtedness	$	(307,270)	(25,970)
Proceeds from issuance of indebtedness		280,150	—
Proceeds from restricted contributions and associated investment income		181	539
Payments on finance lease liabilities		(10,047)	(9,063)
Transfers to the University, net		(137,413)	(135,693)
Net cash used in financing activities		(174,399)	(170,187)
Net increase (decrease) in cash and cash equivalents		62,756	(59,275)
Cash and cash equivalents, beginning of year		98,528	157,803
Cash and cash equivalents, end of year	$	161,284	98,528
Supplemental disclosures of cash flow information:			
Cash paid for interest, net of amount capitalized	$	38,641	27,739
Recoupments of Medicare accelerated advance payments included in cash flow from operations		(202,727)	(35,737)
Supplemental disclosures of noncash investing/financing activities:			
Change in fixed asset payables as of June 30	$	4,093	6,636
Net transfers to the University of property and equipment		3,158	4,961
Net transfers (receivable) payable between the Health System and the University		(623)	3,449

See accompanying notes to consolidated financial statements.

(1) Description of Organization, Related Parties, and the Private Diagnostic Clinic

(a) Duke University Health System, Inc. (the Health System)

The Health System is a North Carolina nonprofit corporation organized and controlled by Duke University (the University). The Health System includes three hospitals operated as divisions and several subsidiaries and controlled affiliates, the most significant of which follow:

- **Duke University Hospital (DUH)** – a quaternary care teaching hospital located on the campus of the University in Durham, North Carolina, licensed for 1,048 acute and specialty care beds and providing patient care; DUH is leased from the University, operated by the Health System and serves as a site for medical education provided by the Duke University School of Medicine (School of Medicine or SOM) and clinical research conducted by the School of Medicine.
- **Duke Regional Hospital (DRH)** – a full-service community hospital located in Durham, North Carolina, licensed for 388 acute and specialty care beds and providing patient care; DRH is owned by Durham County, North Carolina and leased to the Durham County Hospital Corporation which has in turn subleased DRH to the Health System.
- **Duke Raleigh Hospital (DRaH)** – a community hospital located in Raleigh, North Carolina, licensed for 186 acute care beds and providing patient care: DRaH is leased from the University and operated by the Health System.
- **Duke University Affiliated Physicians, Inc. (DUAP)** – a North Carolina nonprofit corporation, doing business predominately as Duke Primary Care. Duke Primary Care consists of 33 primary care physician practices located in Alamance, Chatham, Durham, Franklin, Granville, Orange, Vance, and Wake Counties, North Carolina; 10 urgent care centers located in Durham, Orange, and Wake Counties; and 6 pediatric practices in Durham, Orange, and Wake Counties. Four diabetes education and nutrition and fifteen behavioral health practices are co-located within primary care sites of Duke Primary Care.
- **Durham Casualty Company, Ltd. (DCC)** – a wholly owned subsidiary of the Health System, domiciled in Bermuda, insuring a portion of the medical malpractice risks and patient general liability, privacy/cyber liability, and international liability risks of Health System clinical providers and the Private Diagnostic Clinic (PDC).

The Health System also includes other separately incorporated affiliates and subsidiaries and unincorporated divisions not listed above, including Gothic HSP Corporation and Watts College of Nursing, Inc., whose accounts are included in the accompanying consolidated financial statements.

All significant intercompany accounts and transactions are eliminated in consolidation. The Health System's accounts are included in the consolidated financial statements of the University.

(In thousands)

(b) The University

Pursuant to a lease and operating agreement between the University and the Health System, the Health System acquired, or has acquired the right to operate, certain assets of the University for the operation of the Health System and has assumed all of the University's liabilities and obligations related to the transferred assets. Under the Health System's current Master Trust Indenture, the owners of Health System bonds look solely to the Health System for repayment of those obligations. The operating agreement between the University and the Health System provides for certain common administrative services, human resources policy and practice, fiduciary responsibility, investment policies, and support for the School of Medicine.

Certain shared administrative and general service expenses are incurred by the University for the benefit of the Health System. These are included within other operating expenses in the accompanying consolidated statements of operations and amounted to approximately $48,190 and $43,747 in fiscal years 2022 and 2021, respectively.

(c) School of Medicine (SOM)

The SOM is organized and operated as part of the University and is not included in the Health System's consolidated financial statements. The Health System provides support to the SOM in the form of cash (and some noncash) equity transfers. Examples of transfers to the SOM include but are not limited to support of specific initiatives, specific departments, or general support for the Chancellor for Health Affairs or a departmental chair. For the years ended June 30, 2022 and 2021, net unrestricted transfers to the University are as follows:

		2022	2021
Transfers to the School of Medicine, net	$	120,178	123,104
Transfers to the University, net		14,348	14,933
Total funded transfers, net		134,526	138,037
Fixed assets and other unfunded transfers, net		3,313	4,961
Unrestricted transfers to the University, net	$	137,839	142,998

The Health System plans to transfer $133,198 in cash (and some noncash) equity transfers to the University in fiscal year 2023.

(d) Private Diagnostic Clinic, PLLC (PDC)

The PDC is a professional limited liability company consisting of physicians practicing primarily within Health System facilities and PDC clinics. The PDC was originally created to provide a structure separate from the University and the Health System in which the members of the physician faculty of the SOM could engage in the private practice of medicine and still serve as members of the faculty of the University conducting clinical teaching and medical research.

(In thousands)

Currently the PDC, under agreements with the University and the Health System, occupies and utilizes certain of the Health System's facilities. With the exception of a small number of individuals performing administrative services for the Health System, PDC physicians are not currently employed by the Health System, nor is the PDC included in the Health System's or the University's consolidated financial statements.

The Health System has numerous agreements with the PDC. Many are for services related to clinical operations such as professional service agreements (PSA) for physician staffing of certain Health System facilities, medical directors, and lab services. The Health System, through its Patient Revenue Management Organization (PRMO), has contractual responsibility for the billing and accounts receivable operations of the PDC. DCC is the principal source of malpractice, privacy/cyber, and international liability insurance for the PDC. The PDC subleases from the Health System, at market rates, clinical and administrative space owned by the University and leased to the Health System, and leases from the Health System, at market rates, space owned by the Health System. The Health System also subleases to the PDC, at full cost, leased space from nonaffiliated third parties. The following table summarizes the PDC-related revenue included in other operating revenue in the Health System's accompanying consolidated statements of operations:

		2022	2021
Billing and collection services	$	45,172	43,741
Revenue under service agreements		74,141	64,743
DCC malpractice insurance premiums		11,058	10,292
Rental income		16,682	14,168
Total	$	147,053	132,944

For the years ended June 30, 2022 and 2021, other operating expenses in the Health System's consolidated statements of operations include PDC-related expenses under service agreements of $205,710 and $189,665, respectively. The Health System has net payables to the PDC of $10,396 and $10,571 as of June 30, 2022 and 2021, respectively, related to various transactions.

The Health System and the PDC are currently engaged in discussions about the purchase of PDC assets. The Health System intends to create an integrated clinical practice that would employ faculty physicians and other PDC employees within the Health System. While integration plans are underway, the anticipated timing for such alignment transaction is not until fiscal year 2024.

(Continued)

(e) DUMAC, Inc. (DUMAC)

DUMAC, a separate nonprofit support corporation organized and controlled by the University, manages the investment portfolios of the Health System and the University. DUMAC manages multiple investment pools on behalf of the Health System and the University including the Health System Pool (HSP), the Long Term Pool (LTP), and the Health System Liquidity Management Account (LMA). DUMAC also manages the investment assets of the Employees' Retirement Plan of the University (ERP).

(2) Summary of Significant Accounting Policies

Significant accounting policies of the Health System are as follows:

(a) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with original maturities of three months or less. Cash and cash equivalents that are invested in the HSP, LTP, and LMA are reported within short-term and noncurrent investments as these funds are not typically used for current operating needs.

(b) Short-Term Investments

Short-term investments include debt securities and other instruments with maturities of one year or less from the balance sheet date and are not included in cash and cash equivalents.

(c) Investments

(i) Reporting

Investments are classified as trading securities. As such, investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in excess of revenues over expenses in the accompanying consolidated statements of operations unless the income or loss is restricted by donor or law.

(ii) Valuation

Investments are recorded in the consolidated financial statements at estimated fair value. For investments made directly by the Health System whose values are based on quoted market prices in active markets, the market price of the investment is used to report fair value. For shares in mutual funds, fair values are based on share prices reported by the funds as of the last business day of the fiscal year. The Health System's interests in alternative investment funds such as fixed income, equities, hedged strategies, private capital, and real assets are generally reported at the net asset value (NAV) reported by the fund managers. Unless it is probable that all or a portion of the investment will be sold for an amount other than NAV, the Health System has concluded that NAV is an appropriate practical expedient to estimate fair value.

(In thousands)

(iii) Derivatives

Derivatives are used by the Health System and external investment managers to manage market risks. The most common derivative strategies employed are total return swaps, futures contracts, forward contracts, and credit default index swaps. These derivative instruments are recorded at their respective fair values (note 9).

(d) Assets Limited as to Use

Assets limited as to use include funds on deposit with bond trustees, donor-restricted receivables, investments and other assets, investments designated by the Board of Directors for repayment of the Series 2017 taxable bonds, and receivables and investments required to settle estimated professional liability costs recorded in DCC.

