SECTION III:

FINANCIAL SECTION




Section III Contents

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NOV 15 2005

TO: The Secretary
Through: DS _____
COS _____
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FROM: Daniel R. Levinson
Inspector General

SUBJECT: Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2005 (A-17-05-00001)

PURPOSE

Our purpose is to provide you with the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2005 financial statements, internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (Public Law 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting (CPA) firm of Ernst & Young, LLP (EY), to audit the FY 2005 HHS financial statements. We also contracted with the CPA firm of PricewaterhouseCoopers, LLP, to perform the financial statement audit of the Centers for Medicare & Medicaid Services (CMS). EY's opinion expressed on the FY 2005 HHS financial statements makes reference to the work performed by PricewaterhouseCoopers. The contracts required that the audits be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, "Audit Requirements for Federal Financial Statements."

INFORMATION TEXT

Audit Results

Based on the work performed by both audit firms, EY reported that the FY 2005 HHS consolidated/combined financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. The report on internal controls noted two internal control weaknesses that were

considered to be material weaknesses under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 01-02:

- *Financial Systems and Processes*—As in prior years, HHS continued to have serious internal control weaknesses in its financial management systems and processes for producing financial statements. While the auditors observed some progress in preparing financial statements, the lack of an integrated financial management system(s) and weaknesses in internal controls made it difficult for HHS to prepare timely and reliable financial statements. Substantial manual processes, significant adjustments to reported balances, and numerous accounting entries recorded outside HHS's general ledger system were necessary. In addition, deficiencies were noted in regional office oversight and data analyses and reconciliations.

- *Managed Care Benefits Payment Cycle*—CMS lacks a comprehensive control environment related to the managed care benefits payment cycle, including oversight of managed care organizations. CMS implemented the Medicare Managed Care System despite known deficiencies in the system that led to erroneous payments. In addition, CMS failed to establish a process to ensure that accounting as well as operational issues were addressed throughout the new payment system implementation process. While the majority of these payments have been identified and corrected, existing policies and procedures are not sufficient to adequately reduce the risk of material benefit payment errors from occurring and not being detected and corrected in a timely manner.

As discussed in the report on compliance with laws and regulations, weaknesses in HHS's financial systems and processes and in certain operating divisions' information systems controls represented departures from certain Federal requirements.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 01-02, we reviewed the audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;

- reviewing the approach and planning of the audits;

- attending key meetings with auditors and HHS officials;

- monitoring the progress of the audits;

- examining audit documentation related to the review of internal controls over financial reporting;

- reviewing the auditors' reports; and

- reviewing the HHS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

EY is responsible for the attached reports dated November 11, 2005, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether HHS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which EY did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-05-00001 in all correspondence.

Attachment

cc:
Charles E. Johnson
Assistant Secretary for Budget, Technology and Finance

Terry L. Hurst
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Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services and
the Secretary of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Department of Health and Human Services (HHS), as of September 30, 2005 and 2004, and the related consolidated statements of net costs, changes in net position and financing and the combined statements of budgetary resources for the fiscal years then ended. These financial statements are the responsibility of the HHS's management. Our responsibility is to express an opinion on these financial statements based on our audits. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the years ended September 30, 2005 and 2004. Those statements and financial information were audited by other auditors (the CMS auditors) whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for the CMS excluding the Health Programs aggregating combined assets of $353,986 million and $336,962 million and total combined net costs of $295,713 million and $269,748 million, as of and for the fiscal years ended September 30, 2005 and 2004, are based solely on the report of the other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. These standards and requirements require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the HHS's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the HHS's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

The information presented in the Management Discussion and Analysis, the required supplementary stewardship information, required supplementary information, the supplemental and other accompanying information is not a required part of the basic financial statements but is supplementary information required by OMB Circular A-136, *Financial Reporting Requirements*. We and other auditors have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. We did not audit the information and express no opinion on it. However, we were unable to assess control risk relevant to HHS's intra-governmental transactions and balances, as required by OMB Bulletin No. 01-02, because reconciliations were not performed with certain federal trading partners as required by OMB Circular A-136.

In our opinion, based on our audits and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the HHS as of September 30, 2005 and 2004, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the years then ended, in conformity with accounting principles generally accepted in the United States.

In accordance with *Government Auditing Standards*, we have also issued our reports dated November 11, 2005, on our consideration of the HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audits.

Ernst & Young LLP

November 11, 2005
Washington, D.C.

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Report on Internal Control

To the Inspector General of the
Department of Health and Human Services and
the Secretary of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2005, and have issued our report thereon dated November 11, 2005. We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the year ended September 30, 2005. Those statements and the financial information which is included in HHS's financial statements were audited by other auditors whose report thereon has been furnished to us, and the comments reflected herein, insofar as they relate to the information included for the CMS, excluding the Health Programs, are based solely on the report of other auditors.

In planning and performing our audits, we considered HHS's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal control over financial reporting. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 01-02. We did not test all internal controls relevant to operative objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to ensuring efficient operations. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the HHS's ability to initiate, record, process, and report financial data consistent with the assertions of management in the financial statements. The reportable condition we noted is described below.

A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. We noted the following matters involving the internal control and its operation that we consider to be reportable conditions. We consider the first two matters noted—Financial Systems and Processes, and Managed Care Benefits Payment Cycle —to be material weaknesses.

MATERIAL WEAKNESSES

Financial Systems and Processes (Repeat Condition)

Over the past year, we and other auditors (with respect to CMS) noted that HHS has made progress in addressing the financial systems and processes weakness noted during fiscal year (FY) 2004. For example, management indicated that:

- During April of 2005, HHS transferred payroll processing for its more than 65,000 employees to the Defense Finance and Accounting Service.

- As part of its modernization effort, HHS developed plans to reduce the number of financial management systems from five to two using the Unified Financial Management System (UFMS). The system is expected to integrate the HHS financial management structure to provide more timely and consistent information and to promote the consolidation of accounting operations that would substantially reduce the cost of accounting services throughout HHS. HHS initiated its implementation of the UFMS at the Centers for Disease Control (CDC) and the Food and Drug Administration (FDA) during April of 2005.

- CMS established a Risk Management and Financial Oversight Committee which ensures that there is cross-functional involvement in the monitoring of business activities to identify situations where accounting evaluation or decision-making may be necessary.

- CMS successfully transitioned four Medicare contractor sites to HIGLAS, the agency's fully integrated general ledger system. HIGLAS is now the system of record for these contractor sites.

- CMS enhanced its policies and procedures by developing a formal written process to evaluate and approve changes in accounting and financial reporting policies.

- CMS improved procedures for handling correspondence that relates to complaints and allegations about CMS employees or other matters causing legal, operational, or financial risk to CMS.

- CMS performed Continuous Quality Improvement (CQI) assessments in order to determine whether the managed care audits were timely, completed accurately, and in accordance with established procedures and guidelines. The CQI assessments provided the impetus for the development of additional training, updated monitoring guides, and additional standard policies and procedures.

While progress has been made, the HHS continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. These weaknesses caused delays in meeting milestones created to facilitate accelerated reporting and resulted in unexplained differences in reconciliations and account analyses. Within the context of the approximately $581 billion in departmental outlays, the ultimate resolution of such amounts is not material to the financial statements taken as a whole. However, these matters are indicative of serious systemic issues that must be resolved. These long-standing issues, including system and process limitations and expertise needed in meeting evolving financial reporting requirements, simultaneously with implementing new systems, will require a sustained commitment and qualified support team to resolve in preparation for FY 2006 and future years.

Financial Management Systems Issues

The Federal Financial Management Improvement Act (FFMIA) of 1996 was intended to advance Federal financial management by ensuring that financial management systems provide reliable, consistent disclosure of financial data, that they do so uniformly across the federal government from year to year, and that they consistently use accounting principles generally accepted in the United States. Policies and standards for agencies to follow in developing, operating, evaluating, and reporting on financial management systems are prescribed in OMB Circular A-127, *Financial Management Systems.*

Within HHS, the CMS and the National Institutes of Health (NIH) are responsible for their respective financial management and accounting. The CDC/Agency for Toxic Substances and Disease Registry (ATSDR), and the FDA have implemented the UFMS in April 2005, eliminating their separate financial management systems. The remaining operating divisions, including the Administration for Children and Families (ACF), rely on the Program Support Center's Division of Financial Operations (DFO) for these services.

While we and other auditors observed progress in preparing financial statements, the lack of an integrated financial management system(s) and weaknesses in internal controls made it difficult to prepare timely and reliable financial statements. HHS expects the systems used by certain operating divisions to be significantly enhanced by the end of FY 2007. Ultimately the decision to replace the existing systems is expected to provide improved financial information for better decision-making, potential cost savings, and a means to meet federal accounting and budgetary reporting requirements. However, system implementations, as seen at CDC and FDA, frequently create data conversion and other issues that can lead to difficulties in processing transactions appropriately and preparing accurate reports, and constitute a risk over the next several years. In the interim, substantial "work-arounds," cumbersome reconciliation and consolidation processes, and significant adjustments to reconcile subsidiary records to reported balances have been necessary under the existing systems. The following matters illustrate the challenges presented by departmental systems.

CMS **-** CMS is the largest of the HHS's operating divisions, with approximately $313 billion and $171 billion in combined net FY 2005 budget outlays for Medicare and the Health Programs, respectively. CMS relies on decentralized processes and complex systems—many within the Medicare contractor organizations and CMS regional offices—to accumulate data for financial reporting. An integrated financial system, a sufficient number of properly trained personnel, and a strong oversight function are needed to ensure that periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

Other auditors reported that CMS's financial management systems are not compliant with the FFMIA. FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the former Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair CMS's ability to efficiently and effectively support and analyze account financial reports.

For example, Medicare contractors currently rely on a combination of claims processing systems, personal computer-based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to CMS on the 750 – Statement of Financial Position Reports and the 751 – Status of Accounts Receivable Reports. These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because CMS, and the CMS contractors, do not have a JFMIP compliant financial management system, the preparation of the 750 and 751 reports, and the review and monitoring of individual accounts receivable, are dependent on labor intensive manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS. Likewise the reporting mechanism used by the CMS contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, is heavily dependent on inefficient, labor-intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS.

Other auditors reported that the lack of integration in financial reporting is clearly demonstrated through the results of the SAS 70 reviews performed at Medicare contractors during the current fiscal year. These reports noted a total of 35 auditor qualifications related to the control objectives regarding financial reports at nine of the 14 contractors where reviews were completed. This indicates a potential problem in relying upon the data as reported without completion of significant review by the regional and central office. This prevents the timely use and reliance of this information by both operations and financial reporting personnel. For example, the contractors are unable to report all information required for the completion of quarterly financial statements in accordance with OMB timelines and provide only minimal information at year-end that supports the completion of financial statements but does provide enough data for oversight and management of the contractors' activities.

NIH **-** In FY 2005, NIH had net budget outlays of approximately $27 billion. During FY 2004, because the legacy NIH Central Accounting System was not designed for financial reporting purposes and did not comply with the United States Standard General Ledger (USSGL) at the transaction level, NIH launched the Oracle General Ledger portion of the NIH Business System (NBS). Although the Oracle General Ledger became the official accounting system of record during FY 2004, we noted in FY 2005 that NIH was required to record approximately 120,000 nonstandard accounting entries with an absolute value of $5.6 billion to adjust budgetary and proprietary accounts. Additionally, the NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified. Finally, during our testing we noted that transaction codes for direct, reimbursable, and sponsored travel required manual intervention to assign an identifier, either direct or reimbursable, to the transaction within the NBS. This identifier assigns the required budgetary accounts to the transaction.

Entities Supported by the Program Support Center (PSC) **-** In FY 2005, the operating divisions serviced by the PSC had net budget outlays of approximately $62.7 billion. The PSC's DFO CORE accounting system, which supports the activities of these operating divisions, did not facilitate the preparation of timely financial statements. The necessary data had to be downloaded from CORE, with numerous adjusting entries processed throughout the year before compiling the statements. For example, in FY 2005, approximately 900 nonstandard accounting entries with an absolute value of almost $29.9 billion were recorded in CORE to compensate for noncompliance with the USSGL, to correct for misstatements, to record reclassifications, and to correct reported balances.

UFMS—FDA / CDC **–** The CDC/ATSDR and FDA operated with combined net budget outlays of about $5.9 billion and $1.3 billion in FY 2005, respectively. CDC and FDA continued to use their antiquated systems during FY 2005. These financial management systems were not fully integrated, and FDA's and CDC's ability to fully support financial balances in a timely fashion were impacted by the need for manual analysis to ensure balances were correct.

The CDC and FDA went live with UFMS in April 2005 for core financials, including modules for the general ledger, accounts payable, and accounts receivable and, in addition, Projects for CDC and iProcurement for FDA; however, we were unable to obtain complete documentation of the accounting processes involving UFMS until September 2005—five months after the system was implemented.

HHS has experienced significant challenges in resolving issues with the system conversion and implementation, including configuration issues, insufficient resources, inadequate training, and limited report capability of financial and budget activity within the system. HHS continues to experience significant challenges in resolving issues with the system conversion and implementation, including insufficient resources, untimely preparation of reconciliations, and insufficient training. For example:

- The UFMS executive leadership, consistent with the UFMS guiding principles, directed the initial scope of the core financial systems implementation, and the related financial

management process improvements with the primary focus on the mandatory JFMIP core financial management functions. For this reason, certain elements are not included within the scope of the HHS's UFMS system, including data warehousing and certain feeder systems—including travel, property, grants, budget formulation, and procurement—but are under the authority of the operating divisions. Furthermore, the UFMS, as currently configured, cannot produce financial statements. Therefore, FDA and CDC continue to use cumbersome processes to crosswalk the unadjusted trial balance to the financial statements.

- Both CDC and FDA continued to record thousands of nonstandard accounting entries both prior and subsequent to the UFMS conversion. FDA recorded 14 thousand non-standard accounting entries totaling an absolute value of approximately $9.4 billion to create the September 30, 2005 financial statements. FDA noted this was primarily due to the productivity dip and lack of familiarity with the system.

  To prepare the September 30, 2005 financial statements, CDC indicated that it was required to record the following:

  - Accounting entries totaling an absolute value of $11.3 billion either to its statements or another HHS operating division.
  - Adjustments totaling an absolute value of $24.4 billion with the Automated Desktop Integrator program. Generally, these adjustments related to conversion, data cleanup, corrections, account reclassifications, and other adjustments to conform to UFMS processing.
  - A $19.1 billion absolute value adjustment to the database used to generate financial statements as a result of conversion adjustments made in UFMS which could not be extracted into the database.

- An independent public accounting firm performed certain agreed-upon procedures, including comparing the UFMS transactional accounting treatment manual to the suggested transaction entry per the Treasury Financial Manual USSGL (USSGL). The report noted numerous scenarios where the UFMS accounting treatment differed from the Treasury suggested treatment.

  The UFMS Global Program Management Office noted that the goal in developing the transaction codes for UFMS was to have the net result of a given accounting event recorded based on USSGL guidance. We were informed that due to the standard functionality of the system, the UFMS required the use of additional transaction codes to achieve the same result of the suggested treatment within USSGL or to properly record converted budget authority.

- In some cases, CDC and FDA, in conjunction with HHS, had not completed the development of reports from the UFMS system. Ad-hoc extracts from UFMS and reports generated from the legacy systems were the primary means to support monthly

reconciliations and the interim and year-end financial statements. According to management, the reports and processes were not fully complete as FDA added minimal operating reports for their go-live, while CDC had 19 custom reports developed. As of September 30, 2005, many extracts from UFMS did not agree to the trial balance and had not been reconciled. Processes and data to prepare reports, rather than individual or summarized transactions, needed to aid in the review of account balances were not available to us or routinely available to managers in executing their duties. For example, for both CDC and FDA, we were unable to obtain a download or an aging of undelivered orders from UFMS that would support the undelivered orders within the financial statements. In addition, certain reports used by FDA and CDC budget personnel do not contain the level of detail needed to sufficiently monitor the budget. This monitoring must now be done at a high level or manually.

- Configuration issues and implementation of new business rules within the iProcurement requisitioning of UFMS delayed payment of invoices to vendors. This delay was due in part to instituting decentralized receiving and commitment accounting. For example, as of September 30, 2005, FDA had more than $10 million in invoices delayed for payment.

- Most required reconciliations relating to periods subsequent to the conversion were not completed in a timely fashion. Both FDA and CDC experienced lack of sufficient experienced resources to extract required data in a timely fashion, perform the reconciliation, and perform research to resolve open reconciling items. We have discussed further examples of this within the Department / Operating Division Periodic Analysis and Reconciliation.

- We understand that HHS management continues to develop and implement corrective actions to improve its implementation of UFMS, develop internal controls, train personnel and develop necessary reports, policies and procedures. Sustained efforts will be necessary to overcome the seriousness of the weaknesses noted. Because CDC and FDA comprise less than 1.2% of total HHS expenditures, we were able to determine that amounts were fairly stated within the context of the September 30, 2005 financial statements taken as a whole. However, as additional operating divisions implement UFMS, serious weaknesses could impact the HHS's ability to substantiate balances on its financial statements, if implementation procedures are not improved.

Financial Statement Preparation, Complex Accounting Processes and Substantiation

As noted in FY 2004, accelerating the timeliness of financial reporting, pending implementation of modern accounting systems that are compliant with the former JFMIP and fully support the financial reporting process, provided challenges for us and for the HHS. Accordingly, procedures need to be reassessed and modified to prepare accurate and complete financial statements in a more timely manner.

Financial Statement Preparation

HHS compiles its financial statements through a multistep process using a combination of manual and automated procedures. Furthermore, due to the system limitations, many operating divisions record numerous entries outside the general ledger systems and employ manually intensive procedures using Excel spreadsheets and database queries to prepare the financial statements. These processes increase the risk that errors may occur in the HHS's financial statements. Therefore, management must compensate for the financial management system weaknesses by implementing and strengthening additional controls. Although the HHS has taken additional steps to compensate for the financial management system weaknesses, including a process whereby certain personnel are assigned to review each operating division's financial statements and follow up on discrepancies or anomalies, a more rigorous review of interim and year-end financial statements is still needed. The following represents issues identified during the financial statement preparation process:

- To prepare financial statements, more than 270 entries with an absolute value of more than $208 billion were recorded outside the general ledger system. Many of these accounting entries were made to record year-end accruals, adjust between governmental and nongovernmental accounts, record expenditures not posted to the general ledger prior to the month-end close, adjust proprietary to budgetary accounts, and post reconciliation adjustments. A majority of the entries could have been eliminated by more timely analyses and reconciliations, as well as improved estimation methodologies.

- We noted various errors in supporting spreadsheet calculations used to produce the financial statements that we brought to management's attention. For example, on November 5, 2005, we noted that management incorrectly recorded a $2 billion adjustment relating to an omission of an undelivered order account in crosswalking the trial balance to the financial statements. A $1.5 billion adjustment was recorded on November 9, 2005 to correct the error.

- We identified unexplained adjustments on a consolidated basis totaling an absolute value of more than $3.6 billion in the calculation of the Statement of Budgetary Resources and the Statement of Financing.

- Our review of HHS's financial statement crosswalks identified certain general ledger accounts that were not used consistently with the USSGL. We noted that an absolute value of over $12 billion in general ledger balances were summarized inconsistently with guidance provided by Treasury. For example, the USSGL suggests that the 2190 account "Other Liabilities" should be reported as "Other Liabilities" on the Balance Sheet; however, HHS summarizes the 2190 account as part of "Accounts Payable."

While the errors, unexplained differences, and unsupported entries noted were not material to the Department-level financial statements taken as a whole, they serve to illustrate that errors are more likely to occur in an environment that necessitates a time-consuming, manually intensive

financial statement preparation process, as well as the need for additional strengthening of the HHS's financial statement preparation, review, and approval processes.

Complex Accounting Processes

In addition, HHS has certain complex accounting processes that require further expertise to ensure that the accounting and reporting of amounts are appropriate in the financial statements and footnote disclosures. For example:

- Lease Accounting—The NIH Service and Supply fund has more than 70 leases it procures with commercial entities. In the past three years, questions regarding capitalization and budget scoring of these leases continuously have required interpretations as to the appropriate reporting in the financial statements and to OMB. Currently, HHS has disclosed that the NIH has operating leases that do not have cancellation clauses and the obligation for the full term of the lease is not recorded. The issue is currently under review and resolution will not occur for the FY 2005 reporting period. The total liability for these leases over the life of the lease term is $553.8 million in FY 2005 and $578.6 million in FY 2004.

- National Stockpile Inventories—Certain stockpile materials recorded in Office of the Secretary accounts but maintained by CDC and other parties through interagency agreements monitored by CDC merit additional focus. CDC has acknowledged a need to comprehensively evaluate the management and financial controls in this area. We were unable to obtain a rollforward of activity from balances transferred when the HHS resumed custody of these stockpiles from the Department of Homeland Security in late 2004 through September 30, 2005, or a comparison of related obligation/expenditure transactions to changes, if any, in stockpile inventories. Furthermore, in November 2005, CDC identified a potential $186 million adjustment against its $1.4 billion balance in its accounting records based on an inventory taken by the custodian of the inventory. The CDC does not track stockpile activity during the year but instead adjusts its stockpile inventory account based on inventories taken by the custodians on a periodic basis. Appropriate accounting recognition for stockpile activity should include recording purchases at the time of receipt, monitoring and recording issuances from stock and disposal activity, and reconciling the resulting recorded inventory amounts with amounts reflected in periodic physical inventories, with research performed on cutoff and other reconciling items and/or the resulting shortage or overage reflected in the reconciliation.

- Credit Reform—We noted in our review of the Health Education Assistance Loan program that HHS's methodology for calculating amounts related to the loan liability were not consistent with credit reform guidance and certain footnote disclosures were not complete or clear. For example, we noted a greater than $147 million balance in net position that should be reflected as a payable to Treasury.

- UFMS Software Capitalization and Budget Process—Although software capitalization guidance has been issued, HHS continues to have difficulty implementing the guidance to ensure appropriate accounting of new systems, including UFMS. The project, which began in FY 2001, was initiated with the purchase of modules of an enterprise resource planning package and the contracting of a system integrator. As of September 30, 2005, the projected budget for the UFMS project was approximately $217 million with more than $138 million collected from the Operating Divisions through interagency agreements. Funds expended at the end of FY 2005 are more than $93 million or approximately 43% of the projected budget.

  As of September 30, 2005, approximately $136 million has been obligated for UFMS between FY 2001 and 2005. To date, HHS has incurred costs of approximately $93.6 million but has only capitalized $24.6 million despite the purchase of the software platform during FY 2001. Additionally, individual operating divisions did not follow Departmental policy in the accounting of the UFMS system. The capitalized costs are to be transferred to the Office of the Secretary on a quarterly basis, which has not occurred. As of September 30, 2005, the Office of the Secretary had not determined the costs associated with the deployment of UFMS at FDA and CDC in April 2005 and had not begun amortizing the capitalized balance for the portion of such costs related to the system placed in service. As a result, we were unable to fully substantiate the methodology and capitalized costs related to the UFMS that is currently being implemented throughout HHS.

These processes are currently immaterial to HHS taken as whole; however, the increase of activity or the sensitivity of these accounts may increase the profile of reported balances to financial statement users.

Reporting Substantiation

HHS does not maintain or have readily available sufficient documentation to support transactions included in its general ledger, the Performance and Accountability Report, and required submissions to OMB and Treasury. For example:

- Due to delays in obtaining amounts, disclosures, and supporting documentation from the operating divisions, HHS was unable to complete certain disclosures within its financial statements and related footnotes, the closing package, and other sections included within its Performance and Accountability Report until November 4, 2005.

- Although Treasury's closing submission date of the Federal Agencies' Centralized Trial Balance System (FACTS II) to Treasury was November 2, 2005, HHS was only able to provide FACTS II reconciliations with its trial balances for four of its 12 operating division as of November 5, 2005. As of the end of fieldwork, the differences had not been fully identified to us, but management represented that they consisted principally of year-end accruals.

- We noted that unsupported entries were recorded to the beginning-of-period unobligated balances to ensure that the trial balance agreed with the FY 2005 audited ending unobligated balances. Other unexplained differences existed in preparing budgetary reporting and other financial schedules.

Based on our observations and discussions with management, we noted that the complexity and the decentralized nature of HHS, resource limitations, post-system conversion-related issues, limited reviews of documentation files, and miscommunications and limited understandings of the audit process caused many documents to be either delayed or missing to support its September 30, 2005, financial statements.

Financial Analysis and Oversight

The U.S. Government Accountability Office (GAO)'s *Standards for Internal Control in the Federal Government* states that internal control activities help ensure that management's directives are carried out. The control activities should be effective and efficient in accomplishing the organization's control objectives. Examples of control activities include: top-level reviews, reviews by management at the functional or activity level, segregation of duties, proper execution of transactions and events, accurate and timely recording of transactions and events, and appropriate documentation of transactions and internal control.