(e) Property and Equipment

Property and equipment acquisitions are recorded at original cost or, where original cost data is not available, at estimates of original cost. Property and equipment acquired under finance leases is initially valued and recorded based on the present value of minimum lease payments. Costs associated with the development and installation of internal-use software may be capitalized or expensed. These costs are expensed if they are incurred in the preliminary project or post-implementation/operation stages and capitalized if they are incurred in the application development stage and meet certain capitalization requirements. Depreciation and amortization is calculated on the straight-line basis over the estimated useful lives of the respective assets, except for leasehold improvements and property and equipment held under finance leases, which are amortized over the shorter of the expected useful life of the asset or related lease term. U.S. generally accepted accounting principles does not allow for depreciation of land and construction in progress. The estimated useful lives by asset type are as follows:

Asset type	Useful life
Buildings and utilities	10–50 years
Furnishings and equipment	3–20 years
Computer software	5–10 years

Gains and losses from the disposal of property and equipment are included in other operating expenses in the accompanying consolidated statements of operations. The portion of interest on the DUHS 2020 and 2017 taxable bonds associated with the funding of qualifying assets is capitalized during the construction period, and interest capitalization will continue over the life of the bonds while qualifying capital projects are ongoing. Total interest cost of $11,214 and $25,303 was capitalized in fiscal years 2022 and 2021, respectively, and is included in property and equipment, net in the accompanying consolidated balance sheets.

(Continued)

(f) Lease Right of use Assets

The Health System has operating and finance leases for real estate and equipment. Operating leases as a lessee are included in operating lease right-of-use assets and operating lease liabilities in the accompanying consolidated balance sheets. The assets and liabilities associated with finance leases as a lessee are included in property and equipment, net and finance lease liabilities, respectively, in the accompanying consolidated balance sheets.

The determination of whether or not a contract contains a lease is made at the inception of a contract. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheets. The Health System has agreements that require payments for lease and nonlease components. For these contracts, the Health System separates lease from nonlease components using information within the contract or by obtaining additional information from the respective parties in the contract.

Right-of-use assets represent the Health System's right to use an underlying asset during the lease term, and lease liabilities represent the Health System's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date, based on the present value of fixed lease payments over the lease term. Variable lease payments that depend on an index or a rate are included in the lease payments. Payments for taxes, common area maintenance, and utilities are typically separated from the lease payments and accounted for separately as nonlease components. The commencement date is when the Health System takes possession of the asset, and in the case of real estate is the date the landlord makes the building available for the Health System to use. The Health System's lease term includes options to extend or terminate the lease when it is reasonably certain that the options will be exercised. Since most of the Health System's operating and finance leases do not provide an implicit rate in the lease, the Health System primarily uses its incremental borrowing rate for the discount rate based on the most recent quarterly AA taxable municipal bond yields available at the commencement date to determine the present value of lease payments. For equipment finance leases that include an interest rate in the agreement, the Health System uses the rate per the agreement instead of its incremental borrowing rate to determine present value of fixed lease payments.

(g) Asset Impairment

The Health System assesses the recoverability of long-lived assets by determining whether the carrying value of these assets can be recovered through undiscounted future operating cash flows generated by these assets. The amount of impairment, if any, is measured by comparison of the fair value of the assets to their carrying value. Fair value is determined using market data, if available, or projected discounted future operating cash flows using a discount rate reflecting the Health System's weighted average cost of capital.

(h) Net Assets

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Health System and changes therein are classified and reported as follows:

Net assets without donor restrictions – Net assets available for use in operations that are free from donor-imposed stipulations. All revenues, gains, and losses that are not restricted by donors are included in this classification. All expenses are reported as decreases in net assets without donor restrictions.

Net assets with donor restrictions – Net assets subject to donor-imposed stipulations. Some donor restrictions are temporary in nature that will be met either by actions of the Health System or the passage of time. Other donor-imposed restrictions are perpetual in nature, where the donor specifies that the resources be maintained in perpetuity. Net assets with donor restrictions are restricted for health education, capital expenditures, and other specified purposes.

Expirations of donor restrictions on net assets (i.e., the donor stipulated purpose has been fulfilled and/or the stipulated time period has elapsed) are reported in other revenue in the consolidated statements of operations. Contributions for acquisitions or construction of property and equipment are released from restrictions in the period in which the assets are placed into service and are excluded from excess of revenues over expenses in the consolidated statements of operations.

(i) Excess of Revenues over Expenses

Changes in net assets without donor restrictions that are excluded from excess of revenues over expenses include certain nonperiodic defined benefit plan accounting adjustments, permanent transfers of assets to and from affiliates for other than goods and services, and contributed capital assets and capital assets acquired using contributions, which by donor-imposed restriction, must be used for the purposes of acquiring long-lived assets.

(j) Patient Service Revenue

Patient service revenue relates to contracts with patients in which the performance obligations are to provide healthcare services to patients. The Health System recognizes revenues over time as services (inputs) are provided to patients in the period in which services are rendered. The Health System deems the use of this input method to be a faithful depiction of the transfer of services to the patient over the performance obligation period.

The contractual relationships with patients usually involve a third-party payor, and transaction prices for the services provided are dependent upon the terms provided by or negotiated with third-party payors. The Health System has agreements with third-party payors that provide for payments to the Health System at amounts that are generally less than its established rates. The Health System determines the transaction price based on its established charges for goods and services less explicit and implicit price concessions. Explicit price concessions are contractual adjustments provided to third-party payors and published policy discounts applied to uninsured patients. Implicit price concessions

represent differences between amounts billed and the estimated consideration the Health System expects to receive from patients, which are primarily based on historical collection experience. The Health System generally bills third-party payors and patients within five days after services are rendered and/or patients are discharged from the hospital. Accordingly, patient service revenue is reported at the estimated net realizable amounts to be received from patients, third-party payors, and others, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Adjustments are accrued on an estimated basis in the period the related services are rendered and retroactively adjusted in future periods as changes to estimates become known and tentative and final settlement adjustments are identified.

The Health System applies the following practical expedients provided in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606, *Revenue from Contracts with Customers*, to its contracts with patients:

i. The Health System applies the portfolio approach as a practical expedient allowed under ASC Subtopic 606-10-10-4 to account for most of its patient contracts as a collective group rather than individually. The Health System does not expect the impact to the consolidated financial statements when applying the revenue recognition guidance for patient service revenue to differ materially using the portfolio approach than if applied at an individual contract level. The Health System groups contracts based on similar expected payment patterns. Portfolio groupings include the following categories: hospital or professional; inpatient or outpatient; primary, secondary, and current payor responsibilities and activities. These groupings are also stratified based on aging of related receivables.

ii. The Health System has elected the practical expedient allowed under ASC Subtopic 606-10-32-18 to not adjust the transaction price for the effects of a significant financing component as payment is expected to be received from patients and third-party payors within one year from the date patients receive services. In certain circumstances, the Health System enters into payment arrangements with patients that allow payments in excess of one year. In these arrangements, the financing component is not considered significant to the contract.

iii. The Health System has elected to apply the practical expedient under ASC Subtopic 606-10-50-14 to not disclose the transaction price allocated to unsatisfied or partially unsatisfied performance obligations as of the end of the reporting period because these performance obligations relate to contracts with an expected duration of less than one year. These unsatisfied or partially unsatisfied performance obligations are primarily related to inpatient acute care services at the end of the fiscal year and are generally completed when patients are discharged, typically within days or weeks after year end.

(k) Charity Care

The Health System provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Health System does not pursue collection of amounts determined to qualify as charity care, they are not reported as patient service revenue or included in patient accounts receivable.

(l) Derivative Financial Instruments

The Health System has elected not to use hedge accounting with respect to any of its debt derivative financial instruments. Derivative financial instruments are recognized as assets or liabilities in the consolidated balance sheets at fair value. Realized and unrealized gains and losses on derivatives are included in investment (loss) income in the consolidated statements of operations.

(m) Income Taxes

The Health System and substantially all of its affiliates are organizations described under Section 501(c)(3) of the Internal Revenue Code. Such organizations are not subject to federal and state income tax on income related to their exempt purpose. There were no material uncertain tax positions as of June 30, 2022 or 2021.

(n) Coronavirus Disease (COVID-19)

In March 2020, the Health System began channeling its financial and operating focus into preparing for and responding to COVID-19, a novel coronavirus that became a global pandemic. The Health System suspended nonemergent or noncritical surgeries, procedures, and appointments beginning in mid-March through early May in 2020 due to COVID-19. The resulting financial impacts to the Health System came in the form of significant lost revenue and additional expense. The Health System has received various forms of federal relief described below to partially offset the aforementioned losses.

In response to the economic impact of COVID-19, federal and state governments passed legislation intended to assist industry sectors, small businesses, workers, and families who have been negatively impacted by the COVID-19 pandemic. The Coronavirus Aid, Relief, and Economic Security Act (CARES) was signed into law on March 27, 2020 and included a variety of economic assistance provisions for businesses and individuals, including Provider Relief Funds (PRF) to hospitals and other healthcare providers. The American Rescue Plan Act (ARP) of 2021 also included a number of relief provisions for hospitals and health systems. In addition, the Health System received reimbursement from the Federal Emergency Management Agency (FEMA) for claims submitted to reimburse costs specifically related to COVID-19 expenditures.

(Continued)

(In thousands)

The following table summarizes the impact of the various provisions in these relief acts to the Health System's consolidated financial statements as of and for the years ended June 30, 2022 and 2021:

		2022	2021
Recognized in the consolidated statements of operations:			
CARES and ARP relief funds included in other operating revenue	$	47,975	89,900
FEMA reimbursement included in other operating revenue		18,497	—
Employee retention credit included in salaries, wages, and benefits expenses		—	1,810
COVID-19 relief benefits in operating income	$	66,472	91,710
Liabilities recognized in the consolidated balance sheets:			
Deferred payroll taxes in other current liabilities	$	30,119	30,118
Deferred payroll taxes in other noncurrent liabilities		—	30,118
MAAP in current portion of estimated third-party payor settlements, net		43,665	215,328
MAAP in estimated third-party payor settlements, net of current portion		—	31,064
Deferrals and advance payments in total liabilities	$	73,784	306,628

The Health System considered frequently asked questions and other guidance issued by the U.S. Department of Health and Human Services (HHS) when assessing whether the terms and conditions of the Provider Relief Fund and Rural payments received under the ARP were met. The amounts recognized as revenue could change in the future based on continuing analysis of lost revenues and COVID-19-related expenses as well as the evolving guidance provided by HHS.

The Employee Retention Credit (ERC) is a fully refundable tax credit for eligible employers that kept employees on their payroll during the pandemic. The Health System claimed the ERC for the three consecutive quarters ended December 31, 2020. The deferred payroll taxes in the above table represent the employer portion of the Social Security payroll taxes normally due between March 27, 2020 and December 31, 2020. The CARES Act allowed employers to defer payment of these payroll taxes, with 50% being paid by December 31, 2021 and the remaining 50% due on December 31, 2022.

The Health System received $282,129 in Medicare accelerated and advance payments (MAAP in above table) from the Centers for Medicare & Medicaid Services (CMS) in April 2020, and CMS began recouping these advance payments against Medicare claims beginning in April 2021. The Health System reduced the liability as Medicare recouped the advance payments against claims for services provided during the recoupment period. The Medicare accelerated and advance payments were fully recouped in August 2022.

(Continued)

(o) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include implicit and explicit price concessions, third-party reimbursement settlements, self-insurance liabilities, retirement obligations, and the carrying amounts of property, equipment, right-of-use operating lease assets and related lease liabilities, investments, and derivative instruments. Actual results could differ from those estimates.

(p) Recently Adopted Accounting Standards

The Health System adopted Accounting Standards Update (ASU) 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General (Subtopic 715-20): Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans,* in fiscal year 2022. This ASU intends to improve the effectiveness of disclosures in the notes to consolidated financial statements for employers that sponsor defined benefit pension or other retirement plans by removing, modifying, and adding disclosure requirements deemed as relevant to financial statement users. The Health System modified its benefit plan disclosures on a retrospective basis in note 12 according to the new requirements.

The Health System adopted ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40)*, in fiscal year 2022. This ASU aligns requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to obtain or develop internal-use software. The adoption of ASU 2018-15 in fiscal year 2022 did not have a material effect on the Health System's consolidated financial statements.

The FASB has issued several ASUs in response to various transitions due to reference rate reform initiatives. ASU No. 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting,* was issued in March 2020 and allows for optional expedients for modifications of contracts, hedging relationships, and other transactions that reference LIBOR or another reference rate expected to be discontinued. The amendments are effective for contract modifications by Topic or Industry Subtopic through December 31, 2022. The FASB also issued ASU No. 2021-01, *Reference Rate Reform (Topic 848): Scope*, in January 2021 to further clarify certain optional expedients and exceptions related to derivatives. In fiscal year 2022, the Health System completed steps to adhere to the ISDA Fallbacks Protocol for its two LIBOR-cessation impacted debt derivative contracts whereby upon cessation of one-month LIBOR, a term-adjusted reference rate (SOFR) and spread adjustment will be used to calculate the Health System's fallback rate on these two swaps. In addition, the Health System refinanced its tax-exempt variable rate bonds from one-month LIBOR to Bloomberg Short-Term Bank Yield Index (BSBY) during fiscal year 2022 to address the cessation of one-month LIBOR. The impact of these changes did not have a material impact on the Health System's consolidated financial statements.

(Continued)

(In thousands)

The FASB issued ASU 2020-07, *Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets (Topic 958)* in September 2020. This ASU requires contributed nonfinancial assets to be reported as a separate line item in the statement of operations, apart from contributions of cash or other financial assets. This ASU was effective for the Health System in fiscal year 2022 and did not have a material impact on the consolidated financial statements.

(3) Patient Service Revenue and Estimated Third-Party Payor Settlements

Patient service revenue, net of price concessions, recognized in fiscal years 2022 and 2021 from major payor sources is as follows:

	2022		2021	
	Amount	Percentage	Amount	Percentage
Commercial payors	$ 2,251,855	53.6 %	$ 2,142,411	54.0 %
Medicare	738,039	17.6	765,323	19.3
Medicare managed care	577,506	13.8	455,372	11.5
Medicaid	233,960	5.6	461,249	11.6
Medicaid managed care	248,586	5.9	—	—
Self-pay patients	12,401	0.3	23,720	0.6
Other third-party payors	134,200	3.2	119,321	3.0
Total	$ 4,196,547	100.0 %	$ 3,967,396	100.0 %

The Health System has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors: payors, geography, service lines, and reimbursement method. The Health System's operations are primarily located in Durham and Wake counties in North Carolina, and its patient service revenues are generated predominately from inpatient and outpatient acute care services to patients from the seven North Carolina counties surrounding its three hospitals. The Health System has entered into payment agreements with third-party payors, and payment arrangements by primary payor include the following:

a) Medicare and Medicare managed care – charges for healthcare services are generally paid at prospectively determined rates based on clinical, diagnostic, and other factors.

b) Medicaid and Medicaid managed care – charges for healthcare services are generally paid at prospectively determined rates per discharge, per occasion of service, or per covered member.

c) Commercial payors – agreements with commercial insurance carriers and managed care organizations provide for payments based on predetermined rates per discharge, discounts from established charges, and prospectively determined daily rates.

North Carolina Medicaid transitioned from the state administered fee for services (NC Medicaid Direct) to private managed care (NC Medicaid Managed Care) for most Medicaid beneficiaries on July 1, 2021. Some Medicaid beneficiaries did not transition to NC Medicaid Managed Care but remained in NC Medicaid Direct. The Health System has agreements with the managed care organizations selected for NC Medicaid Managed Care.

The Health System recognizes patient service revenue associated with services provided to patients who have third-party coverage on the basis of contractual rates for the services rendered. For uninsured patients who do not qualify for charity care, the Health System recognizes revenue on the basis of its discounted rates. Uninsured patients automatically receive a discount from billed charges (only medically necessary services are eligible). On the basis of historical experience, a significant portion of the Health System's uninsured patients who do not qualify for charity care will fail to pay for the services provided. Thus, the Health System records significant implicit price concessions related to uninsured patients in the period the services are provided. The Health System analyzes historical collections and write-offs and identifies trends for each of its major payor sources of revenue to estimate the transaction price for patients. After the initial estimated transaction price is recorded, subsequent changes to the transaction price are recorded as adjustments to patient service revenue in the period of the change. For fiscal years 2022 and 2021, adjustments arising from changes in implicit price concessions related to prior period performance obligations were not material.

Patient service revenue includes variable consideration for estimated retroactive adjustments under reimbursement agreements with government programs. Adjustments are accrued on an estimated basis in the period the related services are rendered and retroactively adjusted in future periods as changes to estimates become known and tentative and final settlement adjustments are identified. The amounts due to and from government programs (Medicare and Medicaid) for final settlement of reimbursements are determined based upon cost reports filed annually with the respective programs. The reports for all years through June 30, 2007 for Medicare and June 30, 2016 for Medicaid have been substantially resolved with the Medicare Administrative Contractor and North Carolina Department of Health and Human Services, respectively. In the opinion of management, adequate provisions have been made in the accompanying consolidated financial statements for adjustments that may result from final settlements of reimbursable amounts. The Health System, in part through its Compliance Program, seeks to ensure compliance with government program rules. The effects of retroactive adjustments from government programs' settlement adjustments and compliance reviews to patient service revenue were not material in fiscal years 2022 and 2021.

(Continued)

(In thousands)

The Health System receives supplemental Medicaid payments from the State of North Carolina through a federally-approved disproportionate share hospital program (Medicaid DSH). Medicaid DSH payments are part of the Medicaid Program and are designed to partially offset Medicaid losses. Amounts recognized in the Health System's accompanying consolidated financial statements related to supplemental Medicaid are as follows:

		2022	2021
Supplemental Medicaid amounts included in patient service revenue	$	73,773	223,264
Medicaid assessments included in other operating expenses		(73,918)	(72,540)
Net supplemental Medicaid (expense) revenue in operating income	$	(145)	150,724
Net (payable to) receivable from supplemental Medicaid included in current portion of estimated third-party payor settlements, net	$	(5,880)	113

Fiscal year 2022 net Medicaid DSH revenue reported above reflects a portion of the supplemental payment shifting into the base rate payments for Medicaid patients as part of the change in the North Carolina Medicaid program. There can be no assurance that the Health System will continue to qualify for future participation in this program or that the program will not be discontinued or materially modified as North Carolina Medicaid transitions to private managed care.

The Health System grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at June 30 is as follows:

	2022	2021
Commercial payors	41.8 %	40.7 %
Medicare	17.2	20.1
Medicare managed care	16.5	15.7
Medicaid	8.0	13.0
Medicaid managed care	7.8	—
Self-pay patients	3.1	3.7
Other third-party payors	5.6	6.8
	100.0 %	100.0 %

(Continued)

(In thousands)

(4) Charity Care and Other Community Benefits

The Health System provides services at no charge or at substantially discounted rates to patients who are approved under the guidelines of its financial assistance policy. The Health System does not pursue collection of amounts determined to qualify as charity care. Services qualifying for charity care consideration include emergent and medically necessary services as determined by a Health System physician. Patient household income in relation to the federal poverty guidelines is included in the determination for charity care qualification.