Because weaknesses exist in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of weaknesses that impact HHS's ability to report accurate financial information. During FY 2005, we found that certain processes were not adequately performed to ensure that differences were properly identified, researched and resolved in a timely manner and that account balances were complete and accurate. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

Department/Operating Division Periodic Analysis and Reconciliation

Consistent with FY 2004, during FY 2005, we found that certain processes were not adequately performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- Fund Balance With Treasury - On a monthly basis, the HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2005, the general ledger and Treasury's records differed by an approximate absolute value of $544 million. Management could not explain the variance. Furthermore, we noted that:

- For the PSC-serviced operating divisions, four separate monthly reports are prepared that reconcile the general ledger with Treasury's records. One of the reports generated to compare detailed transactions in the general ledger with Treasury's records has lost its usefulness due to old and invalid items that remained in the general ledger. For example, the September 30, 2005 report identified an absolute value of approximately $5.5 billion of differences in transactions dating back as early as 1993. Management indicated that due to staffing limitations, the PSC primarily focused on the larger, more recent differences. Issues related to delays in reconciliation processes for entities supported by UFMS were noted earlier in this report. Additionally, we noted 53 of 105 reconciliations selected at NIH and PSC-serviced operating divisions were not completed in the HHS's allotted 30-day deadline—several taking up to 84 days to complete.

- FDA did not complete its June fund balance with Treasury reconciliation until September 28, 2005. However, the reconciliation included $84 million in suspense accounts that had not been investigated and almost $15 million of unexplained variances. The September reconciliation still identified a significant number of unresearched reconciling items. In some cases, contractors were used to assist in becoming up-to-date on required reconciliations; however, we noted that many of the reconciliations prepared by the contractor had not been reviewed by entity management.

- Grants Management - We identified more than 32,000 grants with remaining net obligation balances of $2.3 billion that are eligible for close out. These should be actively reviewed for closeout in the Payment Management System (PMS) and the operating divisions' grant subsidiary systems. Many of these grants have been eligible for closeout for several years. Further, CMS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation activity within the PMS, which tracks draws for state grants, are consistent with obligation activity within CMS's general ledger. Currently, the states use a CMS 64 to report accrued expenditures to CMS while the states submit a PMS 272 to report expenditures on a cash basis to the PMS resulting in inconsistent expenditure activity within the two systems for the same grant. Although CMS personnel close out grants on the general ledger once obligations and expenditures match, old obligations are not always de-obligated within the PMS leaving unexpended balances available for draws by the states. The difference between net obligations more than two years old within the two systems was more than $1 billion at September 30, 2005.

- Net Position - Contrary to HHS policy, complete, periodic reconciliations of appropriated capital used and budgetary accounts were not performed until year-end. As a result, approximately 427 miscellaneous adjustments with an absolute value of $12.3 billion were recorded to various net position accounts.

- Medicaid and SCHIP Entitlement Benefits Due and Payable - Medicaid entitlement benefits due and payable (IBNR), totaling approximately $20 billion at September 30, 2005, represent the cost of services incurred by states on behalf of CMS but not paid at the end of the fiscal year. CMS bases its estimate of IBNR receivables and payables on historical trends of expenditures and prior year payables identified on surveys obtained from the states. CMS validates their estimate by considering current year program changes, performing analytical procedures, and evaluating significant differences. Although we believe the methodology currently employed by CMS can produce a reasonable IBNR estimate for Medicaid and is the best estimate currently available, the process is highly dependent on the various states. Errors, inconsistencies and varying interpretations at the state level can occur and significantly affect the CMS IBNR liability. It should be noted that a 15 month time lag exists from the date of the state IBNR information (typically June 30, 2004) to the date of CMS's fiscal year end calculation (September 30, 2005).

  Although the total draws and expenditures used in the overall Medicaid IBNR calculation, were reasonable, we noted various clerical errors in the spreadsheets that were used to calculate IBNR and for trending and analyses purposes. The internal control process over the Medicaid IBNR calculation did not detect the errors in a timely manner. Although the individual state entries in the spreadsheets were primarily used for analyses purposes and the total expenditures used in the national Medicaid calculation were reasonable, these discrepancies indicate that errors may occur without being identified and corrected.

  Further, we noted that although certain supervisory reviews of the IBNR calculation were performed in the Office of Financial Management, additional input from Program or OACT offices was not obtained. These individuals have additional expertise and knowledge that may identify anomalies impacting the estimate. While we believe the amount reported is reasonable based on CMS's and our analysis, there is insufficient assurance that the current process would identify significant anomalies. Adequate analysis, follow-up, and review is therefore, extremely important.

  For SCHIP, CMS has not implemented procedures to accrue an estimate for SCHIP IBNR payables and receivables at year-end. However, a portion of SCHIP expenditures is reimbursed on a fee-for-service basis, indicating the need for an IBNR accrual.

- Subsidiary Ledgers - For FY 2004 and prior years, approximately 151 thousand entries totaling $19.7 trillion remained in the detail supporting the general ledger. Most of these entries were posted to ensure agreement between the subsidiary ledgers and the general ledgers, to record budgetary entries, and to record depreciation for capitalized property maintained by the operating divisions. Maintaining supporting subsidiary ledgers would greatly facilitate the financial reporting process.

Medicaid Regional Office Oversight

Since the late 1990s, the Health Programs' regional office oversight has been identified as a weakness within CMS. The regional office oversight of the states is a key detect control in identifying errors within State submitted financial information related to Medicaid, SCHIP and other health programs. The CMS 64, Quarterly Medicaid Statement of Expenditures, is a key submission which reported the approximately $245 billion in FY 2005 in state expenditures to CMS, which flows directly to the financial statements. In September 2000, CMS issued financial review guides to assist the regional office analysts in examining budget and expenditure reports and to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process, but their use and documentation are currently not required but highly recommended.

The monitoring activities executed by CMS constitute critical oversight activities in light of the 11 states that, we have been informed, recently received disclaimers or qualified reports by independent auditors on compliance with Medicaid program requirements, compliance findings in single auditors' reports requiring resolution, and various differences in processes, systems, and issues from state to state. We noted the following during our review:

- *Documentation and Scope of Reviews* - Within the CMS regional offices analysts are not required to follow the CMS Financial Review Guide to assess each state's budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted in the two regions visited that the regional office did not consistently use the review guide (for quarterly and budgetary reviews) and, when the guide was used (for CMS-64s), the reasons steps were not performed were not always documented. Additionally, we noted that documentation for certain line items on the CMS-64 supporting the analysts' review was lacking. The line items affected included those relating to adjustments and other expenditures for varying amounts. Finally, practically none of the documents examined in our sample had evidence (e.g. sign-off) that a supervisory review was performed.

- *Monitoring of state submissions* - Analysis of changes in quarterly budget and expenditure submissions is a major consideration in a regional office's recommendation to award a grant or validate expenditures and a step in the CMS Financial Review Guide. During our visit to the regional offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain states, although evidence of trend analysis was available, the scope of the items selected for review was not documented in the workpapers and there was no evidence of which amounts were investigated. In many cases, explanations for variances were not sufficiently documented to assist a reviewer in verifying that CMS gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

In FY 2005, CMS took steps to increase regional office personnel by hiring more than 100 analysts to work in the states to ensure compliance with Medicaid requirements. These analysts, who have undergone extensive training to ensure adequate knowledge of CMS policies and procedures, began their oversight activities in FY 2005. Additionally, our review in FY 2005 noted improvements in state oversight as compared to weaknesses identified during FY 2004; however, continued emphasis on the extent of reviews and documentation of procedures performed is still needed. It should be noted that our review encompassed the first two quarters of FY 2005; accordingly, we understand certain corrective actions implemented by CMS were not fully implemented at the time of our review.

Single Audit Monitoring

We noted that improvements are needed in the single audit follow-up process, including more timely responses to audit reports, resolution, and corrective actions._ During our review, we noted that ten out of the top 100 HHS grantees did not submit their single audit reports for their most current fiscal year. Further, we noted that HHS operating divisions were not performing timely follow-up to ensure that weaknesses noted in compliance reports are appropriately resolved. The monitoring activities executed by HHS constitute critical oversight activities in light of the number of grantees receiving disclaimers or qualified reports by independent auditors on compliance with program requirements; compliance findings in single auditors' reports requiring resolution; and various differences in processes, systems, and issues from grantee to grantee.

Recommendations

Pending installation of the new systems under development, routinely meeting accelerated reporting deadlines without heroic efforts will require a change in processes. We recommend that the HHS:

- Ensure that the operating divisions, in conjunction with HHS, implement corrective actions, pending full operation of HIGLAS, the NIH NBS, and the UFMS, to mitigate system deficiencies that impair the capability to support and report accurate financial information.

- Ensure that the operating divisions (1) develop formal procedures to conduct periodic, detailed reviews and analyses of transactions within the subsidiary ledgers and (2) establish controls to identify, research, and resolve significant accounting anomalies in a timely manner.

- Ensure that the operating divisions allocate adequate resources to perform required account reconciliations and analyses monthly.

- Direct that the operating divisions prepare quarterly reports on the status of corrective actions on recommendations identified in the individual operating division reports on internal controls.

- Ensure, as required by OMB Circular A-136, *Financial Reporting Requirements*, the preparation of future years' interim financial statements supported by reconciliations and account analyses to ensure that such reporting is accurate for decision-making.

- Continue to refine its procedures to provide a mechanism for CMS central and regional offices to monitor states' activities and enforce compliance with CMS financial management procedure by:

  - Providing specific guidance in the use and preparation of the Financial Review Guides to ensure that the regional offices consistently use the guide to document procedures performed during the quarterly expenditure and budgetary reviews and that any decision to expand or curtail the scope of the review or review procedures be documented.

  - Developing a specific scope to be used to identify areas for review and that this scope or any deviations from the scope be documented within the trend analysis workpaper(s) along with explanations.

- Enlist the CMS's OACT to help review the annual Medicaid IBNR calculation. OACT is skilled in performing such estimates and brings a good understanding of how healthcare cost trends, program changes, etc., should affect the IBNR calculation. We further recommend that formal analytical review procedures (i.e., documented and reviewed) be developed to catch clerical errors in the spreadsheets and that CMS proactively obtain input from the states via the regional offices on trends, system changes, program changes, etc., associated with individual states. It would be beneficial to prepare a white paper every year addressing the various factors affecting IBNR and creating a link between qualitative information (e.g., trends, state system changes, OACT, regional office, and program office input, etc.) and the quantitative calculation. CMS should also calculate IBNR based on a three-year average using the current year survey (e.g., 2005, 2004, and 2003) as a reasonableness check on the IBNR calculated using state information 15 months in arrears. This procedure can help to detect/and factor in current trends affecting the IBNR calculation. Consideration should also be given to refining the average-days calculation, which does not currently appear to corroborate the IBNR used in the financial statements.

- In order to help strengthen the estimating process, we suggest CMS consider developing a methodology to collect the necessary data to estimate an IBNR amount from claims data maintained internally. We recognize that this is a formidable task and that validated claims information lags a few years; however, development of such a procedure may be helpful to CMS (particularly if OACT becomes involved in the Medicaid IBNR process)

in performing an independent check ("look-back") on the IBNR developed from state surveys if done several years in arrears to benchmark the existing process using actuarial concepts.

- Identify a methodology for estimating an IBNR for SCHIP-related expenditures. We understand CMS is currently pursuing an approach similar to that used for Medicaid, and we encourage finalization of this approach.

- Require reviews of the IBNR calculation and state surveys by the Program, Financial, and OACT divisions to identify any potential anomalies or changes to the Health Programs that could impact the IBNR calculation.

- Continue in the implementation of the pilot project to estimate improper payments for Medicaid, SCHIP and other high-risk programs' related payments within HHS where an error rate methodology has not been developed and fully implemented.

- Provide training to personnel involved in the audit process in order to communicate the types of documentation needed to support financial transactions.

- Establish or revise policies and procedures addressing documentation of transactions that are consistent with GAO's internal control standards. The policies should enable HHS to provide sufficient documentation in a timely fashion to support its financial statements.

- Implement a strategy to perform periodic reviews of files to ensure the appropriate documentation is maintained in accordance with HHS policies.

- Develop and implement a plan to provide for the identification and extraction/ maintenance from post-converted systems of required documentation and reports generally needed for analyses, reconciliations, and audit purposes.

Managed Care Benefits Payment Cycle

Other auditors reported that CMS lacks a comprehensive control environment related to the managed care benefits payment cycle and the oversight of managed care contractors which include Medicare Advantage Organizations (MAO) and Demonstration projects. The existence of a payment process outside the Office of Financial Management and lack of integration of accounting processes within operating procedures related to managed care organizations establishes an environment where the risk of inaccurate payments is not sufficiently mitigated.

Overview

The CMS Medicare benefits expense is composed of two major components: fee-for-service and managed care. Fee-for-service expenditures are processed and paid for by Medicare contractors,

while managed care expenditures are processed and paid by central office. In January of 2005, CMS completed a system conversion to the Medicare Managed Care System (MMCS) for payments to the managed care organizations which resulted in payment adjustments of $1.3 billion in the second quarter, $507 million in the third quarter, and $1.3 billion in the fourth quarter, compared to the adjustments in the first quarter in the previous system, which totaled $469 million.

While other auditors reported that the majority of these payment errors have been identified and corrected or accrued for at the managed care plan level as of November 7, 2005, existing CMS policies and procedures are not sufficient to adequately reduce the risk of material benefit payment errors from occurring and not being detected and corrected in a timely manner in the managed care benefits payment cycle.

Inadequate Procedures to Review and Process Managed Care Payments

Managed care organizations are paid using two methodologies: (1) a risk-based methodology in which multiple demographic and health factors are used to determine the reimbursement rate for a beneficiary and (2) a cost-based methodology in which a plan is reimbursed a predetermined amount per beneficiary which is then adjusted to actual cost incurred during the year through the cost settlement process.

Other auditors noted instances of inadequate policies, documentation, and supervisory review related to the authorization and payment process for risk-based payments as evidenced by the following:

- CMS has not established procedures to reconcile beneficiary-level payments that are calculated and authorized to the actual payment request sent to Treasury. Other auditors attempted to reconcile the total amount calculated by the MMCS system to the amount authorized for payment by DEPO on a monthly basis and noted unreconciled differences ranging from $1.7 million to $66 million.

- CMS did not maintain readily accessible and up-to-date logs of anomalies or errors resulting from their review of plan-level payments.

- The current methodology employed to analyze payment information is based on a simple fluctuation analysis on month-to-month payments. This simplistic model has identified some errors but fails to consider additional variables that may indicate potential payment issues (e.g., change in the number of enrollees).

- CMS was unable to provide accurate beneficiary-level payment information in a timely manner. Other auditors noted inaccuracies between the production files used to calculate the benefit payments and the amounts authorized for payment. These inaccuracies were caused by the maintenance of multiple production files and not properly identifying the beneficiary files used in the production of payment files.

- Adjustments were made to plan payments processed in MMCS based on prior months' actual payments from the predecessor system without considering other factors that may have caused changes. The adjustments ranged from a reduction of $630 thousand to an increase of $7.5 million for the individual plans.

- CMS failed to provide documentation to support the settlement of cost-reimbursed managed care organizations, as well as, documentation to support the recording of payables and receivables for cost settlements. Cost-based reimbursement represents approximately $1.6 billion in annual benefits expense. Other auditors sampled 45 plan settlements, of which CMS failed to provide any documentation for 16 (36%) of the settlements. For the remaining 29 plans in the sample, other auditors tested a total of 1,305 attributes in which the documentation for a total of 74 of the attributes did not meet CMS's requirements. These 74 exceptions were noted in 25 of the 29 files received.

- For risk-based plans, CMS processed manual adjustments for managed care payments without calculating or adjusting the amount at the beneficiary level which is the basis of the transaction (for example, in April 2005, CMS processed $13 million in manual adjustments). This methodology may lead to inaccurate payments.

- CMS was unable to provide policies and procedures related to the validation of the demonstration project payments and settlements.

- CMS has not established proper segregation of duties related to managed care payments. One division has the authority to manually adjust plan payments calculated by the MMCS system and is responsible for validating and authorizing the payments. This process is limited to a small group of people whose work is not subject to independent review.

Lack of Documentation and Procedures to Determine Eligibility of Organizations

- CMS was unable to provide comprehensive documentation of organizations that were approved during the fiscal year as either new managed care providers or for the expansion of their service areas. Other auditors noted exceptions in 19 (42%) of the 45 contracts reviewed where documentation did not meet CMS requirements. Examples of the missing documentation included audited financial statements, marketing materials, reviewer signoff, and state licensures.

- CMS does not have comprehensive policies and procedures for the review of new applications as evidenced by its inability to provide procedures related to new applications for special needs plans.

- CMS was unable to provide policies and procedures to document the acceptance and approval of demonstration projects.

Lack of Comprehensive Methodology in Implementation of New Payment System

- CMS implemented the MMCS system despite known deficiencies in the system that resulted in erroneous payments. The inability of CMS to correct these errors during the year resulted in an accrued payable of $500 million in the September 30th financial statements. Inaccurate payments were made throughout the year due to the use of inaccurate information such as:
  - Improper risk factors were applied.
  - Erroneous demographic factors were applied.
  - Incorrect End Stage Renal Disease payment balances were used.
  - Inaccurate frailty risk factors for institutional beneficiaries were used.
- CMS failed to establish a systematic method for identifying, documenting, and correcting errors found in the MMCS system as demonstrated by the following:
  - CMS was unable to provide, in a timely manner, a listing of system changes and their payment impact.
  - CMS did not establish expectations related to beneficiary population or payment dollar impact prior to implementation of system changes to enable the agency to validate the reasonableness of the payment changes.
  - CMS was unable to categorize managed care plan or beneficiary level adjustments that occurred on a monthly basis related to system changes versus normal payment activity.
  - CMS did not establish a comprehensive testing methodology to review the monthly payments made to managed care organizations. CMS relied on the managed care organizations to inform them of issues and the ad hoc review of system reports by CMS personnel.
  - CMS was unable to quantify the total amount of erroneous payments and corrections made during the fiscal year.
  - CMS was unable to explain unusual anomalies in corrected payment adjustments to managed care plans. For example, for a particular group of managed care plans, an additional payment of $250 per Medicare beneficiary member was paid to correct an earlier underpayment. However, the additional $250 was processed for only approximately 87,000 beneficiaries from a total population of approximately 180,000 beneficiaries. CMS was not able to provide documentation to adequately explain the

logic error that caused this underpayment affecting only a portion of a homogeneous beneficiary population.

- CMS failed to establish a process to ensure that accounting as well as operational issues were addressed throughout the new payment system implementation process. Throughout the testing phase of the audit, we noted significant uncertainty regarding the coordination of responsibilities among Centers for Beneficiary Choices, Office of Information Systems, Office of Financial Management, and other functional and program personnel related to information systems and payments in the managed care benefits payment cycle.

Inadequate Oversight of Managed Care Contractors

- The Health Plan Monitoring System (HPMS) used by the central office to monitor the execution and status of managed care organization oversight contains inaccurate information. This system is the core of the CMS monitoring process for MAOs. Inaccurate information within HPMS weakens the monitoring of MAOs and may cause CMS to pay plans that are ineligible. The following inaccuracies were noted by other auditors:

  - The HPMS monitoring review module does not contain all of the managed care organizations receiving payment from CMS. Thirteen percent of the managed care organizations included in our sample selected for testing were not included in HPMS. Incomplete information in the system may result in missed reviews and the payment of ineligible plans.

  - The HPMS monitoring review module contains inaccurate "organization type" information which is the basis for the timing and extent of oversight to be performed at the MAO. Incorrect review timing or type of review may result in the payment of ineligible plans.

  - The HPMS monitoring review module was not updated in accordance with CMS policy for the results of audits conducted during the fiscal year. The lack of timely information for management to rely upon in making determinations related to an organization's ability to meet contractual requirements may result in ineligible plans receiving payment.

- As discussed last year, CMS was unable to provide sufficient documentation to support the on going monitoring of managed care organizations by the regional offices in accordance with CMS's policies and procedures. During the FY 2005 audit, we continued to identify inconsistencies in the documentation that was available for review. The documentation maintained by the regional offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for regional office reviews.

- CMS lacks comprehensive policies and procedures for monitoring reviews related to demonstration projects. These are specialized healthcare programs/services established to address the needs of specific beneficiary populations.

Recommendations

Other auditors recommended that CMS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare managed care activity. Specifically, CMS should:

- Ensure that the information systems are updated on a timely basis to provide information allowing for adequate management oversight.

- Ensure that established policies address standard documentation and retention requirements for regional office monitoring reviews of the managed care organizations.

- Establish policies for regional office monitoring of demonstration projects that include tailored procedures to address the unique requirements or risks of each demonstration project.

- Perform extensive beneficiary data and payment information analysis to identify potential errors, unusual variances or inappropriate payment trends. This analysis should evaluate information such as: (1) demographic makeup of the plan's population as compared to the coverage area's population and (2) enrollment fluctuations as compared to other plans and enrollment in the overall Medicare managed care program.

- Due to the importance of the payment function in ensuring the validity and accuracy of payments to the managed care organizations and to maximize the detection of payment errors, we recommend that DEPO perform a timely reconciliation of authorized payments made by Treasury. CMS should also establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.

- With the implementation of the new system to replace MMCS for the payment of MAOs and to pay expenses related to the new prescription drug plan, CMS should establish a multi-functional process integrating personnel and systems in the managed care program, finance, and information system areas with clear lines of responsibility to ensure that issues are addressed in a timely manner

- CMS should enhance their testing and documentation methodology related to the implementation of MAO payment systems. This methodology should include:

- Parallel processing documenting differences between systems. Parallel processing should be completed for more than one payment cycle.
- Development of a statistically-valid sampling methodology for the purpose of payment validation at the beneficiary level.
- Process to establish expected impact of system changes prior to implementation.
- Process to maintain an audit trail that identifies system changes and their impact at a beneficiary level.
- Process to perform reconciliations of beneficiary level data to plan payments including plan level adjustments.

- CMS has established strong controls for monitoring fee-for-service contractors in many areas listed in this material weakness and should consider implementing many of those requirements for the MAO program. In particular, implementing the data analysis methodologies employed by Medicare Contractors and Program Safeguard Contractors should provide CBC with a foundation for improving internal control within the managed care benefits payment cycle.

REPORTABLE CONDITIONS

Medicare Electronic Data Processing Access Controls and Application Software Development and Change Control (Modified Repeat Condition)

Overview

The CMS relies on extensive information systems operations at its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud, and other illegal acts.

Other auditors reported that their internal control testing covered both general and application controls. General controls involve organizational security plans, referred to as entity wide security plans (EWSP), access controls (physical and logical), application software development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems, and combined with application level controls, are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and output of data from CMS application systems.

Other auditor's audit included general controls reviews at 13 sites: the CMS central office and 12 Medicare contractors. They also reviewed application controls at the CMS central office and at Medicare contractors for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems' (VIPS) Medicare System (VMS), and the Multi-Carrier System (MCS). Their audit also relied on the work and findings of the Statement on Auditing Standards (SAS 70) examinations for the 12 Medicare contractors audited.

Further, other auditors conducted vulnerability reviews of network controls at all 13 sites audited. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments at all 13 sites, including reviews of security configurations of network servers.

Other auditors' audit noted improvements in the following areas during the FY 2005 audit:

- Entity wide Security Program (EWSP) - These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. Other auditors' audit noted improvements in the entity wide security programs reviewed during the FY 2005 audit when compared to the FY 2004 programs reviews. Other auditors noted improvements regarding assessment of risks, identification of controls to reduce risk, overall security policies and procedures, completeness of EWSP plans, and training of security personnel.

- Systems Software – Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. Other auditors noted considerable improvement regarding mainframe security software and operating system settings when compared to the FY 2004 audit. Other auditors noted that mainframe security settings were generally in compliance with policies, monitoring controls for mainframe activities had been enhanced, and documentation over mainframe operating components, such as exits and supervisor calls, had been enhanced at most of the contractor sites audited. Other auditors also noted the creation and implementation of distributed platform security configuration templates and standards at practically all sites audited. Additionally, although some failure to comply with the templates and standards were noted at contractors, the number of settings and the severity of the weaknesses noted were, in general, reported by other auditors as being significantly reduced when compared to the FY 2004 audit.

- Service Continuity Planning and Testing – Service continuity relates to the readiness of a site in the case of a system outage or an event that disrupts normal processing of operations. Without approved, documented, and tested business and system continuity plans, there is no assurance that normal operations may be recovered efficiently and

timely. Other auditors reported that in FY 2005, they noted significant improvement in the continuity plans and testing of the plans when compared to the FY 2004 audit. The FY 2005 audit noted that plans existed for all contractors and CMS headquarter sites audited and that practically all of the plans had been tested and, in most cases, used to update the prior plan.