While charity care is excluded from patient service revenue and receivables, the Health System maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its financial assistance policy and other equivalent service statistics. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges.

In addition to charity care, the Health System provides services under the Medicare and Medicaid programs, medical education (for which payments received from Medicare and Medicaid are less than the full cost of providing these activities), and research activities. The Health System also provides both in-kind service contributions and direct support payments to Lincoln Community Health Center (LCHC) and the Durham Emergency Medical Services (EMS). LCHC is an outpatient clinic serving the Durham County, North Carolina community, supported in part by a U.S. Public Service Grant. EMS serves as the primary provider of emergency ambulance service in Durham County and is a unit of the Durham County government.

The Health System estimates charity care and other community benefits in accordance with Internal Revenue Code Section 501(r). Estimates of the cost of charity care and other community benefits provided during the years ended June 30 are as follows:

		2022	2021
Charity care at cost	$	145,256	140,912
Unreimbursed Medicaid		167,039	144,223
Total charity care and means-tested programs		312,295	285,135
Health professionals education		85,195	82,583
Cash and in-kind contributions and community health improvement services		13,348	13,406
Total other benefits		98,543	95,989
Total charity care and other community benefits at cost	$	410,838	381,124

(Continued)

(In thousands)

In addition to the above total charity care and other community benefits reported on Internal Revenue Service (IRS) Form 990, Schedule H, the Health System also provided services under the Medicare program for which payments received were less than the full cost of providing the services. The estimated unreimbursed costs attributable to providing services under Medicare are $501,257 and $412,603 for the years ended June 30, 2022 and 2021, respectively. The Health System provides additional uncompensated care in the form of implicit price concessions. Estimated uncompensated costs associated with these uncollectible patient accounts were $32,755 and $29,205 for June 30, 2022 and 2021, respectively.

(5) Cash and Investments

The following is a summary of cash and investments included in the accompanying consolidated balance sheets at June 30:

	2022	2021
Cash and cash equivalents	$ 161,284	98,528
Short-term investments	444,351	770,256
Investments	4,437,035	4,691,913
Cash and investments available for operations	5,042,670	5,560,697
Assets limited as to use, current	17,045	13,167
Assets limited as to use, noncurrent	105,863	92,307
Less: receivables and other assets included in assets limited as to use	(3,574)	(4,149)
Total cash and investments	$ 5,162,004	5,662,022

(Continued)

(In thousands)

The Health System invests through separate accounts and commingled vehicles (including limited partnerships). The fair value of cash and investments consists of the following at June 30:

	2022	2021	Unfunded commitments[2]	Redemption frequency (in days)	Redemption notice period (in days)
Cash and cash equivalents	$ 161,284	98,528	—	daily	1
Deposits with bond trustees	382	300	—	N/A	N/A
Short-term investments	458,346	784,259	—	daily	1
Fixed income	657,197	582,332	—	1 to 30	1 to 30
Equities	631,611	863,768	—	1 to 90	1 to 90
Hedged strategies	1,057,189	1,224,911	554	30 to > 365	2 to 100
Private capital	1,593,332	1,555,117	305,265	N/A	N/A
Real assets	461,528	440,782	134,455	N/A	N/A
Other	141,135	112,025	—	N/A	N/A
Total cash and investments [1]	5,162,004	5,662,022	$ 440,274		
Less: cash and investments included in assets limited as to use	(119,334)	(101,325)			
Cash and investments available for operations	$ 5,042,670	5,560,697			

[1] Includes the Health System's participation in pooled assets of $226,560 and $345,442 at June 30, 2022 and 2021, respectively, which are managed by DUMAC.

[2] Future commitments likely to be called at various dates through 2026. The Health System expects to finance these commitments with available cash and expected proceeds from the sales of securities.

The Health System's investment classes are described in further detail below. Classes include direct holdings, which are generally marketable securities, or interest in funds, which are stated at NAV as a practical expedient for estimated fair value for which the related investment strategies are described.

Short-term investments include short-term U.S. Treasury, agency, corporate, and other highly liquid debt securities with an aggregate duration of less than a year. Short-term investments of $27,069 and $18,242 at June 30, 2022 and 2021, respectively, were posted as collateral under investment derivative agreements and thus are not readily available for use.

Fixed income includes U.S. Treasury debt securities with maturities of more than one year and funds that invest in these types of investments and nongovernment U.S. and non-U.S. debt securities.

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Equities includes U.S. and non-U.S. stocks and interests in funds that invest predominantly long but also short stocks and in certain cases are nonredeemable. The allocation by market is approximately: 33% domestic, 29% developed international, 23% emerging international, and 15% global and real estate.

Hedged strategies include interests in funds that invest both long and short in U.S. and non-U.S. stocks, credit-oriented securities and arbitrage strategies. Approximately 84% of the hedged strategies portfolio is invested through equity oriented strategies, 11% through credit strategies, and 5% through multistrategy funds. Virtually all of the Health System's investments in these funds are redeemable, and the underlying assets of the funds are predominately marketable securities and derivatives.

Private capital primarily includes interest in funds or partnerships that hold illiquid investments in venture capital, buyouts, and credit. Certain private placement securities may also be held. These funds typically have periods of 10 or more years during which committed capital may be drawn. Distributions are received through liquidation of the underlying assets of the funds, which are anticipated to occur over the next 4 to 10 years.

Real assets include interests in funds or partnerships that hold illiquid investments in residential and commercial real estate, oil and gas production, energy, other commodities, and related services businesses. Additionally, certain liquid commodity and real estate–related equities, private placement securities, and related derivatives are included. These funds typically have periods of 10 or more years during which committed capital may be drawn. Distributions are received through liquidations of the underlying assets of the funds, which are anticipated to occur over the next 5 to 12 years.

Other primarily includes other derivative instruments and the Health System's participation in the University LTP.

The Health System's investments are exposed to several risks, including liquidity, currency, interest rate, credit, and market risks. The Health System attempts to manage these risks through diversification, ongoing due diligence of fund managers, and monitoring of economic conditions. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Health System's consolidated financial statements.

The Health System may participate in programs to lend securities to brokers. To limit risk, collateral is posted and maintained daily at 100% to 105% of the market value of the lent securities depending on the type of security. Collateral generally is limited to cash, government securities, and irrevocable letters of credit. Both the Health System and security borrowers have the right to terminate a specific loan of securities at any time. The Health System receives lending fees and continues to earn interest and dividends on the loaned securities.

(Continued)

(In thousands)

The Health System's total investment (loss) income for the years ended June 30 is detailed below:

		2022	2021
Net realized gains from sales of investments	$	361,686	572,994
Net unrealized (losses) gains		(489,204)	1,057,290
Total net (losses) gains		(127,518)	1,630,284
Investment income		23,144	22,051
Investment (losses) gains		(104,374)	1,652,335
Net realized losses on debt derivatives		(11,805)	(12,958)
Net unrealized gains on debt derivatives		36,051	26,298
Total investment (loss) income	$	(80,128)	1,665,675

Investment (loss) income is classified in the consolidated statements of operations and changes in net assets as follows:

		2022	2021
Other operating revenue	$	10,485	9,117
Nonoperating (loss) income		(88,170)	1,642,016
(Decrease) increase in net assets with donor restrictions		(2,443)	14,542
Total investment (loss) income	$	(80,128)	1,665,675

(Continued)

(In thousands)

A summary of assets limited as to use, including externally restricted funds at June 30 is as follows:

	2022	2021
Assets limited as to use:		
Deposits with bond trustees	$ 382	300
Receivables and investments designated to settle estimated professional liability costs	41,098	30,475
Board-designated debt repayment funds	24,000	—
Donor-restricted receivables, investments, and other assets	57,428	74,699
Total assets limited as to use	122,908	105,474
Less: current portion of assets limited as to use	(17,045)	(13,167)
Assets limited as to use, excluding current portion	$ 105,863	92,307

(6) Liquidity and Availability

Financial assets available for general expenditure within one year of June 30 are as follows:

	2022	2021
Cash and cash equivalents	$ 161,284	98,528
Patient accounts receivable, net	550,509	510,291
Other receivables	31,164	47,265
Due from the University, net and accrued income	9,585	2,071
Short-term investments	444,351	770,256
Noncurrent investments	2,298,191	2,667,454
Total	$ 3,495,084	4,095,865

The Health System manages its financial assets to be available as its operating expenditures, liabilities, and other obligations become due. The Health System invests cash in excess of daily requirements in short-term, highly liquid investments. Although the noncurrent investments disclosed in the table above are intended to be held long-term, management could utilize those investments within the next year if deemed necessary.

(Continued)

(In thousands)

(7) Property and Equipment

A summary of property and equipment at June 30 is as follows:

		2022	2021
Buildings and utilities	$	2,765,004	2,168,497
Furnishings and equipment		1,048,725	995,909
Buildings and equipment under finance lease liabilities		189,489	184,937
Computer software		355,225	367,396
Depreciable property and equipment		4,358,443	3,716,739
Less accumulated depreciation and amortization		(2,425,446)	(2,248,006)
Depreciable property and equipment, net		1,932,997	1,468,733
Land and land improvements		182,945	159,219
Construction in progress		158,115	631,683
Property and equipment, net	$	2,274,057	2,259,635

The following table summarizes other property and equipment information for fiscal years 2022 and 2021:

		2022	2021
Depreciation expense	$	173,771	141,670
Finance leases' accumulated amortization		64,604	53,585
Computer software amortization expense		24,279	25,088
Computer software's accumulated amortization		324,729	315,245

(Continued)

(In thousands)

(8) Indebtedness

A summary of indebtedness at June 30 is as follows:

Series	Underlying structure	Mandatory tender date[1]	Fiscal year of maturity	Effective interest rate	Outstanding principal 2022	Outstanding principal 2021
Tax-exempt revenue bonds:						
2005A	Direct placement	6/1/2028	2028	1.0 %	$ 59,400	66,335
2005B	Direct placement	6/1/2028	2028	0.8	19,225	21,470
2006A/B/C	Direct placement	2/29/2032	2039	0.8	121,620	121,620
2012B	Direct placement	6/1/2023	2023	1.1	6,330	12,345
2016B	Direct placement	2/29/2032	2042	0.9	90,000	90,000
2016C	Direct placement	2/29/2032	2042	0.9	90,000	90,000
	Total variable rate				386,575	401,770
2012A	Fixed rate	N/A	2022	0.7	—	1,010
2016A	Fixed rate	N/A	2028	1.9	102,850	113,765
2016D	Fixed rate	N/A	2042	3.4	125,100	125,100
Taxable bonds:						
2017	Fixed rate	N/A	2047	3.9	600,000	600,000
2020	Fixed rate	N/A	2042	2.9	299,432	299,432
	Total fixed rate				1,127,382	1,139,307
	Total indebtedness				1,513,957	1,541,077
	Plus unamortized premium - net				23,063	27,235
	Less unamortized debt issuance costs - net				(14,984)	(15,811)
	Indebtedness, net				1,522,036	1,552,501
	Less current portion				(30,963)	(27,120)
	Indebtedness, net of current portion				$ 1,491,073	1,525,381

[1] Represents the date upon which the bonds are currently subject to mandatory tender by the bank.

The Health System refinanced its tax-exempt, variable rate revenue bonds in three tranches during fiscal year 2022 to a new floating rate index (from one-month LIBOR to one-month BSBY). The refinancing also extended the put dates of the Series 2005B bonds by five years (to maturity, 2028), the Series 2016B and 2016C bonds by six years (to 2032), and the Series 2006A/B/C bonds by seven years (to 2032). The Health System assessed whether the refinancing of the 2005A/B, 2006A/B/C, 2012B, and 2016B/C resulted in an insubstantial modification or an extinguishment of the debt for each variable rate revenue bond series. The Health System determined that $280,150 of the 2005A/B, 2012B, and 2016B/C series was extinguished and debt was remarketed to and purchased by a lender for the same amount, which is

(In thousands)

disclosed as an outflow for and inflow from financing activities in the accompanying 2022 consolidated statement of cash flows. The 2006A/B/C variable rate revenue bonds had insubstantial modifications as the lender continued to participate in the bond series.

All Duke University Health System, Inc. Tax-Exempt Revenue Bonds were issued by the North Carolina Medical Care Commission (NCMCC). The Health System is obligated to make payments of principal and interest that correspond to the obligations of the NCMCC under the bond agreements. The aggregate annual maturities of indebtedness for each of the five fiscal years subsequent to June 30, 2022 and thereafter are as follows:

2023	$	30,963
2024		32,987
2025		34,339
2026		35,754
2027		37,247
Thereafter		1,342,667
Total	$	1,513,957

The Health System must remain compliant with certain covenants and restrictions required by the trust indentures underlying its revenue bonds. These covenants include maintaining a required debt service coverage ratio and a specific liquidity target, as well as other nonfinancial restrictions.

(9) Derivatives and Other Financial Instruments

(a) Debt Derivatives

The Health System has executed derivative financial instruments in the normal course of managing its debt portfolio. The Health System has three interest rate swap agreements that are designed to synthetically reduce the variable rate exposure associated with its portfolio of indebtedness. In addition, the Health System had one basis swap designed to reduce the interest rate risk on variable rate indebtedness by utilizing the spread between the yield curves for taxable debt securities and tax-exempt municipal debt securities. The basis swap terminated on July 6, 2021.

(In thousands)

The following summarizes the general terms for each of the Health System's swap agreements:

Effective date	Associated debt series	Original term	Current notional amount	Health System pays	Health System receives
Interest rate:					
August 12, 1993	2012B	30 years	$ 6,330	5.090 %	SIFMA
May 19, 2005	N/A	23 years	178,185	3.601	61.52% of one-month LIBOR plus 0.28%
April 1, 2009	Portfolio[1]	30 years	127,505	4.107	67.00% of one-month LIBOR
Basis:					
July 6, 2001	N/A	20 years	N/A	SIFMA	72.125% of one-month LIBOR

[1] The notional amount of the April 2009 Interest Rate Swap declines coincidentally with the principal for Series 2006 bonds. The residual portion is $5,885.

Interest rate swap agreements are recorded at the estimated amount the Health System would receive or pay to terminate the swap agreement at the reporting date, taking into account current interest rates, and which approximates fair value. The fair value is included in derivative instruments on the consolidated balance sheets, while the change in fair value and the net settlement amount incurred on the swaps are included as a gain or loss in investment (loss) income on the consolidated statements of operations. The debt derivative instruments contain cross-collateralization provisions that require each counterparty to post collateral if the fair value meets certain thresholds.

(Continued)

(In thousands)

The related financial information on each of these instruments at June 30 is as follows:

	Financial information related to debt derivative instruments					
	2022			2021		
	Fair value [1]	Unrealized gain or (loss) recognized in income [2]	Realized gain or (loss) recognized in income [2]	Fair value [1]	Unrealized gain or (loss) recognized in income [2]	Realized gain or (loss) recognized in income [2]
Derivatives not designated as hedging instruments under ASC Topic 815						
August 1993:						
Interest rate swap	$ (159)	686	(582)	(845)	882	(879)
May 2005:						
Interest rate swap	(9,226)	14,057	(6,223)	(23,283)	9,630	(7,031)
April 2009:						
Interest rate swap	(28,364)	21,308	(5,001)	(49,672)	15,509	(5,123)
July 2001:						
Basis swap	—	—	1	—	277	75
Total derivatives not designated as hedging instruments	$ (37,749)	36,051	(11,805)	(73,800)	26,298	(12,958)

[1] Balance sheet classification is derivative instruments.

[2] The unrealized and realized (loss) gain on derivative instruments recognized in income is included in nonoperating investment (loss) income.

The Health System's debt derivative instruments contain provisions requiring long-term, unsecured debt to be maintained at specified credit ratings from Moody's Investor Service and Standard and Poor's Rating Service. If the ratings of the Health System's debt were to fall below certain benchmarks, the counterparty could request immediate payment on derivatives in net liability positions. At June 30, 2022 and 2021, the Health System's long-term debt ratings exceeded these requirements. The aggregate fair value of all derivative instruments with credit risk–related contingent features that are in a liability position on June 30, 2022 and 2021 is $37,749 and $73,800, respectively, for which the Health System was not required to post any collateral in the normal course of business. If the credit risk related features underlying these agreements were triggered on June 30, 2022 and 2021, the Health System would be required to post collateral of $37,749 and $73,800, respectively, to its counterparties.

The Health System is exposed to financial loss in the event of nonperformance by a counterparty to any of the financial instruments described above. General market conditions could impact the credit standing of the counterparties and, therefore, potentially impact the value of the instruments on the Health System's consolidated balance sheets. The Health System controls this counterparty risk by considering the credit rating, business risk, and reputation of any counterparty before entering into a

(Continued)

(In thousands)

transaction, monitoring for any change in credit standing of its counterparty during the life of the transaction, and requiring collateral be posted when predetermined thresholds are crossed.

(b) Investment Derivatives

Investment strategies employed by DUMAC and investment managers retained by DUMAC incorporate the use of various derivative financial instruments with off balance sheet risk. DUMAC uses these instruments for a number of investment purposes, including hedging or altering exposure to certain asset classes and cost-effectively adding exposures to portions of the portfolio. Positions are expected to create gains or losses that, when combined with the applicable portion of the total investment portfolio, provide an expected result.

The following table provides the net notional amounts and fair values of the Health System's investment derivative activities at June 30, 2022 and 2021. It also provides the net gain amounts included in investment (loss) income during fiscal years 2022 and 2021:

	2022	2021	Location in financial statements
Net notional amounts	$ 3,865,470	3,699,427	N/A
Derivative assets	146,258	49,618	Investments
Derivative liabilities	(89,898)	(26,161)	Investments
Net gain	92,946	161,475	Investment (loss) income
Posted collateral	27,069	18,242	Short-term investments

(10) Fair Value Measurements

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurement*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy assigns a higher priority to observable inputs that reflect verifiable information obtained from independent sources and a lower priority to unobservable inputs that would reflect the Health System's assumptions about how market participants would value an asset or liability based on the best information available. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates, and other factors.

(Continued)

(In thousands)

The three levels of the hierarchy of inputs used to measure fair value are as follows:

Level 1 – Unadjusted quoted prices in active markets for identical assets or liabilities that are available at the measurement date.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly at the measurement date.

Level 3 – Unobservable inputs for the asset or liability, used in situations in which little or no market activity exists for the asset or liability at the measurement date.

The categorization of fair value measurements by level of the hierarchy is based upon the lowest level input that is significant to the overall fair value measurement for a given asset or liability. In the event that changes in the inputs used in the fair value measurement of an asset or liability result in a transfer of the fair value measurement to a different categorization (i.e., from Level 3 to Level 2), such transfers between fair value categories are recognized at the end of the reporting period.