During FY 2005, other auditors noted that CMS made significant progress by continuing its reviews of contractors, including penetration tests and reviews of configuration settings on servers. Further, during FY 2005, CMS undertook a campaign to review, analyze, and thoroughly discuss the proposed corrective action plans of contractors and those of CMS headquarters. This process included extensive discussions both on-site at CMS headquarters, with contractor management in attendance, and remotely with contractor management. The result of the efforts and hours dedicated to this project are clearly evident in the improvement noted in the areas of EWSP, Systems Software and Service Continuity and, other auditors noted that this is the reason for the reduction in risk over IT weaknesses that have resulted in two reportable conditions versus the previously noted material weakness at CMS.

Other auditors reported that during FY 2005, to address the weaknesses noted regarding the control of front end system edits for FISS, MCS and VMS, CMS management issued a new change request (CR) 3862 which provides guidance on the control of edits for the FISS, MCS, and VMS systems. Further, CMS launched a project to determine contractor readiness regarding compliance with CR 3862. Initial results of the testing clearly indicate improved policies and procedures for the control of front end edits for these three systems and enhancements within all three systems which allow automated logging and tracking of edit changes for review, analysis and follow-up.

During FY 2004, CMS launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medical Modernization Act for Medicare. This evaluation program includes all eight key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. This program was continued for FY 2005 and other auditors noted that they believe that the evaluations obtained as a result of this effort have served and continue to serve CMS in better understanding the current state of security operations at all Medicare contractors, not just those contractors testing during the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the reportable conditions noted, other auditors reported that CMS continues its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, CMS continues to request and receive system security

plans and risk assessments from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

Other auditors noted that efforts to address the findings noted in their review have been and continue to be challenged by budgetary constraints and the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to CMS officials, the CMS modernization program represents a long-term solution to simplify the application software code and change controls needed for more robust security. CMS is also in the process of its contractor reform initiative, including data center consolidation, which should reduce the number of contractors and data centers.

Inadequate Logical Access Controls

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Other auditors noted numerous findings regarding logical access during their controls testing. Other auditors noted that numerous security weaknesses existed that would allow internal users to access and update sensitive systems, programs, and data without proper authorization. Other auditors' review did not disclose any exploitation of critical systems tested; however, clear potential existed.

Other auditors consistently noted employees who did not require direct access to data and application software programs to perform their job responsibilities but who nevertheless had been granted inappropriate update access to Medicare data and application software programs. Other auditors also noted that many contractors and, in one instance, CMS central office had not performed procedures to recertify access granted to employees on an annual basis as required by CMS standards.

As a result, they noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites.

Inadequate Application Security, Development, and Program Change Control

Application security, development, and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security, and maintenance and that only authorized and properly tested programs are implemented for production use. Other auditors noted again that contractor processing sites have the ability to turn on and off front end edits in the FISS, MCS and VMS systems without consistent procedures to ensure that edits are only turned off when required, that changes to edits are properly approved prior to the change and that a complete analysis of the effect of the change to an edit and has been conducted and used to assess the overall effect on Medicare processing.

Changes to edits represent a very important area of concern because the ability to negate system edits degrades the ability to ensure that only proper data is introduced into these systems and ultimately, the Common Working File (CWF) and the National Claims History (NCH) System and other databases used to analyze claims and make decisions.

Other auditors also noted again, although at fewer contractor sites, that application changes are being implemented without documented testing and approval and that application change control procedures were not followed at several contractor sites.

Finally, other auditors noted once again that there were numerous contractor sites at which application programmers had the ability to directly update production source code for applications, thereby allowing them to bypass application change controls.

Recommendations

Other auditors recommended that the CMS continue to strengthen controls over Medicare electronic data processing. Specifically, CMS management should:

- Target contractor access control policies and procedures to ensure their sufficiency and enforcement, including recertification of access annually and assurance of proper segregation of duties for application and systems programmers.
- Provide more specific guidance to the contractors regarding procedures to formally assess and reduce risk on an ongoing basis by specifically identifying and matching controls to mitigate risks noted in their systems security plans and by specifically requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness.
- Continue the process to assess the enforcement of CR 3862, especially with regard to the approval of changes to shared system coded edits and the use of the newly developed audit trails in the FISS, MCS and VMS systems to analyze the effect of edit modifications on Medicare claims processing and approval. The analysis of edit modifications from the system audit trails should be used to match the results to error trends resulting from contractor claims processed during periods when edits are turned off and include specific matching of error types to contractors from which the errors emanated.
- Continue and enhance processes to continuously monitor and track compliance with the security configuration models for all platforms maintained within, the CMS contractor sites, the maintainer sites, and the CMS central office. CMS should greatly encourage the use of automated tools to monitor, detect, and report to the CMS Information Security Office, all noncompliance with contractor, maintainer or CMS headquarter platform security configuration standards for distributed servers, including WINDOWS, UNIX, router, switches, Web server, and Oracle database servers on a quarterly basis.

Departmental Information Systems Controls (Repeat Condition)

Many of the business processes that generate information for the financial statements are supported by information systems. Adequate internal controls over these systems are essential to the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. As part of our assessment of internal controls, we have conducted general control reviews for systems that are relevant to the financial reporting process. General controls involve the entity-wide security program, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensure the reliability, confidentiality, and availability of financial information.

While HHS has made significant progress in strengthening controls over its systems, our procedures continued to identify general controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

- Entity-wide security program,
- Access controls (physical and logical),
- Application development and program change controls,
- Systems software, and
- Service continuity.

Because of the pervasive nature of general controls, the cumulative effect of these weaknesses represents significant deficiencies in the overall design and operation of internal controls. Detailed descriptions of control weaknesses may be found in SAS 70 reports and the management letters issued on each system review. The following discusses the summary result by review area.

Entity-wide security programs: These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, systems-based operations. Our procedures identified the following issues:

- Security Plans: Security plans for some of the systems have not been updated, finalized, approved, and communicated.

- Certification & Accreditation: Required certification and accreditation statements for some of the major financial applications and general support systems have expired or have not been reviewed or updated recently.

- Security Training: Relevant security and security awareness training was not provided to all employees and contractors.

- Incident Response Capabilities: The incident response capabilities for some of the systems are limited due to the lack of clearly defined policies and procedures and the inadequate monitoring and assessment of critical events.

Access controls (physical and logical): Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive application, system utilities, and data is granted only when authorized and appropriate. Access controls over operating systems, network components, and communications software are also closely related. These controls help to ensure that only authorized users and computer processes can access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Our procedures identified the following issues:

- Access Authorizations: For some of the systems, the approval of access requests was not or inadequately documented.

- Access Revalidations: For some of the systems, the periodic revalidation of user accounts is either not performed or inadequately documented.

- Password Controls: The password controls applied to some of the systems do not provide an adequate level of authentication controls.

Systems software: Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Our procedures identified the following issues:

- Configuration Controls: Systems settings for selected databases and operating systems are not optimized to provide a secure computing environment.

- Patch Management: The controls over timely and consistent application of system patches are not effective for all of the systems.

Application software development and change controls: A well defined and effectively controlled development and change management process should be in place to ensure that only authorized, tested, approved, and documented new programs or changes to existing programs are applied to the production environment. Additionally, the process facilitates that new or changed programs meet the requirements with regards to security and controls; such as providing for programmed integrity controls, audit trails, logging capabilities, etc. Our procedures identified the following issues:

- Change Controls: For some applications, there is no formal and consistently applied change control process.

Service continuity: Disaster recovery and business continuity plans provide a means for re-establishing both the automated and manual processes under a variety of scenarios ranging from short-term system failures to disastrous, large scale events that impair the functioning of mission-critical processes. A critical part of service continuity is the periodic testing of the disaster recovery and business continuity plans to validate their effectiveness. Besides building redundancies on the systems side, it is critical that relevant data is stored at an off-site location to enable a timely recovery of critical information. Our procedures identified the following issues:

- Disaster Recovery Plans: The contingency plans for some of the systems are either not defined, incomplete, or outdated.

- Disaster Recovery Test: Some of the contingency plans are not tested periodically to validate the effectiveness of the contingency provisions.

Additionally, we noted the following weaknesses within the Division of Financial Operations, the Centers for Information Technology, and Human Resource SAS 70s.

- The Independent Service Auditors' Report for the Human Resource Service Personnel and Payroll Systems' General Information Technology and Application Controls identified certain controls related to the application software development and change controls for the Commissioned Corp Personnel/Payroll System (COPPS) that were not operating effectively.

- The Independent Service Auditors' Report for the Division of Financial Operations related to the general information technology and application control environment over the CORE Accounting Systems and feeder systems identified certain controls related to the application software development and change controls, computer resources' protection against unauthorized modification, disclosure, loss, or impairment and changes to existing systems software and implementation of new system software that were not operating effectively.

- The Independent Service Auditors' Report for the Center for Information Technology related to its general information technology and application control environment identified certain controls related to changes to hardware and operating systems software in the Windows and Mainframe environment that were not operating effectively.

Recommendations

HHS continues to rely on information systems to support its business processes. With the advances of technology; this reliance will most-likely increase over time. To provide a secure computing environment for critical applications throughout all the operating divisions, HHS should continue to develop, implement, and monitor cost-effective controls to include:

- Maintenance of updated security plans to provide security and controls commensurate with the risk associated with any given system.

- Completion of certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.

- Training of all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.

- Strengthening of incident response capabilities through formalized policies and procedures and relevant tools and technologies to increase the likelihood that security relevant events are detected, isolated, and properly treated.

- Maintenance of access approval records to provide for accountability.

- Revalidation of access rights on a periodic basis to limit systems access on a need-to-have basis.

- Strengthening technical password controls to provide an effective mechanism for user authentication.

- Optimizing technical system settings to strengthen security and integrity controls of databases and operating systems.

- Development of an effective patch management process for all critical systems to reduce systems vulnerabilities to a minimum.

- Maintaining effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

- Development and maintenance of disaster recovery plans to enable a timely recovery of systems, data, and processes in the event of a disruption.

- Testing of disaster recovery plans to ensure the effectiveness of recovery provisions.

- Enhance policies and procedures to ensure that (1) system administrators perform periodic reviews of access authorizations for all applications and (2) a process exists for communicating terminated employees to the administrators and for the timely removal of those employees.

OTHER MATTERS

Integration of Performance Reporting With Financial Reporting

As reported in FY 2004, the HHS manages more than 300 programs under its 12 operating divisions and uses more than 650 performance measures to direct program activities and assess progress and achievement. Due to the complexity and volume of the measures, HHS faces significant challenges in meeting the consolidated performance reporting requirements of the Government Performance and Results Act of 1993 and OMB Circular A-11, *Preparation, Submission, and Execution of the Budget*. In FY 2005, OMB provided the following specific guidance to HHS on how to best meet the consolidated performance reporting requirements:

- "HHS will present measures that represent the Department's key priorities in both the Management Discussion and Analysis and the Annual Performance Report sections of the Performance and Accountability Report with reference to individual Operating Division performance budgets submitted to Congress in February;

- Consistent with the Government Performance and Results Act also know as GPRA (P.L. 103-62), OMB Circular A-11, and past HHS practice, the FY 2007 OPDIV performance budgets submitted to Congress in February 2006 will address all performance measures included in the FY 2005 performance plans/budgets; and

- The Secretary will certify the reliability and completeness of the data in the PAR in November as well as for the Congressional submission in February."

Working with OMB, the HHS has taken steps toward integrating performance reporting requirements in its FY 2005 Annual Performance Plan. However, additional efforts are needed to reassess the consistency and data availability of the indicators reported as significant. For example:

- HHS spotlighted 31 measures as significant in the Management Discussion and Analysis as compared to eight measures from the prior year.

- During our review, we noted that one that indicator agreed to by OMB as significant was not included in the MD&A or section II of the Performance and Accountability Report.

- We noted four indicators that were not included in the FY 2006 HHS Annual Plan.

- Fifteen indicators reported did not have actual performance results for FY 2005, and eight indicators identified as significant had no actual results for FY 2004. Management indicated that this was due to natural data lags for the collection and verification of data.

Additionally, although there appears to be a robust review process of the performance information for the budget process, we noted certain deficiencies in the review process of the performance information reported in the Performance and Accountability Report, including inconsistencies within the Management Discussion and Analysis and Section II, inadequate or lack of supporting documentation and lack of linkage between the Management Discussion and Analysis and the HHS Statement of Net Cost. Currently, although the HHS develops the performance information included in the Management Discussion and Analysis, the HHS does not receive nor does it review the documentation supporting the data reported. The supporting documentation was maintained at the Operating Division level. In FY 2005, the Secretary limited his assertion of the reliability and completeness of the performance data in performance information in the PAR by stating "except as noted in the OPDIV performance plans." As previously noted, the Operating Divisions' plans will not be submitted until February 2006; therefore we cannot assess the magnitude of this limitation.

As recommended in FY 2004, HHS should continue to work with OMB on consolidated performance reporting requirements and should ensure that for future Performance and Accountability Report reporting HHS identifies a process for producing the most appropriate measures; that are reflective of HHS's strategic goals and initiatives. In addition, HHS should implement corrective action to assist in addressing the limitations regarding the reliability and completeness of the performance data.

Intragovernmental Transactions

Under OMB Circular A-136, *Financial Reporting Requirements*, government entities are required to reconcile intragovernmental transactions with their trading partners. Some operating divisions were not able to timely and accurately eliminate trading partner information.

Beginning in FY 1996, CMS's accrued expenses for Medicaid benefits incurred but not reported. As of September 30, 2005, these accrued expenses exceeded the available unexpended Medicaid appropriations by $8.9 billion. CMS's Office of General Counsel determined that the indefinite authority provision of the Medicaid appropriations allowed the entire accrued expense to be reported as a funded liability. While Department of the Treasury officials agreed that there was a legal basis for recording the accrued benefit liability, they did not agree to recognize the accounting entry on their records.

A somewhat similar problem occurred in the Supplementary Medical Insurance Program, where section 1844 of the Social Security Act authorizes funds to be appropriated to match Medicare beneficiary premiums. The appropriated amount is an estimate calculated annually by CMS. This year's funding estimate was insufficient to match beneficiaries' premiums by $5.1 billion. HHS discussed these issues with OMB officials, who agreed that the long-standing accounting for these issues should continue for FY 2004 and 2005. Until such time when these matters are resolved, differences between records of the operating divisions and the Department of the Treasury will remain.

Finally, HHS is not performing adequate analysis or confirmation procedures with its trading partners to identify differences in its intragovernmental balances. Based on our review of the 3rd and 4th Quarter Material Differences / Status of Disposition Certification Report from the Financial Management Service's (FMS) IRAS for intra governmental data submitted by HHS, the absolute value of differences between HHS and its trading partners totaled approximately $29.3 billion and $1.6 billion, respectively. These differences were identified primarily as reporting errors and differences in accounting treatment by the two agencies.

Improper Payment Information Act of 2002 (IPIA)

The IPIA requires agencies to review annually all programs and activities they administer and identify those which may be susceptible to significant erroneous payments. HHS has informed us that it coordinated its implementation of the IPIA (IPIA) with the OMB throughout FY 2005 to ensure that their improper payment estimating strategies are substantially consistent with the intent of OMB regulations implementing the IPIA. While an improper payment rate estimate has been prepared for the largest HHS program, Medicare, methodologies for estimating improper payments for several other HHS programs are under development, and therefore were not reported in the FY 2005 Performance and Accountability Report. For example, although both Medicaid and SCHIP have been identified as programs which are susceptible to improper payments, CMS has not completed its implementation of a process to estimate improper payments. CMS is not expected to report a national estimate for Medicaid or SCHIP until FY 2007.

STATUS OF PRIOR YEAR FINDINGS

Summary of FY 2004 Material Weaknesses and Reportable Conditions

Issue Area	Summary Control Issue	FY 2005 Status
Material Weaknesses:		
Financial Systems and Processes	Documentation regarding significant accounting events, recording of non-routine transactions and post-closing adjustments, as well as correction and other adjustments made in connection with data conversion issues must be strengthened. Processes to prepare financial statements need improvement. Financial systems are not FFMIA-compliant. Weaknesses were identified in Department/Operating Division Periodic Analysis, Oversight and Reconciliations	Modified Repeat Condition
Medicare Information Systems Control	Strengthened controls over Medicare electronic data processing are needed.	Progress identified by other auditors. downgraded to reportable condition
Reportable Conditions:		
Departmental Information Systems Control	General and application control environments in the departmental operating divisions need strengthening.	Repeat condition
Internal Control Over Payroll	Documentation was incomplete and not readily available to support calculations of employee pay and deductions. Untimely interaction of payroll systems with core financial systems. Inadequate internal control to ensure human resources and payroll systems are secured and operating effectively, as intended. Training is needed to ensure appropriate knowledge of HHS policies.	In FY 2005, we noted that although certain issues surrounding the payroll and personnel issues still exist, sufficient progress has been made to reduce the weakness for reporting in the management letter; certain areas related to payroll have been included elsewhere within this report.

Issue Area	Summary Control Issue	FY 2005 Status
Omissions and Delays in Obtaining Documentation Impacts the Audit Process	Certain documentation was unable to be provided or not readily available to support financial statement transactions.	Combined into Financial Systems and Process Material Weakness
Other Matters		
Integration of Performance Reporting with Financial Reporting	HHS should identify a process for producing the most appropriate measures; that are reflective of HHS's strategic goals and initiatives	Repeat Condition
Intragovernmental Transactions	Operating divisions were not able to timely and accurately eliminate trading partner information.	Repeat Condition

* * * * *

It is our understanding that management agrees with the facts as presented.

In addition, we and other auditors considered HHS's internal control over required supplementary stewardship information by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on internal control.

In addition, with respect to internal control related to performance measures reported in the Management Discussion and Analysis, we and other auditors obtained an understanding of the design of internal control relating to the existence and completeness assertions and determined whether they have been placed in operation, as required by OMB Bulletin No. 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly we and other auditors do not provide an opinion on such controls.

We noted other matters involving internal control over financial reporting, which we have reported to management in a separate letter dated November 11, 2005.

This report is intended solely for the information and use of the management and Office of Inspector General of the Department of Health and Human Services, OMB, and Congress and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

November 11, 2005
Washington, DC

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Report on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services and
the Secretary of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2005, and have issued our report dated November 11, 2005. We have conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the year ended September 30, 2005. Those statements and the financial information which is included in the HHS's financial statements were audited by other auditors whose report thereon has been furnished to us, and the comments reflected herein, insofar as they relate to the information included for the CMS, excluding the Health Programs, are based solely on the report of other auditors.

The management of the HHS is responsible for complying with laws and regulations applicable to the HHS. As part of obtaining reasonable assurance about whether the HHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin No. 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to the HHS.

The results of our tests disclosed an instance of noncompliance with the laws and regulations discussed in the preceding paragraph exclusive of FFMIA that is required to be reported under *Government Auditing Standards* or OMB Bulletin No. 01-02. HHS has coordinated its implementation of the Improper Payment Information Act of 2002 (IPIA) with the OMB, and management has informed us that the progress made in fiscal year (FY) 2005 and the plans put in place to develop estimates of improper payments and mitigate their causes are substantially consistent with the intent of OMB regulations implementing the IPIA. While an improper payment rate estimate has been prepared for the largest HHS program, Medicare, nationwide estimates of Health Programs improper payments and rates for several other significant HHS programs are under development. Accordingly, HHS has potentially not fully complied with the IPIA requirements.

We were unable to fully test consolidated performance reporting requirements of the Government Performance and Results Act (GPRA) (Public Law 103-62), OMB Circular A-11, and OMB Circular A-136, *Financial Reporting Requirement*. In a letter dated August 10, 2005, OMB said that for FY 2005 performance reporting, HHS should present a key set of measures that HHS management has identified as representing HHS's key priorities for FY 2005 in the Management Discussion and Analysis with reference to individual operating division plans. Because the issuance of the operating divisions' plans will be subsequent to the completion of our fieldwork, we were unable to fully assess compliance with the GPRA, OMB Circular A-11, and OMB Circular A-136 as they relate to consolidated performance reporting requirements.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with Federal financial management systems requirements, applicable Federal accounting standards, and the United States Standard General Ledger (USSGL) at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements.

The results of our tests disclosed instances in which the HHS's financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instances of noncompliance.

- The financial management systems and processes used by HHS and the operating divisions made it difficult to prepare reliable and timely financial statements. The processes required the use of extensive, time-consuming manual spreadsheets and adjustments in order to report reliable financial information.

    - The CMS did not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the financial reporting system did not conform to the requirements specified by the former Joint Financial Management Improvement Program.

    - At most operating divisions, suitable systems were not in place to adequately support sufficient reconciliations and analyses of significant fluctuations in account balances. In addition, some systems were not designed to apply the USSGL at the transaction level.

- General and application controls over CMS's financial management systems, as well as systems of certain other operating divisions, were departures from requirements specified in OMB Circular No. A-127, Financial Management Systems, and OMB Circular No. A-130, Management of Federal Information Resources.

- The Independent Service Auditors' Report for the Human Resource Service Personnel and Payroll Systems' General Information Technology and Application Controls identified certain controls related to the application software development, and change

controls for the Commissioned Corp Personnel/Payroll System that were not operating effectively.

- The Independent Service Auditors' Report for the Division of Financial Operations related to the general information technology and application control environment over the CORE Accounting Systems and feeder systems identified certain controls related to the application software development and change controls, computer resources' protection against unauthorized modification, disclosure, loss, or impairment, and changes to existing systems software and implementation of new system software that were not operating effectively.

- The Independent Service Auditors' Report for the Center for Information Technology related to its general information technology and application control environment identified certain controls related to changes to hardware and operating systems software in the Windows and Mainframe environment that were not operating effectively.

* * * * *

Our Report on Internal Control includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from the HHS's management responsible for addressing the noncompliance are provided as an attachment to its report. Additionally, the HHS is updating its department-wide corrective action plan to address FFMIA and other financial management issues.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit, and accordingly, we do not express such an opinion.

This report is intended solely for the information and use of the management and the Office of Inspector General of the Department of Health and Human Services, OMB, and Congress and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

November 11, 2005
Washington, D.C.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

11/11/2005

Mr. Daniel R. Levinson
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W., Room 5250
Washington, D.C. 20201

Dear Mr. Levinson:

This letter responds to the opinion submitted by the Office of Inspector General on the Department of Health and Human Services' fiscal year 2005 audited financial statements. We concur with your findings and recommendations.

We are pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint efforts, we are able to achieve both a clean and timely departmental financial statement audit.

We also acknowledge that we continue to have material internal control weaknesses in our financial systems and processes. The Department's long-term strategic plan to resolve these weaknesses is to replace the existing accounting systems and certain other financial systems within the Department with a Unified Financial Management System (UFMS). UFMS was successfully implemented at CDC and FDA in April 2005 and the financial statement data was successfully extracted for the preparation of the financial statements. In accordance with the implementation plan, HHS will fully implement the UFMS Departmentwide by fiscal year 2007 and will comply with the requirements of the Federal Financial Management Improvement Act.

I would like to thank your office for its continuing professionalism during the course of the audit.

Sincerely,

Charles E. Johnson
Assistant Secretary for Budget,
Technology and Finance

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U.S. Department of Health and Human Services
CONSOLIDATED BALANCE SHEET
As of September 30, 2005 and 2004
(In Millions)

	9/30/2005	9/30/2004
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 99,638	$ 97,667
Investments, Net (Note 5)	300,664	287,886
Accounts Receivable, Net (Note 6)	738	573
Anticipated Congressional Appropriations (Note 7)	14,272	9,248
Other (Note 11)	169	386
Total Intragovernmental	$ 415,481	$ 395,760
Accounts Receivable, Net (Note 6)	2,103	2,052
Loans Receivable and Foreclosed Property, Net (Note 8)	379	390
Cash and Other Monetary Assets (Note 4)	204	460
Inventory and Related Property, Net (Note 9)	1,614	1,027
General Property, Plant & Equipment, Net (Note 10)	4,557	3,877
Other (Note 11)	4,149	185
Total Assets	**$ 428,487**	**$ 403,751**
Liabilities (Note 12)		
Intragovernmental		
Accounts Payable	$ 365	$ 652
Accrued Payroll and Benefits	69	64
Other (Note 16)	992	785
Total Intragovernmental	$ 1,426	$ 1,501
Accounts Payable	732	759
Entitlement Benefits Due and Payable (Note 13)	53,754	49,229
Accrued Grant Liability (Note 15)	3,783	3,755
Loan Guarantees Liabilities (Note 8)	158	191
Federal Employee & Veterans Benefits (Note 14)	7,183	7,178
Accrued Payroll & Benefits	785	789
Other (Note 16)	3,138	3,416
Total Liabilities	**$ 70,959**	**$ 66,818**
Net Position		
Unexpended Appropriations	87,350	82,052
Cumulative Results of Operations	270,178	254,881
Total Net Position	**$ 357,528**	**$ 336,933**
Total Liabilities & Net Position	**$ 428,487**	**$ 403,751**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U. S. Department of Health and Human Services
CONSOLIDATED STATEMENT OF NET COST
For the Years Ended September 30, 2005 and 2004
(In Millions)

	9/30/2005	9/30/2004
Responsibility Segments		
Administration for Children & Families (ACF)	$ 46,722	$ 45,969
Administration on Aging (AoA)	1,400	1,336
Agency for Healthcare Research & Quality (AHRQ)	(297)	(158)
Centers for Disease Control & Prevention (CDC)	5,242	5,114
Centers for Medicare & Medicaid Services (CMS)	483,645	451,647
Food & Drug Administration (FDA)	1,449	1,510
Health Resources & Services Administration (HRSA)	6,787	7,007
Indian Health Service (IHS)	3,157	3,362
National Institutes of Health (NIH)	27,875	26,167
Office of the Secretary (OS)	2,159	1,867
Program Support Center (PSC)	(18)	282
Substance Abuse & Mental Health Services Administration (SAMHSA)	3,199	3,117
Net Cost of Operations	**$ 581,320**	**$ 547,220**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Years Ended September 30, 2005 and 2004
(In Millions)

	9/30/2005		9/30/2004	
	Cumulative Results of Operations	**Unexpended Appropriations**	**Cumulative Results of Operations**	**Unexpended Appropriations**
Beginning Balances	$ 254,881	$ 82,052	$ 250,734	$ 75,385
Adjustments (+/-) (Note 20)				
Correction of Errors (+/-)	178	(210)	123	281
Beginning balances, as adjusted	$ 255,059	$ 81,842	$ 250,857	$ 75,666
Budgetary Financing Sources:				
Appropriations received	-	420,644	-	392,109
Appropriations transferred-in/out (+/-)	-	241	-	479
Other adjustments (rescissions, etc) (+/-)	(5)	(5,004)	(40)	(5,363)
Appropriations used	410,373	(410,373)	380,839	(380,839)
Nonexchange revenue	186,136	-	170,573	-
Donations and forfeitures of cash and cash equivalents	56	-	41	-
Transfers-in/out without reimbursement (+/-)	(418)	-	(1,185)	-
Other Financing Sources:				
Donations and forfeitures of property	3	-	3	-
Transfers-in/out without reimbursement (+/-)	(46)	-	665	-
Imputed financing from costs absorbed by others	342	-	339	-
Other (+/-)	(2)	-	9	-
Total Financing Sources	$ 596,439	$ 5,508	$ 551,244	$ 6,386
Net Cost of Operations (+/-)	581,320	-	547,220	-
Net Change	15,119	5,508	4,024	6,386
Ending Balances	**$ 270,178**	**$ 87,350**	**$ 254,881**	**$ 82,052**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Years Ended September 30, 2005 and 2004
(In Millions)

	9/30/2005		9/30/2004	
	Budgetary	Non-Budgetary Credit Program Financing Accounts	Budgetary	Non-Budgetary Credit Program Financing Accounts
Budgetary Resources:				
Budget Authority				
Appropriations Received	$ 773,208	$ -	$ 700,102	$ -
Net transfers (+/-)	(77)	-	498	-
Other	(1)	-	1	1
Unobligated Balances – Beginning of Period				
Beginning of Period	18,908	253	7,502	281
Net transfers, actual (+/-)	(9)	-	(19)	-
Spending Authority from Offsetting Collections				
Earned				
Collected	6,806	27	5,492	48
Receivable from Federal sources	204	-	130	-
Change in unfilled customer orders				
Advance received	1	-	(29)	-
Without advance from Federal sources	1,160	-	775	-
Transfers from trust funds	2,945	-	3,758	-
Subtotal	$ 11,116	$ 27	$ 10,126	$ 48
Recoveries of prior year obligations				
Actual	11,672	-	9,733	-
Temporarily not available pursuant to Public Law	(11,470)	-	(4,208)	-
Permanently not available (-)	(9,785)	-	(2,981)	-
Total Budgetary Resources	**$ 793,562**	**$ 280**	**$ 720,754**	**$ 330**
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 768,771	$ -	$ 696,655	$ -
Reimbursable	6,790	74	5,355	77
Subtotal	$ 775,561	$ 74	$ 702,010	$ 77
Unobligated Balances - Available				
Apportioned	12,078	206	13,049	73
Exempt from apportionment	78	-	98	-
Unobligated Balances - Not Available	5,845	-	5,597	180
Total Status of Budgetary Resources	**$ 793,562**	**$ 280**	**$ 720,754**	**$ 330**
Relationship of Obligations to Outlays:				
Obligated Balance, Net – Beginning of Period	$ 113,568	$ -	$ 112,231	$ (23)
Obligated Balance Transferred, Net (+/-)	-	-	476	-
Obligated Balance, Net – End of Period				
Accounts receivable (-)	(2,185)	-	(2,177)	-
Unfilled customer orders from Federal sources (-)	(3,515)	-	(2,356)	-
Undelivered orders	74,329	-	73,442	-
Accounts payable	49,439	-	44,660	-
Outlays				
Disbursements	757,988	74	690,226	54
Collections (-)	(9,715)	(27)	(8,937)	(48)
Subtotal	$ 748,273	$ 47	$ 681,289	$ 6
Less: Offsetting receipts	166,971	55	137,771	49
Net Outlays	**$ 581,302**	**$(8)**	**$ 543,518**	**$ (43)**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENT OF FINANCING
For the Years Ended September 30, 2005 and 2004
(In Millions)

	9/30/2005	9/30/2004
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated		
Obligations Incurred	$775,635	$702,087
Less: Spending Authority from Offsetting Collections and Recoveries	22,815	19,907
Obligations Net of Offsetting Collections and Recoveries	$752,820	$682,180
Less: Offsetting Receipts	167,026	137,820
Net Obligations	$585,794	$544,360
Non-Budgetary Resources		
Donations and Forfeitures of Property	$3	$3
Non-Budgetary Transfers in/out Without Reimbursement	(46)	665
Imputed Financing From Costs Absorbed by Others	342	339
Other Non-Budgetary Resources	(2)	9
Net Non-Budgetary Resources Used to Finance Activities	$297	$1,016
Total Resources Used to Finance Activities	**$586,091**	**$545,376**
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$4,092	$1,060
Resources That Fund Expenses Recognized in Prior Periods	15,802	12,373
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations:		
Credit Program Collections That Increase Liabilities for Loans Guarantees or Allowances for Subsidy	24	(48)
Other	(241)	(184)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,540	1,774
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	(1,232)	2,383
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	$19,985	$17,358
Total Resources Used to Finance the Net Cost of Operations	**$566,106**	**$528,018**
COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD		
Components Requiring or Generating Resources in Future Periods:		
Increase in Annual Leave Liability	$31	$8
Increase in Environmental and Disposal Liability	2	-
Upward/downward Reestimates of Credit Subsidy Expense	(40)	(87)
Increase in Exchange Revenue Receivable from the Public	679	2,476
Other	(219)	2,359
Liability for Unmatched SMI Premium (CMS only) (Note 7)	5,173	5,645
Accrued Entitlement Benefit Costs (CMS only)	9,470	10,039
Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods	$15,096	$20,440
Components Not Requiring or Generating Resources:		
Depreciation and Amortization	$218	$108
Losses or (Gains) from Revaluation of Assets and Liabilities	11	6
Other	(111)	(1,352)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources	$118	$(1,238)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	15,214	19,202
NET COST OF OPERATIONS	**$581,320**	**$547,220**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

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U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

Note 1. Summary of Significant Accounting Policies

Reporting Entity

The Department of Health and Human Services (HHS or Department) is a cabinet-level agency of the executive branch of the Federal Government. Its predecessor, the Department of Health, Education and Welfare (HEW), officially came into existence on April 11, 1953. In 1979, the Department of Education Organization Act of 1979 (Public Law 96-88) was signed into law, providing for a separate Department of Education. HEW officially became HHS on May 4, 1980. The Department is responsible for protecting the health of all Americans and providing essential human services.

Organization and Structure of HHS

HHS is comprised of 11 Operating Divisions (commonly referred to as OPDIVs) with diverse missions and programs. Each OPDIV is considered a responsibility segment representing a component of a reporting entity that is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products or services. The managers of the responsibility segments report to the entity's top management directly, and its resources and results of operations can be clearly distinguished from those of other responsibility segments of the entity. The 12 responsibility segments are:

1. Administration for Children and Families
2. Administration on Aging
3. Agency for Healthcare Research and Quality
4. Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry
5. Centers for Medicare & Medicaid Services
6. Food and Drug Administration
7. Health Resources and Services Administration
8. Indian Health Service
9. National Institutes of Health
10. Office of the Secretary – excluding Program Support Center, a separate responsibility segment
11. Program Support Center
12. Substance Abuse and Mental Health Services Administration

Even though it is part of the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other OPDIVs and Federal agencies. The Agency for Toxic Substances and Disease Registry is combined with the Centers for Disease Control and Prevention for financial reporting purposes; therefore, these footnotes will refer to them as one responsibility segment.

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

Basis of Accounting and Presentation

The accompanying financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of the Chief Financial Officers Act of 1990 (Public Law 101-576), as amended by the Reports Consolidation Act of 2000 (Public Law 106-531) and presented in accordance with the requirements contained in the Office of Management and Budget (OMB) Circular No., A-136 (Revised), *Financial Reporting Requirements*. These statements have been prepared from the Department's financial records on an accrual basis in conformity with accounting principles generally accepted in the United States (GAAP). The GAAP for Federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants (AICPA) as Federal GAAP. These statements are therefore different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control HHS' use of budgetary resources.

The financial statements consolidate the balances of about 140 appropriations and fund accounts, and a number of accounts used for suspense, collection of receipts, and general government functions. Transactions and balances among HHS OPDIVs have been eliminated in the presentation of the Consolidated Balance Sheet, Consolidated Statement of Net Cost, Consolidated Statement of Changes in Net Position, and the Consolidated Statement of Financing. The Combined Statement of Budgetary Resources (SBR) is presented on a combined basis. Supplemental information is accumulated from the OPDIV reports, regulatory reports, and other sources within HHS.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned, and expenses are recognized when incurred, without regard to receipt or payment of cash. Budgetary accounting principles, on the other hand, are designed to recognize the obligation of funds according to legal requirements, which in many cases is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of Federal funds. The Centers for Medicare & Medicaid Services (CMS) uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year-end. CMS also uses the cash basis of accounting in the Medicaid and the State Children's Health Insurance Program (SCHIP) to record funds paid to the states during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to CMS as of the end of the fiscal year. A number of other HHS OPDIVs also use the cash basis of accounting for some programs with an accrual adjustment made by recording year-end estimates of unpaid liabilities.

Unified Financial Management System

HHS has taken a step in streamlining and integrating its financial management systems with the implementation of the Unified Financial Management System (UFMS). HHS' overarching

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

financial management goals seek to (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that HHS resources are used appropriately, efficiently, and effectively. With UFMS, HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. UFMS went live with the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) in April 2005 for core financials, including general ledger, accounts payable, and accounts receivable; and in addition, Projects for CDC and iProcurement for FDA.

Transition of Payroll System to Defense Finance and Accounting Service
HHS has completed its payroll conversion for civilian payroll, except for Public Health Service Commissioned Corps, from the HHS legacy payroll system to the Defense Finance and Accounting Service (DFAS) on April 17, 2005. HHS is the single largest civilian agency payroll conversion ever completed by the DFAS.

The DFAS offers an array of multi-functional payroll processing applications and services, in compliance with existing Joint Financial Management Improvement Program SR-99-5, Human Resources & Payroll Systems Requirements for payroll management activities. These include:

- Time and Attendance, Leave, and Pay Processing;
- Labor Cost and Distribution;
- Reporting, Reconciliation, and Records Retention;
- Employee Self Service (My Pay);
- Integrated Garnishment System and Debt Processing; and
- Client-specific non-recurring reporting.

Use of Estimates in Preparing Financial Statements
Preparation of financial statements in accordance with accounting principles generally accepted in the U.S. requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent liabilities as of the date of the financial statements. Estimates and assumptions also affect the revenues and expenses accrued and reported in the financial statements. Actual results may differ from those estimates.

Entity and Non-Entity Assets
Entity assets are assets that the reporting entity has authority to use in its operations. The authority to use funds in an entity's operations means entity management has the authority to decide how funds are used, or management is legally obligated to use funds to meet entity obligations.

Non-entity assets are those assets that are held by the reporting entity, but are not available for use by the entity. An example of a non-entity asset is the interest accrued on overpayments and cost settlements reported by the Medicare contractors.

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For the Years Ended September 30, 2005 and 2004

The HHS financial statements do not report entity and non-entity assets separately on the face of the statement. Instead, such detail is presented in Note 2, Non-Entity Assets.

Fund Balance with Treasury

The Department maintains its available funds with the Department of the Treasury (Treasury) except for the Medicare Benefit accounts maintained at commercial banks – see Note 4, Cash and Other Monetary Assets. The Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by Treasury, and HHS' records are reconciled with those of Treasury on a regular basis. Note 3, Fund Balance with Treasury, provides additional information.

Investments

Investments consist of U.S. Treasury securities including the CMS Par Value securities carried at face value, and other securities carried at amortized cost. Federal law requires that trust fund balances that are not necessary to meet current expenditures be invested in interest-bearing obligations of the U.S. Government or in obligations guaranteed as to both principal and interest by the U.S. Government. No provision is made for unrealized gains or losses on these securities since it is the Department's intent to hold investments to maturity. Interest income is compounded semiannually in June and December and is adjusted to include an accrual for interest earned from July 1 to September 30.

Note 5, Investments, Net, provides additional information on investments.

Accounts Receivable, Net

Accounts receivable consists of the amounts owed to HHS by other Federal agencies and the public as the result of the provision of goods and services. Intragovernmental accounts receivable arise generally from the provision of reimbursable work to other Federal agencies and no allowance for uncollectible accounts is established as they are considered to be fully collectible. Accounts receivable also includes interest due to HHS that is directly attributable to delinquent accounts receivable.

Accounts receivable from the public typically result from overpayments to Medicare providers and beneficiaries, amounts due from cost disallowance for Medicaid, and amounts due from organizations for civil monetary penalties not yet remitted to the Department of Justice. They are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is determined based on past collection experience and an analysis of outstanding balances.

Note 6, Accounts Receivable, Net, provides additional information on accounts receivable.

Loan Guarantee Receivables and Liabilities

HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loans (HEAL) programs. Loans receivables represent defaulted guaranteed loans

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which have been paid to lenders under this program. Loans receivable also include interest due to HHS on the defaulted loans. Loans guarantee liabilities are valued at the present value of the cash outflows from HHS less the present value of related inflows.

As required under the Federal Credit Reform Act of 1990 (FCRA), for loan guarantees committed on or after October 1, 1991, guaranteed loans are reduced by an allowance for subsidy representing the present value of the amounts not expected to be recovered and thus having to be subsidized by the government for loan guarantees. The FCRA also requires that the subsidy cost estimate be based on the net present value of the specified cash flows discounted at the interest rate of marketable Treasury securities of similar maturities. The liability for loan guarantees committed on or after October 1, 1991 is reported at present value.

For loan guarantees committed prior to October 1, 1991, loan guarantee principal and interest receivable are reduced by an allowance for estimated uncollectible amounts. The allowance is estimated based on past experience and an analysis of outstanding balances. The liability for loan guarantees committed prior to October 1, 1991 is established based upon an average default rate. The liability is adjusted each year for the change in default rates.

Note 8, Loan Guarantee Receivables and Liabilities, provides additional information.

Advances to Grantees/Accrued Grant Liability

HHS awards grants to various grantees and provides advance payments to grantees to meet their cash needs to carry out their programs. Advance payments are recorded as "Advances to Grantees" and are liquidated upon grantees' reporting expenditures. Grantees sometime incur expenditures before drawing down funds that, when claimed, would reduce the "Advances to Grantees" account. An accrued grant liability occurs when the accrued grant expenses exceed the outstanding advances to grantees, resulting in a negative balance in the "Advances to Grantees" account. HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." Progress payments on work in process are not included in grants.

Grants Not Subject to Grant Expense Accrual: These grants represent formula grants (also referred to as "block grants") under which grantees provide a variety of services or payments to individuals and local agencies. Expenses are recorded as the grantees draw funds. These grants are funded on an allocation basis determined by budgets and agreements approved by the sponsoring OPDIV as opposed to a reimbursable basis. Therefore, they are not subject to grant expense accrual.

Grants Subject to Grant Expense Accrual: For grants subject to grant expense accrual (commonly referred to as "non-block grants"), grantees draw funds (recorded as Advances to Grantees in HHS' accounting systems) based on their estimated cash needs. As grantees report their actual disbursements (quarterly), the amounts are recorded as expense, and the advance balance is

reduced. At year-end, the OPDIVs report both actual payments made through the third quarter and an unreported grant expenditures estimate for the fourth quarter based on historical spending patterns of the grantees. The year-end accrual estimate equals the estimate of fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash being draw down.

Exceptions to the definition of "block" or "non-block" grants for reporting purposes are the Temporary Assistance for Needy Families program and the Child Care Development Fund program. These two programs are referred to as "block" grants but since the programs report expenses to HHS, they are treated as "non-block" grants for the estimate of the grant accrual. HHS reports advances other than grant advances in Note 11, Other Assets. Note 15, Accrued Grant Liability, provides additional information on the accrued grant liability.

Inventory and Related Property, Net

Inventory and Related Property primarily consists of Inventory Held for Sale, Operating Materials and Supplies, and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by Service and Supply Funds for sale to HHS components and other Federal entities. Inventories held for sale are valued at historical cost using the first-in first-out (FIFO) cost flow assumption with the exception of the National Institutes of Health, which uses the moving average cost flow assumption method.

Operating Materials and Supplies consist of pharmaceuticals, biological products, and other medical supplies used in providing medical services and conducting medical research. Operating materials and supplies are recorded as assets when purchased, and are expensed when they are consumed. Operating materials and supplies are valued at historical cost using the FIFO cost flow assumption.

As required by the Project BioShield Act of 2004, the Department of Homeland Security transferred Strategic National Stockpile materials to HHS in FY 2004. These materials are held in reserve to respond to local and national emergencies. In addition, the Centers for Disease Control and Prevention (CDC) maintain a stockpile of vaccines to meet unanticipated needs in the cause of a national emergency. The CDC's stockpile of vaccine materials are valued at historical cost using a specific identification cost flow assumption and the Strategic National Stockpile materials are valued at historical cost using First-In First-Out (FIFO) cost flow assumption.

Note 9, Inventory and Related Property, Net, provides additional information.

General Property, Plant and Equipment, Net

General Property, Plant and Equipment (PP&E) consists of buildings, structures, and facilities used for general operations; land acquired for general operating purposes; equipment; assets under

U.S. Department of Health and Human Services
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capital lease; leasehold improvements; construction-in-progress; and internal use software. The basis for recording purchased PP&E is full cost, which includes all costs incurred to bring the PP&E to a form and location suitable for its intended use. The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. The cost of PP&E acquired through donation is the estimated fair value when acquired. The cost of PP&E transferred from other Federal entities is the net book value of the transferring entity. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more are capitalized, except for internal use software discussed below.

PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

Statement of Federal Financial Accounting Standards (SFFAS) No. 10, *Accounting for Internal Use Software,* requires that the capitalization of internally-developed, contractor-developed, and commercial off-the-shelf (COTS) software begin in the software development phase. In FY 2004, HHS incurred development costs for the Unified Financial Management System (UFMS), a COTS software package, and began capitalizing the cost. In FY 2001 the CMS began the HIGLAS project to replace the Medicare contractors' and CMS' current accounting systems with a single, unified system. HIGLAS will eventually replace the different systems now in use by contractors that process and pay claims, in addition to CMS' current mainframe-based administrative accounting financial system. The estimated useful life for internal use software was determined to be seven to ten years for amortization.

SFFAS No. 10 also requires that amortization begins when the asset is placed in use. In April 2005, UFMS was implemented at the Centers for Disease Control and Prevention and the Food and Drug Administration. In FY 2005, Centers for Medicare & Medicaid Services began amortizing the Healthcare Integrated General Ledger Accounting System (HIGLAS) over 10 years using the straight-line method in accordance with HHS policy for UFMS. In addition, CMS has other capitalized internal use software that are currently being amortized over a useful life of 5 years.

The capitalization threshold for internal use software costs for appropriated fund accounts is $1 million or more. The internal use software capitalization threshold for revolving funds is $500,000. Costs below the threshold levels are expensed. The software is depreciated for a period of time consistent with the estimated useful life used for planning and acquisition purposes.

Additional information is provided in Note 10, General Property, Plant and Equipment, Net.

Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing Federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare Health Insurance Trust Fund, since future Medicare benefits are not tied to prior Medicare contributions. The Department's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

Liabilities Covered by Budgetary Resources: Liabilities funded by available budgetary resources include: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of expired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities Not Covered by Budgetary Resources: Sometimes funding has not yet been made available through Congressional appropriations or current earnings. The major liabilities in this category include employee annual leave earned but not taken, and amounts billed by the Department of Labor (DOL) for Federal Employees' Compensation Act (FECA) disability payments, and for portions of the Entitlement Benefits Due and Payable liability (discussed below) for which no obligations have been incurred. Also included in this category is the actuarial FECA liability determined by DOL but not yet billed. For HHS revolving funds, all liabilities are funded as they occur.

Liabilities Covered by Budgetary Resources and Liabilities Not Covered by Budgetary Resources are combined on the balance sheet. The breakout of these resources is presented in Note 12, Liabilities Not Covered by Budgetary Resources; Note 13, Entitlement Benefits Due and Payable; Note 14, Federal Employee and Veterans' Benefits; and Note 16, Other Liabilities.

Accounts Payable

Accounts Payable primarily consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

Accrued Payroll and Benefits

Accrued Payroll and Benefits consist of salaries, wages, leave and benefits earned by employees, but not disbursed as of September 30. Liability for annual and other vested compensatory leave is accrued when earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability since this leave will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken.

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Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represent the liability for Medicare and Medicaid for medical services incurred but not reported as of the balance sheet date. The abbreviation IBNR is periodically used in these statements in place of "incurred but not reported."

Medicare Incurred But Not Reported, or Medicare IBNR

The Medicare liability is developed by the Office of Actuary of the Centers for Medicare & Medicaid Services (CMS) and represents (1) an estimate of claims incurred, which may or may not have been submitted to the Medicare contractors, but which were not yet approved for payment, (2) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (4) periodic interim payments for services rendered in current fiscal year but paid in subsequent fiscal year, and (5) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

Medicaid Incurred But Not Reported, or Medicaid IBNR

The Medicaid estimate represents the net of unreported expenses incurred by the states less amounts owed to the states for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. FY 2005 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Note 13, Entitlement Benefits Due and Payable, provides additional information.

Federal Employee and Veterans' Benefits

Most HHS employees participate in either the Civil Service Retirement System (CSRS) – a defined benefit plan, or the Federal Employees Retirement System (FERS) – a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983 are automatically covered by FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. A primary feature of FERS is that it offers a Thrift Savings Plan (TSP) into which the Department automatically contributes one percent of employee pay and matches employee contributions up to an additional four percent of pay.

The U.S. Office of Personnel Management is the administering Agency for both of these benefit plans and, thus, reports CSRS or FERS assets, accumulated plan benefits, or unfunded liabilities applicable to Federal employees. Therefore, HHS does not recognize any liability on its balance sheet for pensions, other retirement benefits, and other post-employment benefits with the exception of Commission Corps (see below). HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position.

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HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System, a defined noncontributory benefit plan, for its active duty officers and retiree annuitants or survivors.

The plan does not have accumulated assets, and funding is provided entirely on a pay as you go basis by Congressional appropriations. HHS records the actuarial liability based on the present value of accumulated pension plan benefits and the post-retirement health benefits.

The liability for Federal employee and veterans' benefits also includes a liability for actual and estimated future payments for workers' compensation pursuant to FECA. FECA provides income and medical cost protection (1) to Federal employees who were injured on the job or who have sustained a work-related occupational disease and (2) to beneficiaries of employees whose death is attributable to job-related injury or occupational disease. The FECA program is administered by the DOL, which pays valid claims and subsequently bills the employing Federal agency. The FECA liability consists of two components – the actual claims paid by DOL but not yet disbursed, and the estimated liability for future benefit payments as a result of past events, such as death, disability, and medical costs.

Note 14, Federal Employee and Veterans' Benefits, provides additional information.

Revenue and Financing Sources

The Department receives the majority of funding needed to support its programs through Congressional appropriation and through reimbursement for the provision of goods or services to other Federal agencies. The United States Constitution prescribes that no money may be expended by a Federal Agency unless and until funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by the Department. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the consolidated statement of changes in net position.

Appropriations. The Department receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are generally made available for one fiscal year, funds for long-term projects such as major construction will be available for the expected life of the project, and funds used to establish revolving fund operations are generally available indefinitely (i.e., no year funds). The Statement of Budgetary Resources presents information about the resources appropriated to the Department.