The following is a summary of the levels within the fair value hierarchy for the Health System's financial assets and liabilities measured at fair value:

	June 30, 2022	Level 1	Level 2	Level 3	Investments reported at NAV[1]
Assets:					
Cash and cash equivalents	$ 161,284	161,284	—	—	—
Deposits with bond trustees	382	382	—	—	—
Short-term investments	458,346	232,251	226,095	—	—
Fixed income	657,197	43,713	534,882	16,890	61,712
Equities	631,611	387,757	97,900	—	145,954
Hedged strategies	1,057,189	21,857	—	5,763	1,029,569
Private capital	1,593,332	4,476	—	94,062	1,494,794
Real assets	461,528	17,919	(25,644)	14,199	455,054
Other	141,135	—	83,201	—	57,934
Total assets	$ 5,162,004	869,639	916,434	130,914	3,245,017
Liabilities:					
Interest rate derivatives	$ 37,749	—	37,749	—	—
Total liabilities	$ 37,749	—	37,749	—	—

[1] Fund investments reported at NAV as a practical expedient estimate of fair value at June 30, 2022.

(In thousands)

	June 30, 2021	Level 1	Level 2	Level 3	Investments at NAV[1]
Assets:					
Cash and cash equivalents	$ 98,528	98,528	—	—	—
Deposits with bond trustees	300	300	—	—	—
Short-term investments	784,259	612,982	171,277	—	—
Fixed income	582,332	7	494,202	16,731	71,392
Equities	863,768	553,896	133,339	—	176,533
Hedged strategies	1,224,911	27,571	—	—	1,197,340
Private capital	1,555,117	27,283	—	76,932	1,450,902
Real assets	440,782	17,496	11,513	10,799	400,974
Other	112,025	2,641	51,348	—	58,036
Total assets	$ 5,662,022	1,340,704	861,679	104,462	3,355,177
Liabilities:					
Interest rate derivatives	$ 73,800	—	73,800	—	—
Total liabilities	$ 73,800	—	73,800	—	—

[1] Fund investments reported at NAV as a practical expedient estimate of fair value at June 30, 2021.

The following methods and assumptions are used by the Health System in estimating the fair value of each class of financial instruments:

Cash and cash equivalents, patient accounts receivable, other receivables, accounts payable, accrued salaries, wages, and vacation payable and related accruals, estimated third-party payor settlements, and other liabilities: The carrying amounts approximate fair value because of the short maturity of these instruments.

Investments and deposits with bond trustees: Reported at fair value as of the date of the consolidated financial statements.

Finance and operating lease liabilities: Estimated as the present value of future minimum lease payments over the lease term.

Debt-related derivative instruments: Based on a mid-market position obtained from the swap counterparties. The Health System engages a management advisor to validate the reasonableness of the swaps' recorded fair value. Collateral posting requirements are determined each month using the mid-market positions.

(Continued)

(In thousands)

The following tables present additional information about Level 3 financial instruments measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Health System has classified within the Level 3 category. As a result, the unrealized gains and losses for assets within the Level 3 category in the tables below may include changes in fair value that were attributable to both observable and unobservable inputs.

	Balance as of June 30, 2021	Net realized and unrealized gains (losses)	Purchases	Sales	Net transfers in (out)	Balance as of June 30, 2022
Asset category:						
Fixed income	$ 16,731	(1,996)	9,635	(7,623)	143	16,890
Hedged strategies	—	(495)	6,258	—	—	5,763
Private capital	76,932	12,487	9,060	(4,810)	393	94,062
Real assets	10,799	2,808	2,063	(552)	(919)	14,199
Total	$ 104,462	12,804	27,016	(12,985)	(383)	130,914

	Balance as of June 30, 2020	Net realized and unrealized gains (losses)	Purchases	Sales	Net transfers in (out)	Balance as of June 30, 2021
Asset category:						
Fixed income	$ 11,569	822	14,405	(9,740)	(325)	16,731
Private capital	83,218	7,204	3,574	(17,064)	—	76,932
Real assets	9,745	144	984	(74)	—	10,799
Total	$ 104,532	8,170	18,963	(26,878)	(325)	104,462

Net unrealized gains related to Level 3 assets still held at June 30, 2022 and 2021 totaled $15,223 and $25,646, respectively.

(11) Professional Liability Risk Program

The accompanying consolidated financial statements include the assets and liabilities of DCC, a wholly owned subsidiary of the Health System that insures a portion of the medical malpractice risks and patient general liability, privacy/cyber liability, and international liability risks of Health System clinical providers and the PDC. DCC limits its exposure to loss through reinsurance and excess loss agreements.

Estimated professional liability costs include the estimated cost of professional liability in fiscal years 2022 and 2021 for reported claims incurred in the DCC program. DCC evaluates its estimated professional liability on a discounted actuarial basis. The discount rate at June 30, 2022 and 2021 was 3.5%. Accrued professional liability costs excluding estimated incurred but not reported claims as of June 30, 2022 and 2021 amounted to $41,098 and $30,475, respectively. Other receivables and investments in this amount

(Continued)

have been designated by the Health System to settle these claims. Also included in estimated professional liability costs are estimated claims incurred but not reported related to the Health System in the amounts of $6,830 and $6,312 as of June 30, 2022 and 2021, respectively. Estimated professional liability costs are included in other current and other noncurrent liabilities in the consolidated balance sheets.

The estimated liability for professional and patient general liability claims will be significantly affected if current and future claims differ from historical trends. While management monitors reported claims closely and considers potential outcomes as estimated by its actuaries when determining its professional and general liability accruals, the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes complicate the estimation. In the opinion of management, adequate provision has been made for this related risk.

(12) Benefit Plans

(a) Pension and Retirement Plans

Staff members of the Health System are eligible to participate in the University's defined contribution retirement plan and are eligible to receive employer provided contributions in this plan. The Health System contributed $67,565 to this plan in fiscal year 2022 which is reported in salaries, wages, and benefits expense in the consolidated statement of operations. As approved by the University's Board of Trustees, the University suspended the employer provided contributions for the first six months of fiscal year 2021. In June 2021, the decision was made to retroactively reinstate employer contributions for the period January 1 through June 30, 2021. As a result, the Health System accrued $34,383 of retroactive contributions as of June 30, 2021 that were remitted in July 2021 to participant accounts and is reflected within other current liabilities on the 2021 consolidated balance sheet and salaries, wages, and benefits expense in the 2021 consolidated statement of operations. The Health System expects to contribute $75,450 to this plan in fiscal year 2023.

In addition, other full time Health System employees participate in the University's noncontributory defined benefit pension plan (ERP). The benefits for the defined benefit plan are based on years of service and the employee's compensation during the last 10 years of employment. The Health System expects to contribute $20,514 to this plan in fiscal year 2023. The allocation of the prepaid pension asset or pension liability between the University and the Health System is based primarily on compensation expense of covered employees. Health System staff represent approximately 82% and 80% of the total University's defined benefit pension plan for fiscal years 2022 and 2021, respectively.

(b) Postretirement Medical Plan

In addition to the Health System's pension plans, the Health System sponsors an unfunded, defined benefit postretirement medical plan that covers all of its full time employees who elect coverage and satisfy the plan's eligibility requirements when they retire. The plan is contributory with retiree contributions established as a percentage of the total cost for retiree healthcare and for the healthcare of their dependents. The Health System pays all benefits on a current basis. Employees hired after June 30, 2002 are not eligible for Health System contributions to the cost of this benefit and must bear the full cost themselves if elected at retirement. As a healthcare provider, the Health System utilizes an incremental cost approach to determine its liability for the postretirement medical plan. The total liability

(Continued)

(In thousands)

reflects estimated additional costs to provide healthcare benefits to retirees within the Health System plus the full cost to provide healthcare benefits to retirees at facilities other than Health System facilities.

(c) Pension and Postretirement Medical Plans

The measurement date for both the defined benefit pension plan and the postretirement health benefit plan is June 30. Pension and postretirement expense, pension contributions, and the associated liabilities are included in the following tables, which provide a reconciliation of the changes in the Health System's portion of the plans' benefit obligations and fair value of assets for the years ended June 30:

	Pension benefits		Postretirement benefits	
	2022	2021	2022	2021
Reconciliation of projected benefit obligation				
Obligation at beginning of year	$ 1,829,719	1,818,603	73,937	65,212
Service cost	82,819	93,944	988	620
Interest cost	53,999	49,592	2,031	1,589
Actuarial (gain) loss	(457,264)	(77,793)	(1,636)	10,866
Benefits paid	(47,279)	(42,927)	(4,363)	(4,350)
Plan changes	—	—	336	—
Administrative expenses (estimated)	(3,000)	(11,700)	—	—
Projected benefit obligation at end of year	$ 1,458,994	1,829,719	71,293	73,937
Reconciliation of fair value of plan assets				
Fair value of plan assets at beginning of year	$ 1,605,413	1,091,302	—	—
Actual return on plan assets	(34,391)	548,798	—	—
Employer contributions	21,913	20,107	—	—
Benefits paid	(47,279)	(42,927)	—	—
Administrative expenses	(3,008)	(11,867)	—	—
Fair value of plan assets at end of year	$ 1,542,648	1,605,413	—	—

(Continued)

(In thousands)

	Pension benefits		Postretirement benefits	
	2022	2021	2022	2021
Funded status				
Net accrued benefit asset (liability)	$ 83,654	(224,306)	(71,293)	(73,937)

The pension and postretirement benefits expected to be paid for the 10 years subsequent to June 30, 2022 are as follows:

	Pension benefits	Postretirement benefits
2023	$ 52,362	4,761
2024	55,574	5,044
2025	58,919	5,263
2026	62,928	5,382
2027	67,597	5,632
2028-2032	410,497	29,591

The expected benefits to be paid are based on the same assumptions used to measure the Health System's benefit obligation at June 30 and include estimated future employee service.