Exchange and Non-Exchange Revenue. HHS classifies revenues as either exchange revenue or non-exchange revenue. Exchange revenues are recognized when earned, i.e., when goods have been delivered or services have been rendered. These revenues reduce the cost of operations borne by the taxpayer.

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Non-exchange revenues result from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable. Non-exchange revenues are not considered to reduce the cost of the Department's operations and are reported in the Statement of Changes in Net Position.

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employee wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the Hospital Insurance (HI) trust fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Social Security Administration (SSA) from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

With minor exceptions, all receipts of revenues by Federal agencies are processed through Treasury's central accounting system. Regardless of whether they derive from exchange or non-exchange transactions, all receipts that are not earmarked by Congressional appropriation for immediate departmental use are deposited in the general or special funds of the Treasury. Amounts not retained for use by HHS are reported as transfers to other government agencies on the HHS Statement of Changes in Net Position.

Imputed Financing Sources. In certain instances, operating costs of HHS are paid out of funds appropriated to other Federal agencies. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management, and certain legal judgments against HHS are paid from the Judgment Fund maintained by Treasury. When costs that are identifiable to HHS and directly attributable to the Department's operations are paid by other agencies, the Department recognizes these amounts as imputed costs of HHS, and at the same time, this amount is recognized as an imputed financing source on the Consolidated Statement of Changes in Net Position.

Other Financing Sources. Medicare's HI program, or Medicare Part A, is financed through the HI trust fund, whose revenues come primarily from the Medicare portion of payroll and from self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and under the Self-Employment Contribution Act (SECA). The Medicare payroll tax rate is 2.9 percent of annual wages. Contribution rates are discussed under Exchange and Non-Exchange Revenue.

Medicare's Supplemental Medical Insurance (SMI) program, or Medicare Part B, is financed primarily by general fund appropriations (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries. Premium payments from Medicare beneficiaries are matched approximately three to one by Congressional appropriations.

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Aggregate non-exchange revenues consist primarily of FICA taxes of $157,702 million and $142,659 million, SECA taxes of $11,252 million and $10,789 million, and Trust Fund investment interest of $16,484 million and $16,574 million for FY 2005 and FY 2004, respectively.

Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to the Department. The uncertainty should ultimately be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. Statement of Federal Financial Accounting Standards (SFFAS) No. 5, *Accounting for Liabilities of the Federal Government,* as amended by SFFAS No. 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities. With the exception of pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur, and the related future outflow or sacrifice of resources is measurable.

Note 23, Contingencies, provides additional information.

Reclassifications

Certain reclassifications were made to the presentation of the September 30, 2004 financial statements and footnotes to improve their comparability with September 30, 2005 statements and footnotes, in compliance with the form and content prescribed by the OMB Circular No. A-136, the effect of which is immaterial. The Prior Period Adjustments reported in FY 2004 have been reported as Adjustment, Correction of Errors in the FY 2005 Statement of Changes in Net Position. In addition, the Status of Fund Balance section of the Note 3, Fund Balance with Treasury from the prior year was reclassified based on the revised format in the OMB Circular No. A-136.

Reconciliation of FACTS II to the Statement of Budgetary Resources

Management recognizes that the Federal Agencies' Centralized Trial-balance System II (FACTS II) submission of budgetary data does not agree with HHS' Statement of Budgetary Resources as presented in the audited financial statements. There are many known recurring differences that contribute to the differences that are properly reported on the SBR and are appropriately not included in the FACTS II submission. Some of these reconciling items include: accounts payable adjustments, estimated Grantee Expenditure Reports (SF 272s) not yet received for the fourth quarter, estimated grantee expenses incurred but not reported, and certain intra-departmental transactions, such as Intra-Departmental Delegations of Authority.

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Intragovernmental Relationships and Transactions

In the course of its operations, HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are the Social Security Administration (SSA) and the Department of the Treasury. The SSA determines eligibility for Medicare programs and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. At the government-wide level, the assets related to the trust funds on HHS' financial statements and the corresponding liabilities on the Treasury's financial statements would be eliminated.

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by Centers for Medicare & Medicaid Services to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services as well as any related administrative costs are charged to the HI trust fund. The CMS payments to managed care plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Treasury. This trust fund has permanent indefinite budgetary authority.

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end-stage renal disease treatment providers, rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to managed care plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. This trust fund has permanent indefinite budgetary authority.

Medicare Prescription Drug Discount Card and Transitional Assistance

The Medicare Prescription Drug Discount Card and Transitional Assistance Program was enacted into law in December 2003 with passage of the Medicare Modernization Act of 2003 (MMA). The Drug Discount Card program enables Medicare beneficiaries to obtain discounts of 10 to 25 percent on prescription drugs.

Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act (Public Law 104-191) established the MIP and codified the program integrity activities previously known as "payment safeguards." This account is also referred to as the Health Care Fraud and Abuse Control (HCFAC) program or simply "Fraud and Abuse." To safeguard the Medicare system, the CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI trust fund.

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Medicaid
Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the states. Grant awards limit the funds that can be drawn by the states to cover current expenses. The grant awards, which are prepared at the beginning of each quarter and are amended as necessary, are an estimate of the CMS share of states' Medicaid costs. At the end of each quarter, states report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and grant awards previously issued.

Note 2. Non-Entity Assets

Non-entity assets at September 30, 2005 and 2004 consisted of the following:

(Dollars in Millions)

	2005	2004
Intragovernmental:		
Fund Balance with Treasury	$ 23	$ 19
Accounts receivable	-	-
Other	-	-
Total Intragovernmental	$ 23	$ 19
Accounts receivable	$ 14	$ 24
Cash and other monetary assets	-	-
Other	-	-
Total non-entity assets	$ 37	$ 43
Total entity assets	428,450	403,708
Total Assets	$ 428,487	$ 403,751

The $23 million non-entity asset Fund Balance with Treasury includes: $13 million of tax refunds collected by the Internal Revenue Service for past due child support payments that were transferred to HHS' Administration for Children and Families for distribution to the states; $9 million in collections of royalties from licenses for which a portion is paid to inventors under the Federal Technology Transfer Act; and $1 million representing withholdings for state payroll deductions, collections of interest, and other miscellaneous receipts. The majority of the $14 million accounts receivable represents the interest accrued on overpayments as well as any cost settlements reported by the Medicare contractors.

The amount of unused funds that were transferred to Treasury due to cancelled appropriations or no longer available at the end of FY 2005 and FY 2004 were approximately $5.3 billion and $600 million, respectively.

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Note 3. Fund Balance with Treasury

The Fund Balance with Treasury (FBWT) and the status of the fund balance at September 30, 2005 and 2004 are listed below by fund type.

(Dollars in Millions)

	2005	2004
Fund Balance with Treasury		
Trust Funds	$ 1,964	$ 2,753
Revolving Funds	757	767
Appropriated Funds	96,315	93,530
Other Funds	602	617
Total	$ 99,638	$ 97,667

Status of Fund Balance with Treasury

Unobligated Balance	2005	2004
Available	$ 12,362	$ 13,220
Unavailable	5,845	5,777
Obligated Balance not yet Disbursed	117,876	113,595
Non-Budgetary FBWT	(36,445)	(34,925)
Total	$ 99,638	$ 97,667

Other Funds include balances in deposit, suspense, clearing, and related non-spending accounts.

The Unobligated Balance includes $2.1 billion, which is restricted for future use and is not apportioned for current use. These funds are: Contingency Fund for State Welfare Programs of the Administration for Children and Families; the Program Management Funds of the Centers for Medicare & Medicaid Services; the Federal Interest Subsidies for Medical Facilities, Medical Facilities Guarantee and Loan Fund of the Health Resources and Services Administration; and the Service and Supply Funds of the Program Support Center.

The Non-Budgetary FBWT negative balance is due primarily to CMS Medicare trust funds temporarily precluded from obligation.

Note 4. Cash and Other Monetary Assets

Cash and Other Monetary Assets consist primarily of the time account balances at the Medicare contractors' commercial banks. CMS uses the "Checks Paid Letter-of-Credit" method for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against Medicare Benefits Accounts maintained at commercial banks. To compensate the commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest bearing time accounts. The interest foregone by the CMS on these time accounts is used to reimburse the commercial banks for the service. The account balances as of September 30, 2005 and 2004 were $204 million and $460 million, respectively.

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Note 5. Investments, Net

HHS' investments at September 30, 2005 and 2004 are summarized below.

	2005				
(Dollars in Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Other Adjustments	Market Value Disclosure
Intragovernmental Securities					
Marketable	$18	$ -	$ 18	$ -	$ 18
Non-Marketable: Par Value	294,471	-	294,471	-	294,471
Non-Marketable: Market-based	2,169	21	2,190	-	2,190
Subtotal	$296,658	$21	$ 296,679	$-	$296,679
Accrued Interest	3,985	-	3,985	-	3,985
Total, Intragovernmental	$300,643	$21	$ 300,664	$-	$300,664

	2004				
(Dollars in Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Other Adjustments	Market Value Disclosure
Intragovernmental Securities					
Marketable	$17	$ -	$ 17	$ 1	$ 18
Non-Marketable: Par Value	281,814	-	281,814	-	281,814
Non-Marketable: Market-based	2,018	48	2,066	-	2,066
Subtotal	$283,849	$ 48	$ 283,897	1	$ 283,898
Accrued Interest	3,988	-	3,988	-	3,988
Total, Intragovernmental	$287,837	$48	$ 287,885	$ 1	$ 287,886

HHS invests entity trust fund balances in excess of current needs in U.S. Treasury securities. The majority of HHS investments in securities are redeemed at maturity and no provision is made for unrealized gains or losses. The Department of Treasury acts as the fiscal agent for the U.S. Government's investments in securities. HHS securities purchased and redeemed include Marketable, Non-Marketable (Par Value), and Non-Marketable Market-based (MK) securities.

Par value securities purchased by the Centers for Medicare & Medicaid Services (CMS) are recorded at cost, interest is earned based on a statutory formula, and securities are redeemed at face value. CMS invests in U.S. Treasury Special Issue bonds (Par value securities) that are special public obligations for exclusive purchase by the Medicare trust funds. Section 1817 (for Hospital Insurance) and section 1841 (for Supplemental Medical Insurance) of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December). The Medicare bonds paid from 3 ½ percent to 8 ⅛ percent in FY 2005 and 3 ½ percent to 8 ¾ in FY 2004. The One Day Certificates are short-term and paid 4 ⅛ percent in FY 2005 and 4 ½ percent in FY 2004.

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Note 5. Investments, Net (continued)

Health Resources and Services Administration (HRSA) invests in One Day Certificates, Market Based Notes and Market Based Bills. MK securities purchased by HRSA mirror marketable securities terms that are not traded on any securities exchange, and include Non-Marketable, MK, and One Day Certificates. MKs are purchased by HRSA's Vaccine Injury Compensation Program (VICP) trust fund. Discounts and premiums are recorded and amortized on a straight-line basis. Currently, securities held by the VICP will mature in fiscal years 2005 through 2009. The Market Based Notes paid from 1.625 percent to 6.25 percent in FY 2005 and FY 2004. One Day Certificates paid from 1.71 percent to 3.17 percent in FY 2005 and from .91 percent to 1.77 percent in FY 2004.

Marketable securities purchased by the National Institutes of Health gift funds are recorded at cost based on market terms.

Note 6. Accounts Receivable, Net

HHS' accounts receivable as of September 30, 2005 and 2004 are summarized below.

	2005								
(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Combined	Intra-OPDIV Eliminations	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental									
Entity	$42,854	$-	$-	$42,854	$-	$ 42,854	$(41,884)	$ (232)	$ 738
Non-Entity	-	-	-	-	-	-	-	-	-
Total, Intragovernmental	$42,854	$-	$-	$42,854	$-	$ 42,854	$(41,884)	$ (232)	$ 738
With the Public									
Entity									
Medicare	$3,322	$-	$-	$3,322	$(1,508)	$ 1,814	$-	$ -	$ 1,814
Other	465	-	69	534	(259)	275	-	-	275
Non-Entity	12	44	-	56	(42)	14	-	-	14
Total, With the Public	$3,799	$44	$69	$3,912	$(1,809)	$ 2,103	$-	$ -	$ 2,103

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Note 6. Accounts Receivable, Net (continued)

(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Combined	Intra-OPDIV Eliminations	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
	2004								
Intragovernmental									
Entity	$41,518	$-	$-	$41,518	$-	$41,518	$(40,708)	$(237)	$ 573
Non-Entity	-	-	-	-	-	-	-	-	-
Total, Intragovernmental	$41,518	$-	$-	$41,518	$-	$41,518	$(40,708)	$(237)	$ 573
With the Public									
Entity									
Medicare	$2,908	$-	$-	$2,908	$(1,556)	$1,352	$-	$-	$ 1,352
Other	1,419	-	-	1,419	(743)	676	-	-	676
Non-Entity	15	83	-	98	(74)	24	-	-	24
Total, With the Public	$4,342	$83	$-	$4,425	$(2,373)	$2,052	$-	$-	$ 2,052

The Federal Hospital Insurance (HI) Trust Fund accrues a receivable from the Railroad Retirement Board (RRB) for amounts transferred through a financial interchange between the HI and RRB. The financial interchange is intended to place the HI trust fund in the same position it would have been had railroad employment been covered by the Federal Insurance Contributions Act. Of the Intragovernmental Accounts Receivable, net as of September 30, 2005 and 2004, $454 million and $421 million were owed by the RRB, respectively.

The Department's accounts receivable with the public is primarily composed of Medicare receivables resulting from overpayments to Medicare providers, beneficiaries, physicians and suppliers, as well as repayments owed on claims where Medicare should have been the secondary payer. The remainder represents receivables arising from Medicaid cost disallowances.

For Medicare receivables, the Centers for Medicare & Medicaid Services calculates the allowance for uncollectible accounts receivable based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable have been recorded at a net realizable amount based on historic analysis of actual recoveries and the rate of disallowances found in favor of the states.

Non-entity accounts receivable consists of receivables for interest and penalties that cannot be used by the Department once collected. Such collections are transferred to the General Fund of the Treasury.

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Note 7. Anticipated Congressional Appropriation

The Centers for Medicare & Medicaid Services (CMS) has recorded $14,272 million in anticipated Congressional appropriations as of September 30, 2005 ($9,248 million for FY 2004) to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds appropriation, as discussed below:

Medicaid

Beginning in FY 1996, CMS has accrued an expense and liability for Medicaid claims "Incurred But Not Reported," or Medicaid IBNR, as of September 30. In FY 2005, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $9,099 million ($3,603 million in FY 2004). A review of appropriation language by CMS' Office of General Counsel has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, CMS has recorded a $9,099 million anticipated appropriation in FY 2005 ($3,603 million in FY 2004) for Medicaid IBNR claims that exceed the available appropriation.

Payments to the Health Care Trust Funds

The Supplemental Medical Insurance (SMI) program is financed primarily by the General Fund appropriation, Payments to the Health Care Trust Funds, and monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the General Fund to match premiums payable and deposited in the trust fund. Section 1844 also outlines the ratio for the match as well as the method used to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by CMS' Office of the Actuary (OACT) and may be insufficient in any particular fiscal year.

In FY 2005, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30, approximately $5,107.4 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $65.3 million in interest on unmatched amounts, leaving a cumulative liability of $5,173 million owed to SMI. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI trust fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, CMS has recorded $5,173 million anticipated appropriation in FY 2005 ($5,645 million in FY 2004) for the amount of the unmatched SMI premiums. Although the actual transfer of funds will occur in FY 2006, CMS has reported the $5,173 million as revenues earned in FY 2005.

In addition, the $5,173 million in unmatched SMI premiums is reported as Other Liability "Requiring or Generating Resources in Future Periods" on the Consolidated Statement of Financing.

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Note 8. Loan Guarantee Receivables and Liabilities

The Health Resources and Services Administration (HRSA) operates guaranteed loan programs for the Health Education Assistance Loans (HEAL) and the Health Center programs.

For HEAL loans, HRSA guarantees the payment of the principal and interest on the loans made by private lenders to medical students (who are enrolled in various approved fields of practice) in the event of:

- Default,
- Death, or
- Permanent disability.

In the event of default on a HEAL loan, the lender is responsible for 2 percent of the cost of each defaulted loan. In cases of death or permanent disability, the full amount of the principal and related interest are written off against the Allowance for Uncollectible Accounts since no further collection action is warranted.

Legislation that enabled the HEAL program to guarantee new loans to student borrowers expired September 30, 1998. Through September 30, 2004, HHS was authorized to allow existing HEAL recipients to refinance their loans into new guaranteed loans. The retirement of loans being refinanced was considered a receipt of principal and interest. This receipt was offset by the disbursement related to the newly-created loan. The underlying loan, in any given cohort, was paid off in its original cohort, and a new loan was opened in the cohort in which refinancing activity occurred.

For reporting purposes under the Credit Reform Act of 1990 (Public Law 101-508), loans are classified by date of obligation as either Pre-1992 or Post-1991 loans. The HEAL program has loans in both categories.

The Health Center Program guarantees loans (classified as Post-1991) to HRSA grantees, which are made by non-federal lenders to the health centers for the cost of developing and operating managed care networks or plans. HRSA guarantees the negotiated contract percentage of the outstanding balance at no greater than 80 percent. Loans guaranteed at greater than 80 percent must receive a waiver from the Office of Management and Budget (OMB) to do so.

On guaranteed loans obligated beginning in FY 1992 (Post-1991), subsidy cost is calculated using the net present value of projected lifetime costs and is revalued annually through the OMB Subsidy Credit Model re-estimate process. This subsidy cost may be positive or negative. A negative subsidy occurs when expected program inflows of cash exceed expected outflows.

HRSA uses a computerized cash flow projection model to calculate estimates of all future cash flows associated with Post-1991 HEAL or Health Center loans to develop subsidy estimates. Cash flows are projected for 30 years and aggregated by cohort year. A loan's cohort year represents the year a loan was guaranteed, regardless of the timing of the disbursement.

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Note 8. Loan Guarantee Receivables and Liabilities (continued)

Total loans guaranteed under these programs, as of September 30, 2005 and 2004 are summarized as follows.

(Dollars in Millions)	2005		2004	
HEAL Loan Guarantees:	No. of Loans	Amount	No. of Loans	Amount
Pre-1992 loans	35,050	$272	41,734	$331
Post-1991 loans	55,313	1,465	66,815	1,697
Health Centers Loan Guarantees	10	32	12	39
Total	90,373	$ 1,769	108,561	$2,067

Loan guarantee receivables:

The receivable amount reported in the Balance Sheet represents both the defaulted loans and the related interest, which have been paid to lenders under the guarantee. The lenders are required to perform certain debt collection procedures in an effort to collect amounts due prior to submitting the guaranteed loan for payment. An allowance for loss has been established for estimated uncollectible amounts on the loans. The allowance is based on management's assessment of the future collectibility of these aged loans based on the last date of collection.

Interest receivable and interest revenue are recognized on all loans at the stated rate or, in cases of judgment, court-mandated rate. Interest is accrued monthly and compounded semiannually for non-judgment cases, and accrued quarterly and compounded annually for judgment cases. Nevertheless, interest is accrued on both performing and non-performing loans.

The defaulted loans receivable for guaranteed loans at September 30, 2005 and 2004 are summarized below.

	2005				
(Dollars in Millions)	Loans, Receivable, Principal	Interest Receivable	Loans Receivable, Gross	Allowance	Loans, Receivable, Net
Defaulted Guaranteed Loans					
HEAL Loans (HRSA)					
Pre-1992 Loans	$ 461	$15	$ 476	$ (199)	$ 277
Post-1991 Loans	140	7	147	(45)	102
Subtotal	$ 601	$ 22	$ 623	$(244)	$ 379
Health Centers					
Pre-1992 Loans	-	-	-	-	-
Post-1991 Loans	4	-	4	(4)	-
Total	$ 605	$ 22	$ 627	$ (248)	$ 379

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Note 8. Loan Guarantee Receivables and Liabilities (continued)

	2004				
(Dollars in Millions)	Loans, Receivable, Principal	Interest Receivable	Loans Receivable, Gross	Allowance	Loans, Receivable, Net
Defaulted Guaranteed Loans					
HEAL Loans (HRSA)					
Pre-1992 Loans	$ 472	$ 12	$ 484	$ (198)	$ 286
Post-1991 Loans	133	5	138	(34)	104
Subtotal	$ 605	$ 17	$ 622	$ (232)	$ 390
Health Centers					
Post-1991 Loans	4	-	4	(4)	-
Total	$609	$ 17	$ 626	$ (236)	$ 390

Loan guarantee liabilities:

In accordance with the Credit Reform Act of 1990, the loan guarantee liability for the Post-1991 loans is established based on the present value of cash flows, associated with the estimated amount to be paid out under loan guarantees for each fiscal (cohort) year as determined by original date of the loan guarantee or refinancing. The calculation is performed using a computer model established by OMB. The model utilizes assumptions made by the HEAL program based on historical data, such as default rates and interest rates. The liability is adjusted and accounted for independently each year based on loans issued annually under the guarantee.

The pre-1992 loan guarantee liability for loans is established based upon an average default rate of approximately 3.58 percent in fiscal year 2005 and 3.65 percent in fiscal year 2004. This liability is adjusted each year for the change in default rates.

The loans guarantee liabilities at September 30, 2005 and 2004 are summarized below.

(Dollars in Millions)	2005	2004
Loan Guarantee Liabilities:		
HEAL Loans		
Pre-1992 Loans	$ 10	$ 13
Post-1991 Loans	144	172
Subtotal	$ 154	$ 185
Health Center		
Post-1991 Loans	4	6
Total Loan Guarantee Liabilities	$ 158	$ 191

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Note 8. Loan Guarantee Receivables and Liabilities (continued)

The reconciliation of loan guarantee liability for the Post-1991 loans is as follows:

(Dollars in Millions)	2005	2004
Beginning Balance, Liability for Loan Guarantees	$178	$347
Add: Subsidy Expense		
Default Costs (net of recoveries)	$12	$ (3)
Fees and Other Collections	(12)	(15)
Other Subsidy Cost (death and disability)	(15)	(38)
Total Subsidy Expense	$(15)	$(56)
Adjustments:		
Interest Supplements	0	0
Other	40	(64)
Total Adjustments	$ 40	$(64)
Subsidy Re-estimates		
Technical Re-estimates	$(40)	$(38)
Interest Re-estimates	(15)	(11)
Total Subsidy Re-estimates	$(55)	$(49)
Ending Balance, Liability for Loan Guarantees	$148	$178

Administrative expenses for the fiscal years reported are immaterial.

Loan guarantee subsidy expense:

The subsidy costs for the year ended September 30, 2005 is summarized as follows:

(Dollars in Millions)	2005	2004
Subsidy Expense		
Default Costs (net of recoveries)	$ 12	$(3)
Fees and Other Collections	(12)	(15)
Subsidy Re-Estimates (death and disability)	(15)	(38)
Total Subsidy Expense	$(15)	$(56)

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Note 8. Loan Guarantee Receivables and Liabilities (continued)

The subsidy rates for Post-1991 loan guarantees programs are as follows for the current cohort year:

Loan Guarantee Programs:	Subsidy	Fees & Other Collections	Other	Total
2005				
a. Health Education Assistance Loan Program (HEAL)	N/A*	N/A*		N/A*
b. Health Center Guarantee Loan Program (HCGLP)	5.64%	1%		6.64%
2004				
a. Health Education Assistance Loan Program (HEAL)	16.48%			16.48%
b. Health Center Guarantee Loan Program (HCGLP)	4.68%	1%		5.68%

* Note that the subsidy rates are not applicable for there were no new loans for FY 2005.

Note 9. Inventory and Related Property, Net

HHS' inventory and related property, net at September 30, 2005 and 2004 are summarized below.

(Dollars in Millions)	2005	2004
Inventory Held for Sale:		
Inventory Held for Current Sale	$19	$ 34
Inventory Held for Repair	-	-
Total Inventory Held for Sale	$19	$34
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	$5	$7
Operating Materials and Supplies Reserved for Future Use	-	-
Total Operating Materials and Supplies	$5	$7
Stockpile Materials:		
Stockpile Materials Held for Emergency or Contingency	$1,590	$986
Total Stockpile Materials	$1,590	$986
Inventory and Related Property, Gross	$1,614	$1,027
Less: Allowance for Loss/Obsolescence/Spoilage	-	-
Inventory and Related Property, Net	$1,614	$1,027

On August 13, 2004, pursuant to the Project BioShield Act of 2004, the stockpile of vaccines and other medical supplies held in the Strategic National Stockpile (SNS) were transferred from the Department of Homeland Security to HHS in the amount of $868 million, with a corresponding budget authority of $626 million. SNS materials are not for sale and are maintained for use during local and national emergencies. The total SNS balance at the end of FY2005 amounts to $1,415 million and the SNS is valued at historical cost using the First-In/First-Out (FIFO) cost flow assumption method.

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Note 10. General Property, Plant and Equipment, Net

Major categories of HHS General Property, Plant and Equipment (PP&E) at September 30, 2005 and 2004 are listed below.

			2005			2004
(Dollars in Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value	Net Book Value
Land & Land Rights			$48	$ -	$48	$48
Construction in Progress			723	-	723	1,389
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	3,827	(1,355)	2,472	1,583
Equipment	Straight Line	3-20 Yrs	1,209	(530)	679	571
Internal Use Software	Straight Line	7-10 Years	606	(119)	487	133
Assets Under Capital Lease	Straight Line	1-20 Years	142	(32)	110	115
Leasehold Improvements	Straight Line	*Life of Lease	43	(5)	38	38
Totals			$6,598	$ (2,041)	$4,557	$3,877

*7 to 15 years or the life of the lease.

Included in the FY 2005 and FY 2004 Net Book Value for Internal Use Software are UFMS capitalized costs totaling approximately $13 million for FY 2005 and $12 million for FY 2004. The $25 million represents capitalized cost incurred by the Program Management Office.

Note 11. Other Assets

Other Assets at September 30, 2005 and 2004 are comprised of the following, all of which are considered entity assets.

(Dollars in Millions)	2005	2004
Intragovernmental		
Advances to Other Federal Entities	$538	$745
Prepayments & Deferred Charges	-	-
Other	1	1
OPDIV Combined, Intragovernmental	539	746
Less: Intra-OPDIV Eliminations	(366)	(338)
OPDIV Consolidated, Intragovernmental	173	408
Less: Inter-OPDIV Eliminations	(4)	(22)
HHS Consolidated, Intragovernmental	$169	$386
With the Public		
Prepayments and Deferred Charges	$4,044	$80
Travel Advances & Emergency Employee Salary Advances	5	4
Other	100	101
HHS Consolidated, With the Public	$4,149	$185

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Note 11. Other Assets (continued)

Advances to Other Federal Entities is largely comprised of advances from the National Institutes of Health (NIH) to the NIH Service and Supply Fund and the Management Fund to finance the NIH Business System (NBS) and the NIH Clinical Center, as well as advances from the Centers for Disease Control and Prevention and the Office of Secretary to the Department of Veterans Affairs for Strategic National Stockpile items.

The Prepayments and Deferred Charges with the Public primarily represent Managed Care advance payments made by the Center for Medicare & Medicaid Services under the Medicare Advantage plans for services that will be provided in October 2005.

Note 12. Liabilities Not Covered by Budgetary Resources

HHS' liabilities not covered by budgetary resources at September 30, 2005 and 2004 are summarized below.

(Dollars in Millions)	2005	2004
Intragovernmental		
Accounts Payable	$-	$ -
Accrued Payroll and Benefits	21	19
Other	169	98
Total Intragovernmental	$ 190	$ 117
Entitlement Benefits Due and Payable	$ 9,470	$ 10,039
Federal Employees and Veterans' Benefits	7,183	7,178
Accrued Payroll and Benefits	453	431
Other	2,581	2,822
Total Liabilities Not Covered by Budgetary Resources	$ 19,877	$ 20,587
Total Liabilities Covered by Budgetary Resources	51,082	46,231
Total Liabilities	$ 70,959	$ 66,818

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Note 13. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represent benefits due and payable to the Public at year-end from entitlement programs enacted by law. The Medicare and Medicaid programs are the largest entitlement programs in HHS and comprise all of the HHS Entitlement Benefits Due and Payable.

Entitlement Benefits Due and Payable at September 30, 2005 and 2004 are summarized below.

	2005			2004		
(Dollars in Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Medicare	$ 33,399	$ -	$ 33,399	$ 29,875	$ -	$29,875
Medicaid	10,635	9,470	20,105	9,315	10,039	19,354
Other	250	-	250	-	-	-
Totals	$ 44,284	$9,470	$ 53,754	$ 39,190	$ 10,039	$49,229

As of September 30, 2005, Medicare benefits payable consisted of $33.4 billion of Medicare services incurred but not paid, as calculated by the CMS' Office of the Acturary. The majority of the Medicaid benefits payable of $20 billion is for the estimated Federal share of expenses incurred by the states but not yet reported to CMS, based on historical relationships between Medicaid payables and current Medicaid activity. The estimate is reduced by amounts owed by the states for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Note 14. Federal Employee and Veterans' Benefits

HHS' Federal Employee and Veterans' Benefits at September 30, 2005 and 2004 are summarized below. These liabilities are not covered by budgetary resources.

(Dollars in Millions)	2005	2004
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 6,287	$ 6,327
PHS Commissioned Corp Post-retirement Health Benefits	627	582
Workers' Compensation Benefits (Actuarial FECA Liability)	269	269
Total, Federal Employee and Veterans' Benefits	$ 7,183	$ 7,178

Public Health Service Commissioned Corps: HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System for approximately 5,880 active duty officers and 5,108 retiree annuitants or survivors. Authorized by Public Law 78-410, it is a defined noncontributory

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Note 14. Federal Employee and Veterans' Benefits (continued)
benefit plan. The plan does not have accumulated assets; funding is provided entirely on a pay as you go basis by Congressional appropriations. Administrative costs are borne by the plan. The plan provides pension payments and medical benefits to eligible retirees. At September 30, 2005, the actuarial present value of accumulated plan pension benefits was $6,287 million of which $596 million was not vested, and the liability for medical benefits was actuarially determined to be $627 million.

Significant assumptions used by the actuary in its reports on the pension and medical programs as of September 30, 2005, were as follows:

Interest on Federal securities	6.25 percent
Annual basic pay scale increase	3.75 percent
Annual inflation	3.00 percent

Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system. HHS applies aggregate entry age normal actuarial cost method to both programs to determine their liabilities.

The following shows key valuation results as of September 30, 2005 and 2004, in conformance with the actuarial reporting standards set forth in the Statement of Federal Financial Accounting Standards (SFFAS) No. 5, *Accounting for Liabilities of the Federal Government*.

(Dollars in Millions)	2005	Restated 2004
SFFAS 5 Expense		
(a) Normal Cost	$ 154	$ 150
(b) Interest Cost	423	404
(c) Ongoing Cost (a & b)	577	554
(d) Prior Service Cost & (Gains)/Losses	(294)	73
(e) Total Expense	$ 283	$ 627

Workers' Compensation Benefits: The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical, and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims.

The liability utilizes historical benefit payment patterns related to a specific incurred period to predict the ultimate payment related to that period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the OMB's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in FY 2005 and 2004 appear below.

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Note 14. Federal Employee and Veterans' Benefits (continued)

FY 2005	FY 2004
4.528% in Year 1	4.883% in Year 1
5.020% in Year 2 and thereafter	5.235% in Year 2 and thereafter

To provide more specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (cost of living adjustments (COLAs)) and medical inflation factors (consumer price index medical (CPIMs)) are applied to the calculations for projected future benefits. These factors are also used to adjust historical payments to current year dollars. The anticipated percentages for COLAs and CPIMs used in projections are:

FY	COLA	CPIM
2005	2.20%	4.33%
2006	3.33%	4.09%
2007	2.93%	4.01%
2008	2.40%	4.01%
2009+	2.40%	4.01%

Note 15. Accrued Grant Liability

Grant advances are liquidated upon the grantees' reporting of expenditures on the quarterly Federal Cash Transaction Report (SF-272). In many cases, HHS receives these reports several months after the grantee incurs the expense, resulting in an understated grant expense in the financial statements. To mitigate this, HHS developed departmental procedures to estimate and accrue amounts due grantees for their unreported expenses through September 30.

At fiscal year-end, the OPDIVs record the liability based on the estimated accrual for unreported grantees' expenses. If the amount of the collective OPDIV advances outstanding exceeds the amount of the collective estimated expenses, HHS reports the difference as "Advances to Grantees". On the other hand, if the amount of the estimated expenses exceeds the amount of the collective advances outstanding, HHS reports the difference as "Accrued Grant Liability". For additional information on this subject, see Note 1 under subtitle "Advances to Grantees/Accrued Grant Liability".

HHS' net grant advances (liability) at September 30, 2005 and 2004 are summarized below.

	2005	2004
Grant Advances Outstanding (before year-end grant accrual)	$ 15,491	$ 15,087
Less: Estimated Accrual for Amounts Due to Grantees	(19,274)	(18,842)
Net Grant Advances (Liability)	$ (3,783)	$ (3,755)

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Note 16. Other Liabilities

HHS' other liabilities at September 30, 2005 and 2004 are summarized below.

(Dollars in Millions) 2005	Intragovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ -	$ -	$ -	$ 15	$ -	$ 15
Deferred Revenue	475	-	475	552	-	552
Liabilities for Deposit Funds, Clearing Accounts and Undeposited Collections	1	-	1	(177)	-	(177)
Contingent Liabilities	-	-	-	-	2,266	2,266
Capital Lease Liability	-	86	86	31	5	36
Custodial Liabilities	-	84	84	-	5	5
Vaccine Injury Compensation Program	-	-	-	-	265	265
Environmental and Disposal Costs	-	-	-	2	31	33
Other	805	(1)	804	134	9	143
Combined OPDIV Totals	$ 1,281	$ 169	$ 1,450	$ 557	$ 2,581	$ 3,138
Less: Intra-OPDIV Eliminations	(366)	-	(366)	-	-	-
Consolidated OPDIV Totals	$ 915	$ 169	$ 1,084	$ 557	$ 2,581	$ 3,138
Less: Inter-OPDIV Eliminations	(92)	-	(92)	-	-	-
Consolidated HHS Totals	$ 823	$ 169	$ 992	$ 557	$ 2,581	$ 3,138

(Dollars in Millions) 2004	Intragovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ 115	$ -	$ 115	$ -	$ -	$ -
Deferred Revenue	351	-	351	262	-	262
Liabilities for Deposit Funds, Clearing Accounts and Undeposited Collections	-	-	-	19	-	19
Contingent Liabilities	-	-	-	-	2,455	2,455
Capital Lease Liability	-	88	88	30	5	35
Custodial Liabilities	-	10	10	-	-	-
Vaccine Injury Compensation Program	-	-	-	-	313	313
Environmental and Disposal Costs	-	-	-	3	33	36
Other	691	-	691	280	16	296
Combined OPDIV Totals	$ 1,157	$ 98	$ 1,255	$ 594	$ 2,822	$ 3,416
Less: Intra-OPDIV Eliminations	(338)	-	(338)	-	-	-
Consolidated OPDIV Totals	$ 819	$ 98	$ 917	$ 594	$ 2,822	$ 3,416
Less: Inter-OPDIV Eliminations	(132)	-	(132)	-	-	-
Consolidated HHS Totals	$ 687	$ 98	$ 785	$ 594	$ 2,822	$ 3,416

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Note 16. Other Liabilities (continued)
The majority of the other liabilities include Deferred Revenue, Contingent Liabilities, and the Vaccine Injury Compensation Program, and Other Intragovernmental Liabilities.

Deferred Revenue:
The Centers for Medicare & Medicaid Services routinely receive premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill. CMS accounts for $267 million of the Deferred Revenue with the Public.

In addition, Food and Drug Administration (FDA) collects fees in relation to its various user fee appropriations. FDA accounts for $186 million of the Deferred Revenue with the Public for the portion of the fees collected during current fiscal year that should be applied to the next fiscal year. Indian Health Service accounts for $148 million of the Intragovernmental Deferred Revenue for construction-in-process projects primarily under the Contribution, Indian Health Facilities fund, and $52 million of the Deferred Revenue with the Public for the Tribal Buybacks. Substance Abuse and Mental Health Services Administration accounts for $122 million Intragovernmental Deferred Revenue for interagency agreement with another federal agency to award and administer the Drug Free Communities program grants. The Vaccine Injury Compensation Program administered by the Health Resources and Services Administration accounts for $79 million in Intragovernmental Deferred Revenue arising from the provision of goods and services by the program.

Contingent Liabilities:
Through the issuance of grants, HRSA supports the operation of certain health centers under the Health Centers Consolidation Act of 1996. These grantees, and many of their health professionals, are provided malpractice insurance under the Federally Supported Health Centers Assistance Act. Settlements and awards are paid from a separate Fund in the Treasury (Appropriation 75x0365). Accordingly, there are numerous malpractice legal actions pending against these grantees, which if settled, will be paid by HRSA. HRSA's legal actions make up the majority of the Contingent Liabilities. For FY 2005 and FY 2004, HRSA's actuarial contractor estimated the preliminary Contingent Liability to be $586 million. These liabilities include the incurred but not reported (IBNR) amount of $194 million and the expected payouts for fiscal years 2005 to 2007 of $203 million for the Community Health Center program.

CMS routinely process and settle cost reports and payment issues for institutional providers and healthcare insurers. As part of this process, some providers/insurers have filed suits challenging the amount of reimbursement to which they claim entitlement. CMS cannot reasonably estimate the probability of the providers successfully winning their suits or the exact amount of the potential loss to the Medicare trust funds.

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Note 16. Other Liabilities (continued)

Included in other liabilities at September 30, 2005 is an estimated amount for a contingent liability payable to States (to reimburse them for payments they have paid on behalf of beneficiaries) at an amount of approximately $1,648 million ($1,867 million in FY 2004), for probable unasserted claims that resulted from processing errors where incorrect Medicare eligibility determinations were made. No claims have been filed. Because appropriation law requires Congress to authorize the transfer of funds out of the Medicare Trust Funds into an appropriation account, the Medicare Trust Funds cannot reimburse the Health Program accounts in the General Fund of the Treasury absent Congressional authorization. The CMS does not intend to seek such Congressional authorization and there will be no transactions recorded between the Trust Funds and the Health Programs' accounts in the general fund.

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB) since monetary effect of those appears is generally not known until a decision is rendered. The PRRB gets no information on the value of the cases that are settled prior to a hearing. Data is available for only the 72 cases that were decided in FY 2005. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

The following contingent liabilities for which a loss has been determined to be reasonably possible have not been accrued in the Department's financial statements:

The CMS expects that as of September 30, 2005, it is reasonably possible that as much as $2.8 billion could be owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. Two United States Circuit Courts of Appeals have decided cases in which CMS has litigated these issues. One court has ruled in favor of CMS, reaffirming CMS' decision to deny cost report reopenings. The other court has ruled against CMS and instructed CMS to reopen certain providers' cost reports. CMS intends to vigorously contest this latter decision. Any potential payment of any funds related to these claims would be based on the providers' ability to comply with the legal requirement that they provide adequate documentation to support their claims and overcome any other legal defenses.

Under earlier applicable law, Medicare, in certain circumstances, reimbursed hospitals for losses incurred on the disposal of assets. The CMS is currently defending claims relating to a number of mergers and consolidations that occurred between non-profit hospitals prior to the 1997 change in the law. The CMS expects that as of September 30, 2005, it is reasonably possible that from $119 million to $259 million may be owed to providers for unreimbursed costs reported on their Medicare cost reports. CMS intends to vigorously defend this case.

As of September 30, 2005, management expects that it is reasonably possible that up to $106 million may be owed for asserted claims associated with Medicaid cost disallowance cases.

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Note 16. Other Liabilities (continued)
In addition, SAMHSA expects that it is reasonably possible that the agency may owe as much as $12 million as a result of federal claims court case. At this time, the parties are considering options including appeal and settlement, and pending legislation may affect whether any funds will be owed to the litigant.

In the opinion of management, the resolution of these matters will not have a material impact on the results of operations and financial condition of HHS.

Vaccine Injury Compensation Program (VICP):
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $265.4 million VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2005.

Other Intragovernmental Liabilities:
Other Intragovernmental Liabilities of $992 million are comprised of $433 million, of which CMS owe to other Federal entities, primarily to the Department of Treasury ($401 million at September 30, 2005). CMS' payable to Treasury is a result of the receivables from the beneficiaries and Medicare contractors. As of September 30, 2005 beneficiaries owe $388 million to CMS for Medicare Hospital Insurance and Supplemental Medical Insurance premiums. Medicare contractors have also reported $13 million in interest owed on Medicare overpayments. CMS owes other Federal entities $32 million for services performed through interagency agreements.

Environmental and Disposal Costs:
The Comprehensive Environmental Response Compensation and Liability Act, the Comprehensive Environmental Cleanup and Responsibility Act, the Superfund Amendments and Reauthorization Act of 1986, and the Conservation Recovery Act of 1976, are several laws and regulations, which require HHS to remove, contain, and/or dispose of hazardous waste. Environmental and disposal costs are the costs of removing, containing, and/or disposing of (1) hazardous waste from property, or (2) material and or property that consists of hazardous waste at a permanent or temporary closure or shutdown of associated property, plant or equipment. The majority of the environmental and disposal costs consist of Indian Health Service's liabilities associated with surveying, testing, and remediating contaminated sites and National Institutes of Health ground water remediation project in accordance with applicable laws and regulations.

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Note 17. Leases

Capital Leases:
HHS has entered into various capital leases with Native American and Alaskan Native tribes and with the General Services Administrations (GSA) for office and warehouse space. Lease terms vary from 1 to 20 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments.

Operating Leases:
HHS has commitments under various operating leases with private entities and GSA for office, laboratory spaces, and land. Leases with private entities have initial or remaining noncancelable lease terms from 1 to 20 years. GSA leases in general are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

During FY 2003, based on the criteria set forth by the OMB Circular No. A-11, *Preparation, Submission, and Execution of the Budget*, NIH identified eight capital leases that were previously recorded as operating leases; however, the analysis of the terms of the leases and the final determination was not completed until FY 2004. The FY 2003 operating and capital leases were restated to record the eight capital leases. Subsequently, the lease agreements were modified and, in the final quarter of FY 2004, options were dropped on six of the eight capital leases, leaving only two capital leases reclassified under the OMB criteria. FY 2004 does not include the six leases reclassified as operating leases after options were dropped. After reclassifying, only two leases are capital leases under the OMB criteria. In FY 2005, the remaining two leases are properly reported as capital leases, and the issue has been closed with OMB. In addition to the capital lease issue, NIH has operating leases that do not have cancellation clauses and the obligation for the full term of the lease is not recorded. The issue is currently under review and resolution will not occur for the FY 2005 reporting period. The total liability for these leases over the life of the lease term is $553.8 million in FY 2005 and $578.6 million in FY 2004.

A Summary of Net Assets under Capital Lease and Future Minimum Lease Payments at September 30, 2005 and 2004 follows.

(Dollars in Millions)	2005	2004
Summary of Net Assets Under Capital Lease		
Land and Building	$ 140	$ 140
Machinery and Equipment	2	1
Other	-	-
Subtotal	$ 142	$ 141
Less: Accumulated Amortization	(32)	(26)
Assets Under Capital Lease	$ 110	$ 115

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Note 17. Leases (continued)

(Dollars in Millions)	2005 Capital Leases	2005 Operating Lease	2004 Capital Leases	2004 Operating Lease
Future Minimum Lease Payments				
Year 1	$ 12	$ 322	$ 12	$ 263
Year 2	12	342	12	260
Year 3	12	348	12	266
Year 4	13	355	12	271
Year 5	13	340	12	276
Later Years	149	1,064	152	463
Total Minimum Lease Payments	$ 211	$ 2,771	$ 212	$ 1,799
Less: Imputed Interest	(89)		(89)	
Total Capital Lease Liability	$ 122		$ 123	

Note 18. Consolidated Gross Cost and Earned Revenue by Budget Functional Classification

HHS' consolidated gross cost and exchange revenue by budget functional classification for the fiscal years ended September 30, 2005 and 2004 are summarized below.

(Dollars in Millions)	2005 Education Training and Social Services	Health	Medicare	Income Security	Admin. of Justice	Natural Resources/ Environment	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals	2004 HHS Consolidated Totals
Intragovernmental										
Gross Cost	$ 171	$ 4,667	$ 547	$ 25	$ -	$ -	$ 5,410	$ (1,875)	$ 3,535	$ 3,412
Less: Earned Revenue	(25)	(2,736)	(10)	(6)	-	-	(2,777)	1,692	(1,085)	(839)
Net Cost, Intragovernmental	$ 146	$ 1,931	$537	$19	$ -	$ -	$ 2,633	$ (183)	$ 2,450	$ 2,573
With the Public										
Gross Cost	$ 12,469	$237,123	$333,425	$35,446	$ -	$ -	$ 618,463	$ -	$ 618,463	$ 578,056
Less: Earned Revenue	-	(1,344)	(38,249)	-	-	-	(39,593)	-	(39,593)	(33,409)
Net Cost, With the Public	$ 12,469	$235,779	$295,176	$35,446	$ -	$ -	$ 578,870	$ -	$ 578,870	$ 544,647
Totals										
Gross Cost	$ 12,640	$241,790	$333,972	$35,471	$ -	$ -	$ 623,873	$ (1,875)	$ 621,998	$ 581,468
Less: Earned Revenue	(25)	(4,080)	(38,259)	(6)	-	-	(42,370)	1,692	(40,678)	(34,248)
Net Cost of Operations	$ 12,615	$237,710	$295,713	$35,465	$ -	$ -	$ 581,503	$ (183)	$ 581,320	$ 547,220

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Note 19. Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $40.7 billion and $34.2 billion for the years ended September 30, 2005 and 2004, respectively. HHS' exchange revenue primarily consists of Medicare premiums collected from beneficiaries.

Premiums Collected are used to finance Supplemental Medical Insurance (SMI) benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

HHS' pricing policy under the reimbursable agreements is to recover full cost and to incur no profit or loss. Most OPDIVs either charge full cost or are implementing procedures to do so. In addition to revenues related to reimbursable agreements, HHS collects various user fees to finance its programs. Certain fees charged by HHS are based on an amount set by law or regulations and may not represent full cost.

Note 20. Prior Period Adjustments

To correct errors and accounting changes with retroactive effect, HHS included prior period adjustments in the calculation of the net change in cumulative results of operations and unexpended appropriations. The following is a summary of the prior period adjustments comprised mainly of the IHS' adjustments to accrued unfunded payroll, the NIH's adjustments to royalty activity, and the OS' adjustments to the stockpile transfer as of September 30, 2005 and 2004, respectively.

(Dollars in Millions)

	2005	2004
Increases (Decreases) to Equity		
Correction of Errors	$ (32)	$ 404
Change in Accounting Principles	-	-
Total	$ (32)	404

Note 21. Custodial Activity

The Administration for Children and Families receives monies from the Internal Revenue Service for outlay to the states for child support. These monies represent delinquent child support payments withheld from Federal tax refunds. Receipts are transferred to HHS appropriation 75X6234 to cover outlays. During FY 2005, receipts amounted to $1,573 million ($1,489 million for FY 2004) and outlays amounted to $1,562 million ($1,480 million for FY 2004).

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Note 21. Custodial Activity (continued)

The Food and Drug Administration (FDA) custodial activity involves collections of civil monetary penalties (CMP) assessed by the Department of Justice on behalf of FDA. Penalties are assessed for violations in areas such as illegally manufactured, marketed, and distributed animal feeds and drug products. Total CMP collections in FY 2005 were $4.7 million ($51 million for FY 2004). CMP collections are immediately forwarded to the Department of Treasury and cannot be used for FDA operations.

The Centers for Disease Control and Prevention (CDC) custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status. Total custodial liabilities for FY 2005 and FY 2004 were $84 thousand and $20 thousand, respectively. CDC custodial collections are also forwarded to the Department of Treasury and cannot be used for CDC operations.

Note 22. Federal Matching Contribution

Supplemental Medical Insurance (SMI) benefits and administrative expenses are financed by monthly premiums, which are paid by Medicare beneficiaries and which are matched by the Federal Government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected and outlines both the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $66.60 from October 2004 through December 2004 and $78.20 from January 2005 through September 2005. Premiums collected from beneficiaries totaled $35.9 billion in FY 2005 ($30.3 billion in FY 2004) and were matched by $113.5 billion ($96.7 billion in FY 2004) contribution from the Federal Government.

Note 23. Contingencies

The Department and its components are parties to various administrative proceedings, legal actions, and claims brought by or against it. These contingencies arise in the normal course of operations and their ultimate disposition is unknown. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS No.5, as amended by SFFAS No. 12, contains the criteria for recognition and disclosure of contingent liabilities. To the extent that a past transaction or event has occurred, a future outflow or other sacrifice of resources is probable, and the related future outflow or sacrifice of resources is measurable, a contingent liability will be accrued and reported in Note 16, Other Liabilities. In respect to all other contingencies, management, in consultation with legal counsel, has determined that it is reasonably possible that certain claims may result in an adverse outcome to the Department. However, an estimate of the range of possible liability cannot be determined. Based on information currently available, it is management's opinion that the expected outcome of these matters, individually or in the aggregate, will not have a material adverse effect on the financial statements of the Department.

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Note 23. Contingencies (continued)

Obligations Related to Cancelled Appropriations
Payments may be required of up to 1 percent of current year appropriations for valid obligations incurred against prior year appropriations that have been cancelled. The total payments related to cancelled appropriations are estimated at $1,136 million and $1,047 million as of September 30, 2005 and 2004, respectively.