The following table provides the components of net periodic benefit cost for the plans for the years ended June 30:

	Pension benefits		Postretirement benefits	
	2022	2021	2022	2021
Service cost	$ 82,819	93,944	988	620
Interest cost	53,999	49,592	2,031	1,589
Expected return on plan assets	(95,150)	(84,535)	—	—
Amortization of prior-service cost and losses (gains)	907	907	(437)	(923)
Recognized actuarial loss	11,542	32,073	—	—
Net periodic benefit cost	$ 54,117	91,981	2,582	1,286

(Continued)

(In thousands)

The service cost component of net periodic benefit cost is included in salaries, wages, and benefits in operating expenses with the other components of net periodic benefit cost included in nonoperating components of net periodic benefit cost in the consolidated statements of operations. The prior-service costs are amortized on a straight-line basis over the average remaining service period of active participants. Included in net assets without donor restrictions are the following amounts that have not been recognized in net periodic benefit cost at June 30, 2022 and 2021, respectively:

	Pension benefits		Postretirement benefits	
	2022	2021	2022	2021
Unrecognized prior service cost	$ 3,885	4,792	336	—
Unrecognized actuarial gains	(342,126)	(2,870)	(8,786)	(7,587)

The assumptions used in the measurement of the Health System's benefit obligation and benefit cost are shown in the following table:

	Pension benefits				Postretirement benefits			
	2022		2021		2022		2021	
	Obligation	Cost	Obligation	Cost	Obligation	Cost	Obligation	Cost
Weighted average assumptions as of measurement date:								
Discount rate	4.73 %	2.99 %	2.99 %	2.76 %	4.68 %	2.83 %	2.83 %	2.52 %
Expected return on plan assets	N/A	7.50 %	N/A	7.50 %	N/A	N/A	N/A	N/A
Rate of compensation increase	3.0%/2.0%[1]	3.0%/2.0%[1]	3.0%/2.0%[1]	3.0%/2.0%[1]	N/A	N/A	N/A	N/A

[1]Compensation increase for first 20 years of service/thereafter

In order to determine the benefit obligation as of June 30, 2022, the per capita costs of covered healthcare benefits was assumed to increase 7.5% for non-Medicare eligible employees and 6.7% for Medicare eligible employees, declining to an ultimate annual rate of increase of 4.5% by 2035 for non-Medicare and 2030 for Medicare eligible employees. The benefit expense for fiscal year 2022 was driven by the rates of increase used to determine the benefit obligation as of June 30, 2021, which were 7.8% for non-Medicare eligible employees and 7.1% for Medicare eligible employees, declining to an ultimate annual rate of increase of 4.5% by 2035 for non-Medicare and 2030 for Medicare eligible employees.

(In thousands)

The following table provides details of the significant gains and losses related to changes in the defined benefit obligations:

	Pension benefits		Postretirement benefits	
	2022	2021	2022	2021
Actuarial (loss) gain due to investment performance	$ (129,549)	464,095	—	—
Actuarial gain due to change in discount rate	489,656	78,306	11,338	2,102
Actuarial loss (gain) recognized in current year expense	11,542	32,073	(437)	(923)
Other changes in net actuarial assumptions	(2,783)	2,358	(11,632)	(13,634)
Total other pension and postretirement benefit changes	$ 368,866	576,832	(731)	(12,455)

The defined benefit pension plan's investment strategy focuses on maximizing total return and places limited emphasis on liability matching and no emphasis on generating income. Over the long term, the plan's average exposure target is 48% equity (public and private investments in companies), 9% commodity (direct commodity exposure, commodity related equities, and private investments in energy, power, infrastructure, and timber), 9% real estate (private real estate and REITs), 15% credit (investment-grade bonds, corporate bonds, bank debt, asset backed securities, etc.), 13% absolute return oriented strategies, 4% rates (public obligations including treasuries and agencies), and 2% inflation-linked strategies.

The expected return on plan assets is established at an amount that reflects the targeted asset allocation and expected returns for each component of the plan assets. The expected return on pension plan assets was developed using a stochastic forecast model of long-term expected returns for each asset class. The rate is reviewed periodically and adjusted as appropriate to reflect changes in the expected market performance or in targeted asset allocation ranges.

(Continued)

(In thousands)

The same levels of the fair value hierarchy as described in note 10 are used to categorize the pension plan assets. The Health System's portion of the assets was initially based on the Health System's employee liability as of June 30, 2008 and rolled forward each fiscal year using the Health System's associated employee benefit payments since fiscal year 2008. The fair value of the Health System's portion of assets available for pension benefits as of the June 30 measurement date is as follows:

	June 30, 2022	Level 1	Level 2	Level 3	Investments reported at NAV[1]
Asset category:					
Short-term investments	$ 110,124	54,406	55,718	—	—
Fixed income	180,906	10,634	137,305	—	32,967
Equities	184,444	139,476	(4,267)	—	49,235
Hedged strategies	301,120	330	1,931	—	298,859
Private capital	568,715	1,402	—	32,020	535,293
Real assets	163,165	6,052	(12,760)	—	169,873
Other investments	34,175	(106)	34,281	—	—
	$ 1,542,649	212,194	212,208	32,020	1,086,227

	June 30, 2021	Level 1	Level 2	Level 3	Investments Reported at NAV[1]
Asset category:					
Short-term investments	$ 195,777	116,353	79,424	—	—
Fixed income	90,243	10,303	42,835	—	37,105
Equities	241,162	178,710	1,841	—	60,611
Hedged strategies	319,815	13,688	(170)	—	306,297
Private capital	590,114	7,281	—	26,388	556,445
Real assets	161,259	8,743	(2,672)	—	155,188
Other investments	7,043	(7,748)	14,791	—	—
	$ 1,605,413	327,330	136,049	26,388	1,115,646

[1] Fund investments reported at NAV as a practical expedient estimate of fair value.

(Continued)

(In thousands)

The following tables present additional information about the Level 3 financial instruments available for pension benefits measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Health System has classified within the Level 3 category. As a result, the unrealized gains and losses for assets within the Level 3 category in the tables below may include changes in fair value that were attributable to both observable and unobservable inputs:

	Balance as of June 30, 2021	Net realized and unrealized gains	Purchases	Sales	Net transfers out	Balance as of June 30, 2022
Private capital	$ 26,388	3,307	3,975	(1,650)	—	32,020

	Balance as of June 30, 2020	Net realized and unrealized gains	Purchases	Sales	Net transfers out	Balance as of June 30, 2021
Private capital	$ 31,934	763	1,419	(7,728)	—	26,388

The change in net unrealized gains related to Level 3 assets still held at June 30, 2022 and 2021 was $5,570 and $8,375, respectively, and was recorded within change in funded status of defined benefit plans on the consolidated statements of changes in net assets.

At June 30, 2022 and 2021, the accumulated benefit obligation for pension benefits was $1,338,809 and $1,665,732, respectively, as compared to the fair value of the plan assets of $1,542,648 and $1,605,413, respectively. At June 30, 2022 and 2021, the plan was over (under) funded in relation to accumulated benefits by $203,839 and $(60,319), respectively.

(Continued)

(In thousands)

(13) Functional Expenses

The Health System provides general healthcare services to residents within its geographic location. The following table presents expenses related to providing these services by both their nature and function as follows:

	Healthcare services	General and administrative	Total
For the year ended June 30, 2022:			
Salaries, wages, and benefits	$ 1,728,918	486,392	2,215,310
Medical supplies	1,196,544	—	1,196,544
Interest	37,584	—	37,584
Depreciation and amortization	183,157	25,912	209,069
Other operating expenses	565,799	272,252	838,051
Total	$ 3,712,002	784,556	4,496,558

	Healthcare services	General and administrative	Total
For the year ended June 30, 2021:			
Salaries, wages, and benefits	$ 1,497,308	532,309	2,029,617
Medical supplies	1,147,452	—	1,147,452
Interest	24,081	—	24,081
Depreciation and amortization	151,235	25,684	176,919
Other operating expenses	525,107	245,613	770,720
Total	$ 3,345,183	803,606	4,148,789

The accompanying consolidated financial statements report certain natural expense classifications that are attributed to both healthcare services and general and administrative functions. Natural expenses attributed to more than one functional expense category are allocated using a variety of cost allocation techniques such as occupancy, services utilized, and time and effort.

(Continued)

(In thousands)

(14) Leases

The following table shows operating expenses related to the Health System's leasing activity for the years ended June 30:

Lease type	Classification in Statement of Operations	2022	2021
Finance lease expense:			
Amortization of right-of-use assets	Depreciation and amortization	$ 11,019	10,161
Interest on lease liabilities	Interest	5,247	5,415
Operating lease expense	Other operating expenses	43,503	45,665
Short-term lease expense	Other operating expenses	16,940	18,625
Total lease expense		$ 76,709	79,866

Other information related to the Health System's operating and finance right-of-use assets and lease liabilities for the years ended June 30 is reported in the below table:

	2022	2021
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows for finance leases	$ 5,273	5,411
Operating cash flows for operating leases	40,294	40,090
Right-of-use assets obtained in exchange for new lease liabilities:		
Finance leases	$ 4,542	12,037
Operating leases	33,221	66,183
Weighted-average remaining lease term:		
Finance leases	35.1	34.1 years
Operating leases	13.5	12.5 years
Weighted-average discount rate:		
Finance leases	3.40	3.15 %
Operating leases	1.98	2.00

(Continued)

(In thousands)

The aggregate future lease payments under finance and operating leases as of June 30, 2022 are as follows:

		Finance leases	Operating leases
Year ending June 30:			
2023	$	15,283	35,299
2024		14,048	37,401
2025		10,950	32,988
2026		9,011	31,103
2027		7,873	30,852
Thereafter		233,627	260,395
Total minimum lease payments		290,792	428,038
Less: amount of lease payments representing interest		(120,293)	(55,556)
Present value of future minimum lease payments		170,499	372,482
Less: current portion		(9,864)	(28,202)
Lease liabilities, net of current portion	$	160,635	344,280

The DRH facility lease, which is a forty-year-minimum automatically renewing “evergreen” lease, is the Health System’s largest finance lease, accounting for approximately 89% and 86% of the total finance lease liability as of June 30, 2022 and 2021, respectively. The Health System made principal and interest payments for this lease of $7,307 and $7,233 in fiscal years 2022 and 2021, respectively.

(15) Commitments and Contingencies

(a) Construction and Purchase Commitments

At June 30, 2022, open contracts for the construction of physical properties and other capital expenditures amounted to approximately $141,400 and outstanding purchase orders for normal operating supplies and equipment amounted to approximately $33,000.

(b) Self-Insurance

The Health System provides employee healthcare benefits, long-term disability benefits, unemployment benefits, and workers’ compensation benefits primarily through employer contributions, participant contributions, and excess loss insurance and manages those programs through third-party administrators. In the opinion of management, adequate provision has been made for the related risks.

(Continued)

(c) Legal Considerations

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Health System, in part through its Compliance Program, seeks to ensure compliance with such laws and regulations, and to rectify instances of noncompliance with government program (Medicare, Medicaid, and Tricare) rules. The Health System believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Health System's consolidated financial statements. Compliance with such laws and regulations is subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs.

In addition to the above, the Health System is involved in various legal actions occurring in the normal course of business. While the final outcomes cannot be determined at this time, management is of the opinion that the resolution of these matters will not have a material adverse effect on the Health System's financial position.

(16) Subsequent Events

The Health System has evaluated subsequent events from the balance sheet date through October 4, 2022, the date on which the consolidated financial statements were issued, and determined that there are no other items to disclose.

Schedule 1

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Combined Group under April 13, 1999 Master Trust Indenture (MTI) and Consolidated

Combining and Consolidating Balance Sheet Information

June 30, 2022

(In thousands)

Assets	Duke University Hospital	Duke Regional Hospital	Duke Raleigh Hospital	Other MTI	MTI Combined Group	Duke Univ. Affiliated Physicians	Durham Casualty Company	Other Non-MTI	2022 total DUHS consolidated
Current assets:									
Cash and cash equivalents	$ (2)	—	—	140,262	140,260	—	19,546	1,478	161,284
Patient accounts receivable	405,812	47,686	64,790	12,825	531,113	12,911	—	6,485	550,509
Other receivables	14,849	1,620	2,991	9,861	29,321	92	—	1,751	31,164
Inventories of drugs and supplies	100,062	10,968	19,177	7,535	137,742	1,626	—	3,682	143,050
Short-term investments	—	—	—	444,351	444,351	—	—	—	444,351
Assets limited as to use	—	—	—	—	—	—	17,045	—	17,045
Other current assets	(155,816)	(21,620)	(25,360)	239,254	36,458	7,451	(645)	2,773	46,037
Total current assets	364,905	38,654	61,598	854,088	1,319,245	22,080	35,946	16,169	1,393,440
Assets limited as to use	—	—	—	81,810	81,810	—	24,053	—	105,863
Investments	—	—	—	4,208,862	4,208,862	—	228,173	—	4,437,035
Property and equipment, net	1,241,647	283,235	338,886	301,274	2,165,042	63,369	—	45,646	2,274,057
Prepaid pension asset	—	—	—	83,654	83,654	—	—	—	83,654
Right-of-use operating lease assets	9,219	775	1,820	332,400	344,214	625	—	1,802	346,641
Other noncurrent assets	—	—	21,966	34,989	56,955	—	—	2,795	59,750
Total assets	$ 1,615,771	322,664	424,270	5,897,077	8,259,782	86,074	288,172	66,412	8,700,440
Liabilities and Net Assets									
Current liabilities:									
Accounts payable	$ 130,581	14,977	35,806	38,007	219,371	3,522	132	10,444	233,469
Accrued salaries, wages, and vacation payable	110,257	25,760	24,357	65,828	226,202	26,025	—	17,679	269,906
Current portion of estimated third-party payor settlements, net	24,373	4,807	13,625	—	42,805	(417)	—	—	42,388
Current portion of postretirement and postemployment benefit obligations	—	—	—	8,850	8,850	—	—	—	8,850
Current portion of indebtedness	—	—	—	30,963	30,963	—	—	—	30,963
Current portion of finance lease liabilities	3,564	4,406	273	1,621	9,864	—	—	—	9,864
Current portion of operating lease liabilities	3,852	475	1,002	22,223	27,552	468	—	182	28,202
Other current liabilities	12,089	2,595	1,909	44,792	61,385	2,981	17,045	1,152	82,563
Total current liabilities	284,716	53,020	76,972	212,284	626,992	32,579	17,177	29,457	706,205
Postretirement and postemployment benefit obligations, net of current portion	—	—	—	74,759	74,759	—	—	—	74,759
Indebtedness, net of current portion	—	—	—	1,491,073	1,491,073	—	—	—	1,491,073
Finance lease liabilities, net of current portion	4,286	151,541	256	4,401	160,484	—	—	151	160,635
Operating lease liabilities, net of current portion	5,407	300	823	335,937	342,467	158	—	1,655	344,280
Derivative instruments	—	—	—	37,749	37,749	—	—	—	37,749
Other noncurrent liabilities	10,492	6,576	5,951	23,680	46,699	11,475	24,053	1,689	83,916
Total liabilities	304,901	211,437	84,002	2,179,883	2,780,223	44,212	41,230	32,952	2,898,617
Net assets:									
Without donor restrictions	1,310,870	111,227	340,268	3,659,766	5,422,131	41,862	246,942	33,460	5,744,395
With donor restrictions	—	—	—	57,428	57,428	—	—	—	57,428
Total net assets	1,310,870	111,227	340,268	3,717,194	5,479,559	41,862	246,942	33,460	5,801,823
Total liabilities and net assets	$ 1,615,771	322,664	424,270	5,897,077	8,259,782	86,074	288,172	66,412	8,700,440

See accompanying independent auditors' report.

Schedule 2

DUKE UNIVERSITY HEALTH SYSTEM, INC.
AND AFFILIATES

Combined Group under April 13, 1999 Master Trust Indenture (MTI) and Consolidated

Combining and Consolidating Statement of Operations Information

Year ended June 30, 2022

(In thousands)

	Duke University Hospital	Duke Regional Hospital	Duke Raleigh Hospital	Other MTI	MTI Group eliminations	MTI Combined Group	Duke Univ. Affiliated Physicians	Durham Casualty Company	Other Non-MTI	Other eliminations	2022 total DUHS consolidated
Revenues, gains, and other support without donor restrictions:											
Patient service revenue	$ 2,847,146	406,875	623,304	82,458	—	3,959,783	182,381	—	54,383	—	4,196,547
Other revenue	117,387	15,840	22,292	218,461	(172,627)	201,353	6,152	29,490	198,354	(148,867)	286,482
Total revenues, gains, and other support	2,964,533	422,715	645,596	300,919	(172,627)	4,161,136	188,533	29,490	252,737	(148,867)	4,483,029
Expenses:											
Salaries, wages, and benefits	1,079,521	240,069	213,679	359,595	—	1,892,864	173,053	—	149,393	—	2,215,310
Medical supplies	790,390	71,227	191,907	101,292	—	1,154,816	19,142	—	22,586	—	1,196,544
Interest	24,597	6,060	6,881	35	—	37,573	—	—	11	—	37,584
Depreciation and amortization	93,433	24,893	32,848	45,739	—	196,913	6,291	—	5,865	—	209,069
Other operating expenses	935,283	122,905	177,439	(211,876)	(172,627)	851,124	38,736	22,766	74,292	(148,867)	838,051
Total expenses	2,923,224	465,154	622,754	294,785	(172,627)	4,133,290	237,222	22,766	252,147	(148,867)	4,496,558
Operating income (loss)	41,309	(42,439)	22,842	6,134	—	27,846	(48,689)	6,724	590	—	(13,529)
Nonoperating (loss) income:											
Investment (loss) income	5	—	—	(45,410)	—	(45,405)	—	(42,765)	—	—	(88,170)
Nonoperating components of net periodic benefit cost	—	—	—	27,108	—	27,108	—	—	—	—	27,108
Other	78	40	10	(4,790)	—	(4,662)	—	—	131	—	(4,531)
Total nonoperating (loss) income	83	40	10	(23,092)	—	(22,959)	—	(42,765)	131	—	(65,593)
(Deficit) excess of revenues over expenses	41,392	(42,399)	22,852	(16,958)	—	4,887	(48,689)	(36,041)	721	—	(79,122)
Change in funded status of defined benefit plans	—	—	—	341,027	—	341,027	—	—	—	—	341,027
Net assets released from restrictions for purchase of property and equipment	16,374	—	77	9	—	16,460	—	—	—	—	16,460
Intracompany transfers, net	208,570	57,573	(4,810)	(335,886)	—	(74,553)	53,228	—	21,325	—	—
Transfers (to) from the University, net	(138,879)	(362)	33	(159)	—	(139,367)	654	—	874	—	(137,839)
Increase (decrease) in net assets without donor restrictions	$ 127,457	14,812	18,152	(11,967)	—	148,454	5,193	(36,041)	22,920	—	140,526

See accompanying independent auditors' report.