Note 24. Apportionment Categories of Obligations Incurred
Obligations incurred by apportionment categories at September 30, 2005 and 2004 are summarized below:

	2005		
(Dollars in Millions)	Direct	Reimbursable	Totals
Category A	$ 89,605	$ 5,466	$ 95,071
Category B	332,565	1,398	333,963
Exempt from apportionment	346,601	-	346,601
Total Obligations Incurred	$ 768,771	$ 6,864	$ 775,635

	2004		
(Dollars in Millions)	Direct	Reimbursable	Totals
Category A	$ 83,148	$ 4,540	$ 87,688
Category B	305,656	892	306,548
Exempt from apportionment	307,851	-	307,851
Total Obligations Incurred	$ 696,655	$ 5,432	$ 702,087

Obligations Incurred consist of expended authority and the change in undelivered orders. Current system limitations prevent CMS from reporting the recoveries of prior year obligations. The Office of Management and Budget (OMB) has exempted CMS from the Circular No. A-11 requirement to report the refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that CMS report all Medicare cash collections as an offsetting receipt beginning in FY 2005. Therefore, CMS has reported $2.5 billion as an offsetting receipt in the financial statements for FY 2005.

Note 25. Legal Arrangements Affecting Use of Unobligated Balances
Unobligated balances consist of appropriated funds, revolving funds, management funds, trust funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. Annual appropriations are available for new obligations in the year the appropriation was received and for adjustments to valid obligations for five (5) subsequent years. Revolving funds are no-year funds without any time limit. The National Institutes of Health Management Fund is available for two (2) fiscal years. The trust funds are also no-year funds without time limits. CRADA funds are available for the performance of the contractual agreement.

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

Note 25. Legal Arrangements Affecting Use of Unobligated Balances (continued)
Trust fund receipts collected by CMS in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in the fiscal year is precluded by law from being available for obligation. CMS reported $11,150 million and $3,921 million at September 30, 2005 and 2004, respectively. This excess of receipts over obligations is reported as "Temporarily Not Available Pursuant to Public Law" in the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed.

FDA has a Contingency Fund that was established in FY 1983 whereby funds are to be used for unusual direct costs of product emergencies. The remaining balance of $1 million was obligated in FY 2003 and the fund is now inactive.

FDA received $168 million in funding in FY 2002 to remain available until expended, to support Counter Terrorism projects that recognize the important role FDA plays in protecting the public health. The attacks of September 11, 2001 and subsequent national events resulted in an accelerated and intensified need for attention to activities related to counter terrorism. The amount obligated for counter terrorism projects through FY 2005 was approximately $150 million.

Note 26. Explanation of Differences Between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government
SFFAS No. 7, *Accounting for Revenue and Other Financing Sources, re*quires for explanations of any material differences between the information required by paragraph 77 (of SFFAS No. 7) and the amounts described as "Actual" in the "*Budget of the United States Government"* (also called the "President's Budget"). Paragraph 77 of the SFFAS No. 7 requires for the presentation of total budgetary resources available to a reporting entity, the status of those resources, and any outlays of the reporting entity. This information is provided in the Department's SBR.

Chapter 11, Title 31, U.S. Code requires: "On or after the first Monday in January but not later than the first Monday in February of each year, the President shall submit a budget of the United States Government for the following fiscal year." The FY 2007 *President's Budget*, with actual amounts for FY 2005, has not yet been published, and therefore no comparisons can be made between FY 2005 amounts presented in the SBR with amounts reported in the "Actual" column of the *President's Budget*. The FY 2007 *President's Budget* is expected to be released in February 2006, and may be obtained from the OMB website http://www.whitehouse.gov/omb/budget or the Government Printing Office.

The *Budget of the United States Government*, FY 2006 – Appendix for the HHS, was used as the reference for the Total Budgetary Resources amount. Information in the Federal Programs by Agency and the Account in Chapter 27 of the FY 2006 Analytical Perspectives were used as the reference for the Net Outlays (less Offsetting Receipts) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2004.

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

Note 26. Explanation of Differences Between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government (continued)

The reconciliation is disclosed in the following table:

	2004	
(Dollars in Millions)	Budgetary Resources	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$ 721,084	$ 543,475
Unobligated Balances – Not Available	(5,226)	-
Other	421	(86)
Budget of the U.S. Government	$ 716,279	$ 543,389

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the SBR and not in the *President's Budget* is the budgetary resources that were not available. This line amount includes expired authority, recoveries, and other amounts included in the SBR that are not included in the *President's Budget*. The "Other" line in the table above includes timing and rounding differences between the SBR and the *President's Budget*.

Note 27. Explanation of Differences Between Liabilities Not Covered by Budgetary Resources and Components Requiring or Generating Resources in Future Periods

The Components Requiring Resources in Future Periods includes increases in certain liability accounts, such as accrued annual leave, that are also included in the category "Not Covered by Budgetary Resources". In this instance the expense is recorded for the period when the leave is earned and is included as a current period cost on the Statement of Net Cost.

The Balance Sheet uses proprietary accounts to present the balances for "Liabilities Not Covered by Budgetary Resources". An increase in the annual leave liability increases the unfunded liability on the Balance Sheet and the expenses on the Statement of Net Cost. The increase is not included in the Statement of Budgetary Resources since the liability will be paid from future resources. As a result, the Statement of Financing reports "Components Requiring Resources in Future Periods" which includes items such as accrued annual leave to reconcile budgetary resources to net cost.

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

Note 28. Permanent Indefinite Appropriations

The HHS permanent indefinite appropriations are open ended; that is, the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

The list below includes the Treasury Fund Symbols that meet the criteria stated above and are considered permanent indefinite appropriations. The list also includes the period of availability (fiscal year or no-year) and the titles of the accounts.

75 0340 (fiscal year) Health Education Assistance Loans Program
75X0350 (no year) Health Centers Loan Program, Health Resources and Services Administration
75X0513 (no year) Payments for Credits Against Health Care Contributions
75X0585 (no year) Taxation on Old-Age, Survivors and Disability Insurance Benefits
75 1552 (fiscal year) Temporary Assistance for Needy Families
75 1553 (fiscal year) Children's Research and Technical Assistance
75X1553 (no year) Children's Research and Technical Assistance
75X4305 (no year) Health Professions Graduate Student Loan Insurance Fund, Liquidating Acct
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8247 (no year) Food and Drug Administration Unconditional Gift Fund
75X8248 (no year) National Institutes of Health Unconditional Gift Fund
75X8249 (no year) Unconditional Gift Fund, Health Resources and Services Administration
75X8250 (no year) Gifts and Donations, Centers for Disease Control
75X8253 (no year) National Institutes of Health Conditional Gift Fund
75X8254 (no year) Conditional Gift Fund, Health Resources and Services Administration
75X8510 (no year) Administration on Aging Gift Fund
75X8511 (no year) Indian Health Service Gift Fund
75X8512 (no year) Agency for Healthcare Research and Quality Gift Fund
75X8513 (no year) Substance Abuse and Mental Health Administration Gift Fund
75X8514 (no year) Office of the Secretary Gift Fund
75X8888 (no year) Patients Benefit Fund, National Institutes of Health
75X8889 (no year) Patients Benefit Fund, Health Resources and Services Administration
7520X8004 (no year) Federal Supplementary Medical Insurance Trust Fund
7520X8005 (no year) Federal Hospital Insurance Trust Fund
7520X8175 (no year) Vaccine Injury Compensation Trust Fund

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2005 and 2004

Note 29. Adjustments to Beginning Balance of Budgetary Resources

During FY 2004, FDA accelerated the billing and collection of FY 2005 advanced fees from the drug industry. The fees collected in advance were unavailable in FY 2004 and did not become available until the beginning of FY 2005 after the passage of the FDA appropriation. The collection of these advances is authorized by the Prescription Drug User Fee Act of 1992 and re-authorized by the Prescription Drug User Fee Amendments of 2002 (Title 5 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188).

As a result of collecting the fees in advance, FDA adjusted the beginning of the year budgetary resources available balance in their SBR for FY 2005. This resulted in a $164 million difference in the ending unobligated balance for FY 2004 and the beginning unobligated balance for FY 2005.

U.S. Department of Health and Human Services
Stewardship Property, Plant, and Equipment
For the Year Ended September 30, 2005

HHS has two types of property, plant, and equipment (PP&E) for stewardship reporting: Heritage Assets and Indian Trust Lands.

Heritage Assets are PP&E of historical, natural, cultural, educational, or artistic significance. Heritage Assets are generally expected to be preserved indefinitely. This category includes buildings on the National Historic Register, cemetery sites, etc.

Stewardship Land includes land and land rights other than that acquired for or in connection with general PP&E. "Land" is defined as the solid part of the surface of the earth, excluding natural resources related to land. Examples of Stewardship Land include land used as forests and parks, and land used for wildlife and grazing.

Indian Trust Lands are those lands that do not meet the definition of Stewardship Land, but are held by IHS as separate and distinct, because of the Federal Government's long-term trust responsibility. All Indian Trust lands, when no longer needed by IHS in connection with its General PP&E, must be returned to the Department of the Interior's Bureau of Indian Affairs for continuing trust responsibility and oversight. IHS separately reports Indian Trust land parcels by site and installation numbers, and Indian Trust Lands from General PP&E situated thereon.

IHS Stewardship Classes and Trust Land

Asset Descriptions	Number of Sites	Total Square Footage	Federal Hectares	Total Hectares
Heritage Assets	2	2,295	<1.82 (4+/- acres)	<1.82 (4+/- acres)
Indian Trust Lands	79	N/A	424.9 (1,049 acres)	424.9 (1,049acres)

Distribution of Stewardship Assets by Type and Area

	Heritage Assets			Indian Trust Lands	
	Number of Sites	Square Footage	Total Hectares	Number Of Sites	Total Hectares
Aberdeen				9	75
Alaska	1		< 1.82		
Albuquerque				4	4
Bemidji				2	9
Billings				7	48
Navajo				35	255
Oklahoma City				1	2
Phoenix	1	2,295		13	19
Portland				3	1
Tucson				5	12
Total IHS	2	2,295	< 1.82	79	425

U.S. Department of Health and Human Services
Investment in Human Capital
For the Year Ended September 30, 2005

RESPONSIBILITY SEGMENT PROGRAM	2005	2004	2003	2002	2001
ACF					
Administration on Developmental Disabilities	$8	$9	$10	$6	$6
NIH					
Research Training and Career Development	1,699	1,696	1,405	1,248	1,118
Totals	**$1,707**	**$1,705**	**$1,415**	**$1,254**	**$1,124**

"Investments in Human Capital" are expenses incurred by Federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Two operating divisions of the Department conduct education and training programs under this category: Administration for Children and Families, and the National Institutes of Health.

Administration for Children and Families (ACF)

ACF is able to estimate investment in human capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 53 grants were awarded for Projects of National Significance (PNS). PNS grants are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. Monies also support the development of national and state policy to serve this community. Grants awarded total $8 million in FY 2005 and $9 million in FY 2004.

National Institutes of Health (NIH)

The NIH Research Training and Career Development Program addresses the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the Nation's health. Our ability to maintain the momentum of recent scientific progress and our international leadership in medical research depends upon the continued development of new, highly trained investigators.

U.S. Department of Health and Human Services
Investment in Research and Development
For the Year Ended September 30, 2005

Responsibility Segments	2005 Basic	2005 Applied	2005 Develop-Mental	2005 Total	2004 Total	2003 Total	2002 Total	2001 Total	Grand Total
ACF		$21		$21	$21	$24	$29	$32	$127
AHRQ	162			162	170	163	150	127	772
CDC		521		521	549	557	533	557	2,717
FDA *		26	5	31	28	31	29	26	145
HRSA		23		23	16	16	16	16	87
NIH	15,192	10,128		25,320	23,700	21,359	19,058	16,007	105,444
Totals	**$15,354**	**$10,719**	**$5**	**$26,078**	**$24,484**	**$22,150**	**$19,815**	**$16,765**	**$109,292**

*FDA restated its FY 2003 amount by 1 as compared to their FY 2003 statements.

The many research and development programs in HHS include the following:
FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While FDA's center components conduct scientific studies, FDA does not consider this type of research as "research and development" because it is used to support FDA's regulatory policy and decision-making processes.

The OPD Program was established by the Orphan Drug Act (Public Law 97-414, as amended) with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device, or medical food that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the United States.)

The FDA Research Grants Program is a grants program which is listed as No. 93-103 under the Catalog of Federal Domestic Assistance, whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

Infectious Diseases, Occupational Safety and Health, Health Promotion, and Environmental Health and Injury Prevention were the primary areas where CDC's research and development was invested.

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational and population-based research, behavioral research, and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches; and health services research. NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

ACF, HRSA and AHRQ oversee research and development programs that contribute to a better understanding of how to improve the economic and social well being of families and children so that they lead more healthy and productive lives.

U.S. Department of Health and Human Services
Social Insurance
For the Year Ended September 30, 2005

Medicare, the largest health insurance program in the country, has helped fund medical care for the Nation's aged and disabled for four decades. The recent Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a new prescription drug benefit. A separate Part D account within the SMI trust fund will handle the transactions for this new coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included on pages III.C.4 to III.C.7 of this report.

The required supplementary stewardship information (RSSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

CMS' RSSI material is generally drawn from the *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Printed copies of the Trustees Report may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from www.cms.hhs.gov/publications/ trusteesreport/default.asp.

Actuarial Projections

Cashflow in Nominal Dollars

Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

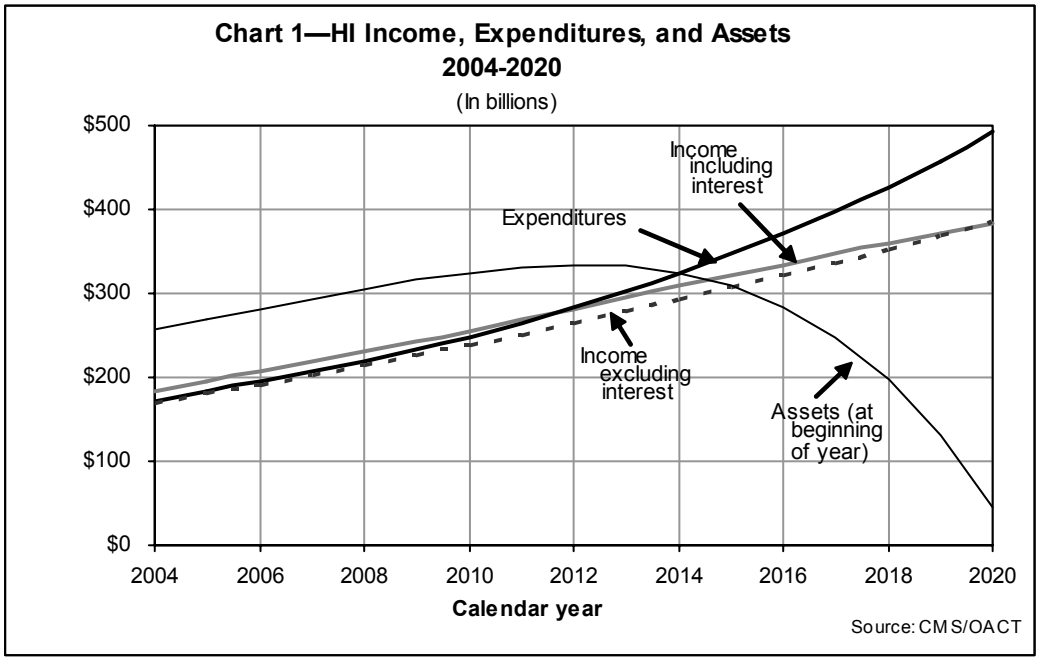
For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2020. Estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the next 16 years, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the trust fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the "open group" population—all persons who will participate during the period as either HI taxpayers or beneficiaries, or both—and consist of payments from, and

[1] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 16 years. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.



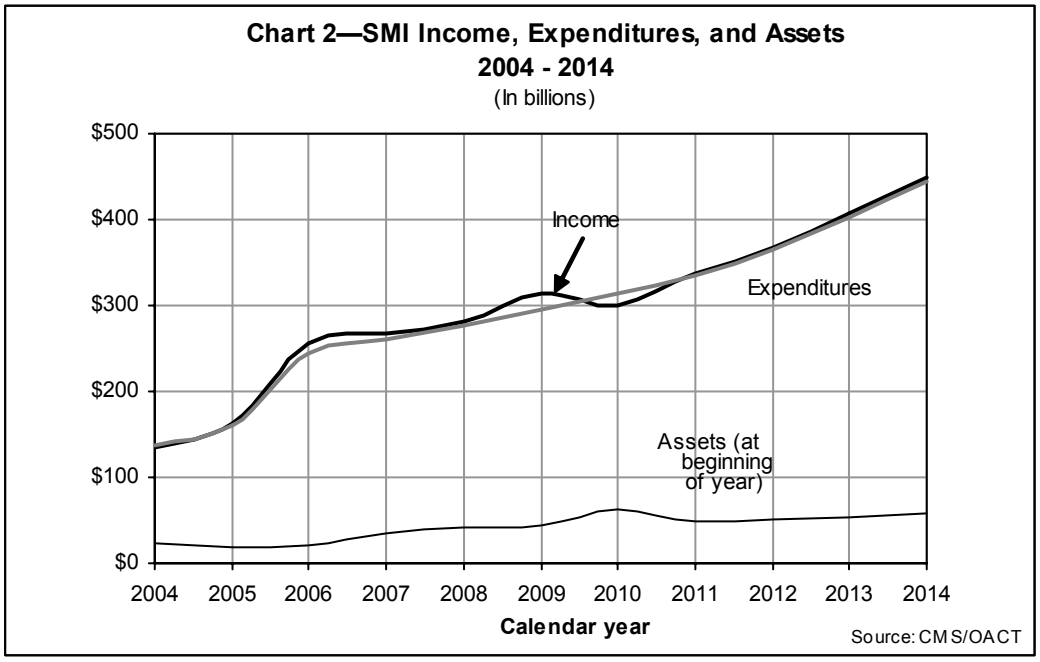
As Chart 1 shows, HI expenditures exceeded income excluding interest in 2004 and, under the intermediate assumptions, would begin to exceed income including interest in 2012. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2012, the trust fund would start redeeming trust fund assets; by the end of 2020, the assets would be depleted—1 year later than estimated in the 2004 Trustees Report. For the second year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

The projected year of depletion of the trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

By law, Medicare trust fund assets are invested in special U.S. Treasury Securities, which earn interest while Treasury uses those cash resources for other Federal purposes. During times of Federal "on-budget" surpluses, this process reduces the Federal debt held by the public. In times of Federal budget deficits, Medicare surpluses reduce the amount that must be borrowed from the public to finance those deficits. The trust fund assets are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing other Federal expenditures. (When the assets are financed by borrowing, the effect is to defer today's costs to later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, represents an important obligation of the government to pay future Medicare benefits but does not necessarily make it easier for the government to pay those benefits.

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2020, SMI estimates cover only the next 10 years, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures.[2] Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in Chart 2, and so are not shown in nominal dollars separately beyond 10 years.[3]



Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, and interest earned on the U.S. Treasury securities held by the trust fund.[4] Chart 2 displays only total income; it does not separately show income excluding

[2] The Part D account also receives special payments from the States, representing a portion of their forgone Medicaid expenditures attributable to the new Medicare drug benefit.

[3] Delivery of benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. Consequently, the Part B premiums withheld from the checks and the associated general revenue contributions are expected to be added to the Part B account on December 31, 2009. These amounts are excluded from the premium income and general revenue income for 2010.

[4] In the financial statements for CMS, Medicare income and expenditures are shown from a "trust fund perspective." All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual *Financial Report of the United States Government*, also known as the government-wide consolidated financial statement. On a consolidated basis, the estimates are shown from a "Federal budget perspective." In particular, certain categories of trust fund income—primarily interest payments and SMI general revenues—are excluded because they represent intragovernmental transfers, rather than revenues received from the public. Thus, the consolidated financial statement focuses not on the financial status of individual trust funds, but on the overall balance between revenues and outlays for the Federal budget. Each perspective is appropriate and useful for its intended purpose.

interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[5] Expenditures include benefit payments as well as administrative expenses.

As Chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.

It should be noted that the projected Part B expenditure and income growth is unrealistically low, due to the structure of physician payment updates under current law. This structure will result in multiple years of significant reductions in physician payments per service, though such reductions are very unlikely to occur before legislative changes intervene. But since these reductions are required under the current law payment system, they are reflected in this report. Consequently, the current law Part B projections shown are very likely to understate actual future expenditures in 2006 and later. Nevertheless, because of the financing mechanism for Part B, its income and expenditures will still be equivalent.[6]

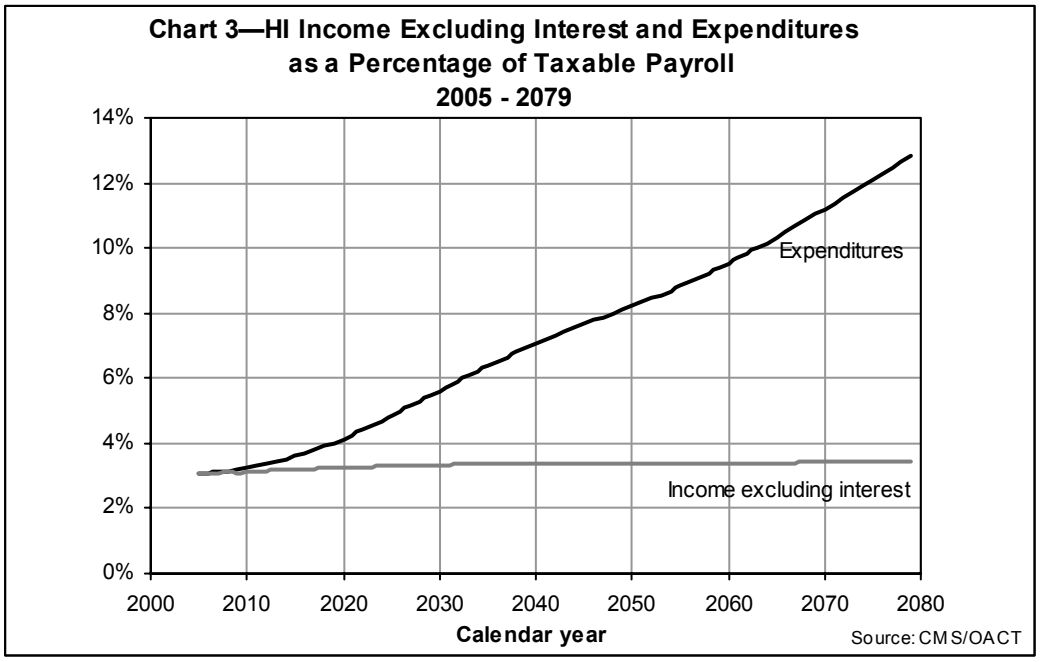
In addition to the inherent variability that underlies the cost projections prepared for all parts of Medicare, the Part D projections have an added uncertainty in that they were prepared for a new benefit, so there is no current program experience upon which to base the estimates. Accordingly, there is a very substantial level of uncertainty surrounding these cost projections.

HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because of the difficulty in meaningfully comparing dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as "taxable payroll").

Chart 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The long-range increase in average expenditures per beneficiary is assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point—reflecting an expectation that the impact of advances in medical technology on health care costs will continue, both in Medicare and in the health sector as a whole.

[5] Interest income is generally about 1 percent of total SMI income.
[6] Source: *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.*



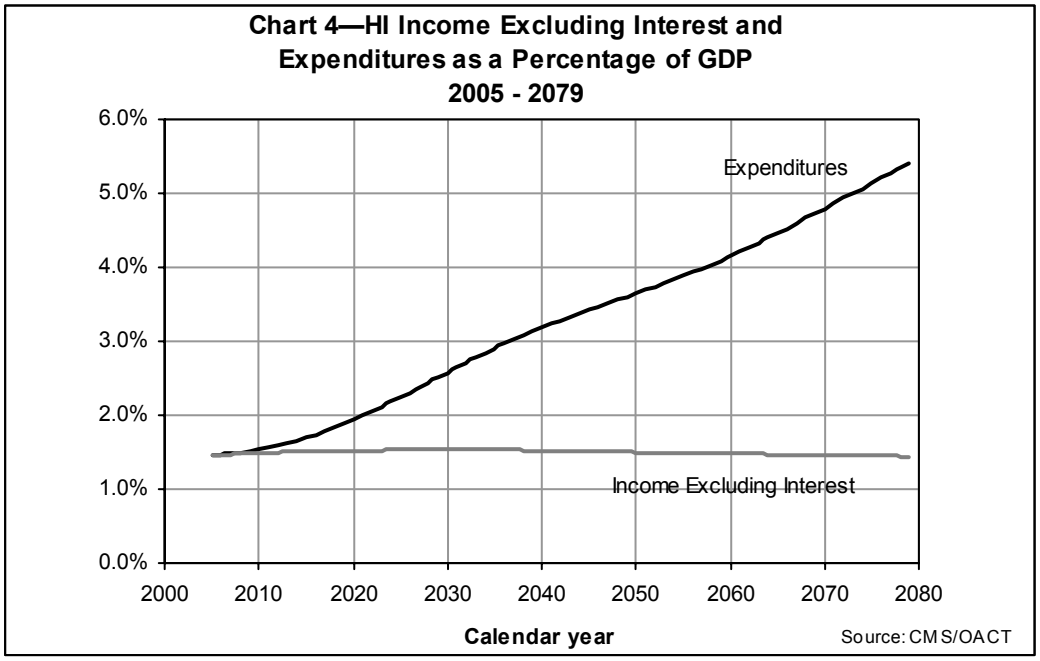
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as Chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.

HI and SMI Cashflow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2004, the expenditures were $170.6 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.

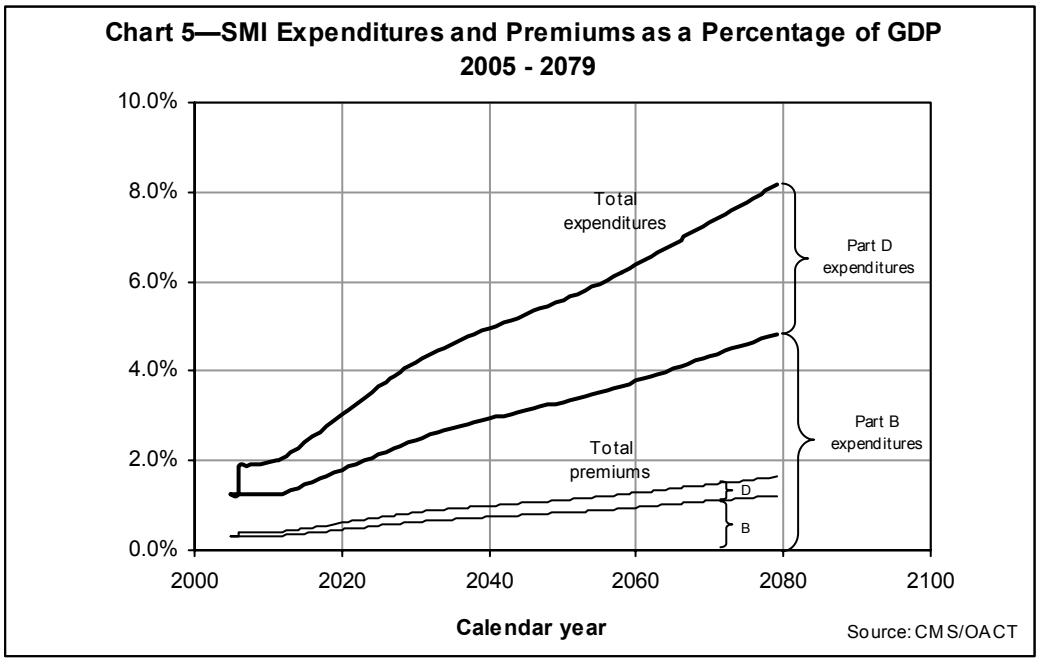


SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the long-range increase in average expenditures per beneficiary is assumed to equal growth in per capita GDP plus 1 percentage point. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures would grow from about 1.2 percent of GDP in 2004 to 1.9 percent of GDP in 2006 with the commencement of the full prescription drug coverage. Then, within 25 years, they would grow to 4 percent of GDP and to more than 8 percent by the end of the projection period.

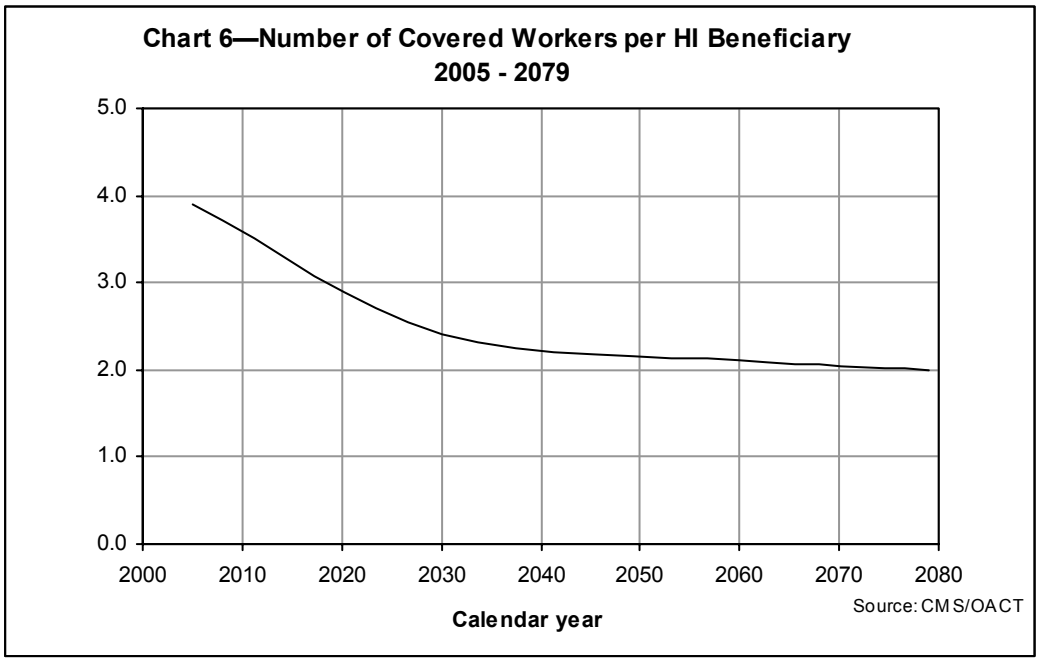


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special state payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the new Medicare drug benefit. The percentage is 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2004, every beneficiary had almost 4.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary in about 2055 and later.



Actuarial Present Values

Projected future expenditures can be summarized by computing an "actuarial present value." This value represents the lump-sum amount that, if invested today in trust fund securities, would be just sufficient to pay each year's expenditures over the next 75 years, with the fund being drawn down to zero at the end of the period. Similarly, future revenues (excluding interest) can be summarized as a single, equivalent amount as of the current year.

Actuarial present values are calculated by discounting the future annual amounts of non-interest income and expenditures at the assumed rates of interest credited to the HI and SMI trust funds. Present values are computed as of the beginning of the 75-year projection period for three different groups of participants: current workers and other individuals who have not yet attained eligibility age; current beneficiaries who have attained eligibility age; and new entrants, or those who are expected to become participants in the future.

Table 1 sets forth, for each of these three groups, the actuarial present values of all future HI (Part A) and SMI (Part B and Part D) expenditures and all future non-interest income for the next 75 years. Also shown is the net present value of cashflow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. Present values are shown (where available) based on each of the last five Trustees Reports. For each year shown, the present values are calculated as of January 1 of that year.

Table 1—Actuarial Present Values of Hospital Insurance and Supplementary Medical Insurance Revenues and Expenditures: 75-year Projection as of January 1, 2005 and prior base years

(In billions)

	HI					SMI[2] Part B					SMI[2] Part D				
	2005	2004	2003	2002	2001	2005	2004	2003	2002	2001	2005	2004	2003	2002	2001
Actuarial present value[1] of estimated future income (excluding interest) received from or on behalf of:															
Current participants[3] who, at start of projection period:															
Have not yet attained eligibility age (ages 15-64)	$5,064	$4,820	$4,510	$4,408	$4,136	$11,477	$10,505	$8,796	$7,423	$7,378	$7,895	$7,545	—	—	—
Have attained eligibility age (age 65 and over)	162	148	128	125	113	1,436	1,310	1,160	1,008	1,032	817	713	—	—	—
Those expected to become participants (under age 15)	4,209	4,009	3,773	3,753	3,507	3,658	3,514	2,817	2,402	2,370	2,522	2,511	—	—	—
All current and future participants	9,435	8,976	8,411	8,286	7,757	16,571	15,329	12,773	10,833	10,780	11,233	10,770	—	—	—
Actuarial present value[1] of estimated future expenditures[4] paid to or on behalf of:															
Current participants[3] who, at start of projection period:															
Have not yet attained eligibility age (ages 15-64)	12,668	12,054	10,028	9,195	8,568	11,541	10,577	8,845	7,463	7,415	7,913	7,566	—	—	—
Have attained eligibility age (age 65 and over)	2,179	2,168	1,897	1,747	1,693	1,622	1,475	1,306	1,132	1,159	880	773	—	—	—
Those expected to become participants (under age 15)	3,417	3,246	2,653	2,470	2,225	3,408	3,277	2,622	2,238	2,206	2,440	2,431	—	—	—
All current and future participants	18,264	17,468	14,577	13,412	12,487	16,571	15,329	12,773	10,833	10,780	11,233	10,770	—	—	—
Actuarial present value[1] of estimated future income (excluding interest) less expenditures	-8,829	-8,492	-6,166	-5,126	-4,730	0	0	0	0	0	0	0	—	—	—
Trust fund assets at start of period	268	256	235	209	177	19	24	34	41	44	0	0	—	—	—
Assets at start of period plus actuarial present value[1] of estimated future income (excluding interest) less expenditures	-8,561	-8,236	-5,931	-4,917	-4,553	19	24	34	41	44	0	0	—	—	—
HI actuarial present value of estimated future taxable payroll	286,019	272,352	256,370	254,065	240,971	n/a	n/a	n/a	n/a	n/a	n/a	n/a	—	—	—
Assets plus actuarial present value of future income less expenditures as a percent of future taxable payroll (HI "actuarial balance")	3.09%	3.12%	2.40%	2.02%	1.97%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	—	—	—

[1] Present values are computed on the basis of the intermediate set of economic and demographic assumptions specified in the Report of the Boards of Trustees for the year shown and over the 75-year projection period beginning January 1 of that year.

[2] SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from state governments are also included as income for Part D of SMI. See footnote 4 on page III.C.6 concerning treatment of SMI general revenues in the consolidated financial statement of the U.S. Government.

[3] Current participants are the "closed group" of individuals age 15 and over at the start of each period, although not all those older than 15 have yet participated. The projection period consists of 75 years, a period that covers most of the participants' working and retirement years. As a practical matter, the present values of future income and expenditures from/for current participants beyond 75 years are not material to this calculation. The projection period for new entrants covers the next 75 years.

[4] Expenditures include benefit payments and administrative expenses.

Note: Totals do not necessarily equal the sums of rounded components.

As shown in table 1, the HI trust fund has an actuarial deficit[7] of almost $8.6 trillion over the 75-year projection period, as compared to about $8.2 trillion in the CMS 2004 Financial Report. On the other hand, neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its financing mechanism.[8]

The existence of a large actuarial deficit for the HI trust fund indicates that, under reasonable assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures in the long range. Although the deficits are not anticipated in the immediate future, as indicated by the preceding cashflow projections, they nonetheless pose a serious financial problem for the HI trust fund.

A figure as large as $8.6 trillion can be difficult to interpret without some relative basis of comparison. To put this number in perspective, it is helpful to consider that the present value of future taxable payroll over the same 75-year period is estimated to be $286 trillion in the 2005 Trustees Report. Thus, the $8.6-trillion deficit represents approximately 3.0 percent of future taxable payroll.

As indicated in Table 1, there has been substantial growth in the present values from one valuation period to the next. Much of this growth, however, is attributable to using a new valuation period each year.[9] The remainder reflects any changes in assumptions, methods, and/or base-year data that have been incorporated into the estimates. The impact of the changing valuation period can be largely eliminated by using the relative estimates. As indicated in the table, the 75-year actuarial deficit has increased from 1.97 percent of taxable payroll in the 2001 Trustees Report to 3.09 percent in the most recent report.

It is important to note that no liability has been recognized on the balance sheet for future payments to be made to current and future program participants beyond the existing "incurred but not reported" Medicare claim amounts as of September 30, 2005. This is because Medicare is accounted for as a social insurance program rather than a pension program. Accounting for a social insurance program recognizes the expense of benefits when they are actually paid, or are due to be paid, because benefit payments are primarily non-exchange transactions and, unlike employer-sponsored pension benefits for employees, are not considered deferred compensation. Accrual accounting for a pension program, by contrast, recognizes retirement benefit expenses as they are earned so that the full actuarial present value of the worker's expected retirement benefits has been recognized by the time the worker retires.

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[7] Present value of estimated future income less expenditures, calculated over the 75-year projection period, plus start-of-period assets.

[8] As noted in footnote 4 on page III.C.6, the actuarial deficit is calculated from a *trust fund perspective*, reflecting all sources of income and expenditures to or from the HI and SMI trust funds. If, instead, a *budget perspective* is considered, as used in the consolidated financial statement, one would compare Medicare outlays to the public with revenues received directly from the public and state governments. On this basis, transfers to the SMI trust fund from the general fund of the Treasury would be excluded, with the result that the present value of projected SMI expenditures through 2079 would exceed the present value of projected SMI premium and state transfer revenue by $21.1 trillion. When added to the corresponding differential for HI, the present value of expenditures for the Medicare program overall is projected to exceed non-general revenue receipts by $30.0 trillion. This theoretical *budget impact* reflects both (i) the cost to the Federal budget of SMI general revenues provided under current law and (ii) the amount that HI revenues would have to be increased to enable HI benefits to be paid at their currently scheduled level—for which there is no provision in current law.

[9] The present values of income and expenditures, from one valuation period to the next, tend to increase by the growth in average wages and benefits, respectively. The present value of income less expenditures tends to increase by the interest rate plus the addition of a new 75th year difference between income and expenditures.

Actuarial Assumptions and Sensitivity Analysis

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that the trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions, including changes in per beneficiary cost, wages and the consumer price index (CPI), fertility rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period.

Table 2 shows the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. Further details on these assumptions are available in the Social Security and Medicare Trustees Reports for 2005. In practice, a number of specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The per beneficiary cost increases displayed in Table 2 reflect the overall impact of these more detailed assumptions.

Table 2—Medicare Assumptions

	Fertility rate[1]	Net immigration	Real-wage differential[2]	Annual percentage change in: Wages	CPI	Real GDP	Per beneficiary cost[3] HI	SMI B	SMI D	Real-interest rate[4]
2005	2.02	1,075,000	2.1	4.2	2.2	3.6	5.4	6.6	—	2.0
2010	2.01	1,000,000	1.3	4.1	2.8	2.5	4.3	3.2	7.0	2.9
2020	1.98	950,000	1.1	3.9	2.8	1.9	4.3	5.4	6.5	3.0
2030	1.95	900,000	1.1	3.9	2.8	1.8	5.5	5.2	4.9	3.0
2040	1.95	900,000	1.1	3.9	2.8	1.9	5.7	5.2	5.1	3.0
2050	1.95	900,000	1.1	3.9	2.8	1.8	5.1	5.0	5.1	3.0
2060	1.95	900,000	1.1	3.9	2.8	1.8	5.2	5.2	5.1	3.0
2070	1.95	900,000	1.1	3.9	2.8	1.8	5.3	5.1	5.1	3.0
2079	1.95	900,000	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0

[1]Average number of children per woman.
[2]Difference between percentage increases in wages and the consumer price index.
[3]See text for nature of this assumption.
[4]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

Estimates made in prior years have sometimes changed substantially because of revisions to the assumptions, which are due either to changed conditions or to more information. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty. In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.[10] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, CPI, and real-interest rate.[11]

For this analysis, the intermediate economic and demographic assumptions in the *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2005 and are based on estimates of income and expenditures during the 75-year projection period.
Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2020 under all three scenarios displayed. On the present value charts, the same pattern is evident, though the magnitudes are lower because of the discounting process used for computing present values.

[10] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

[11] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

Health Care Cost Factors

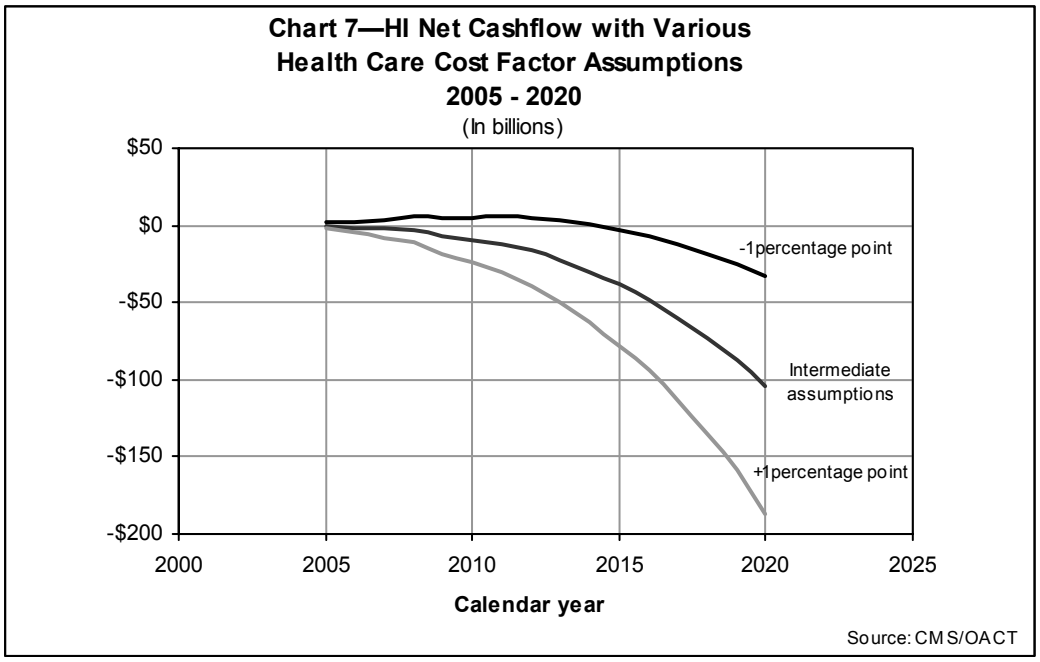
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

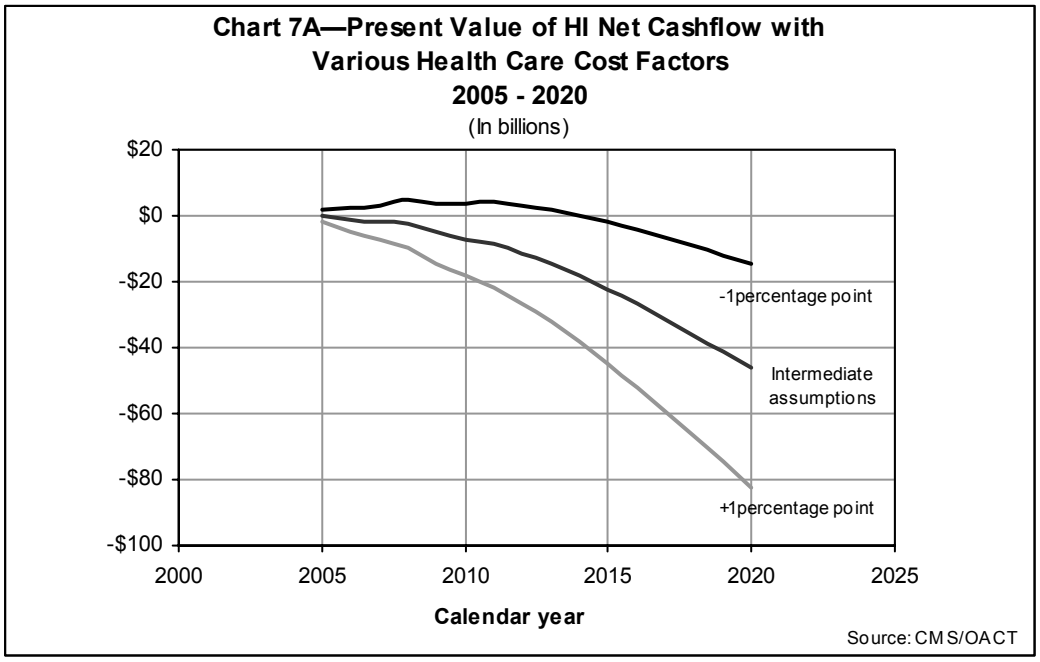
Table 3—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	-$3,140	-$8,829	-$18,113

Table 3 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income versus expenditures decreases by $5,689 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $9,284 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in Table 3.





This assumption has a dramatic impact on projected HI cashflow. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Charts 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Fertility Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 1.95, and 2.2 children per woman.

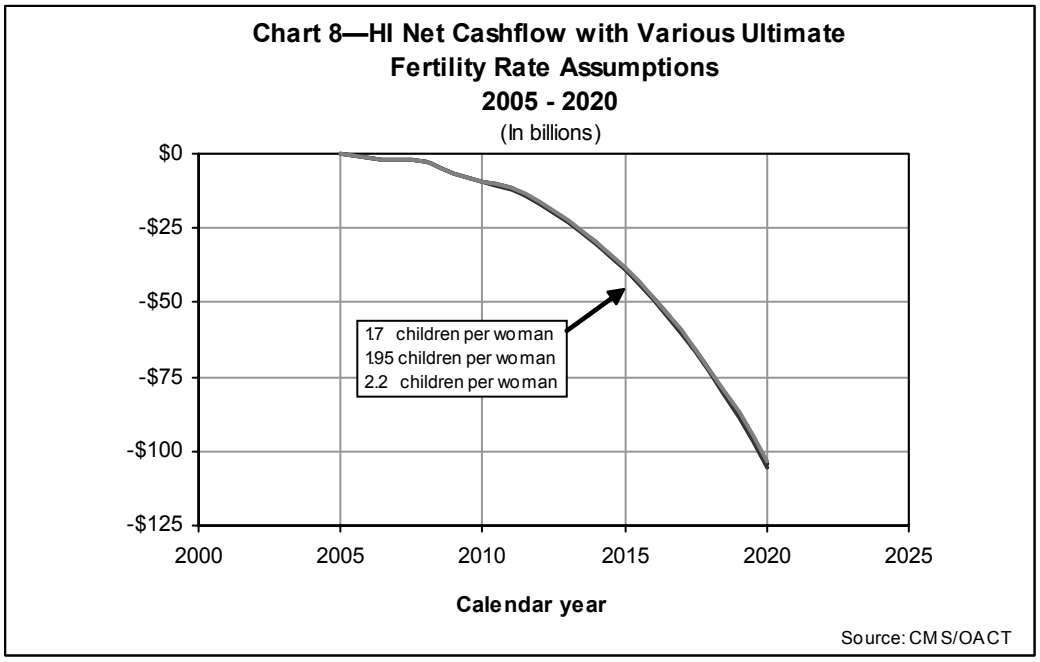
Table 4—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

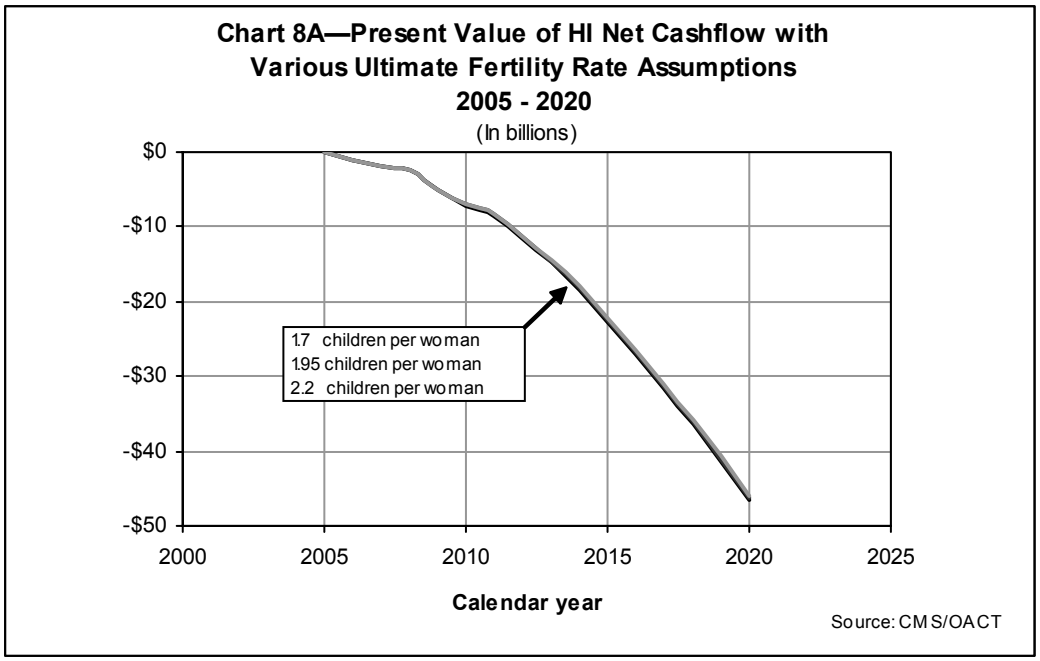
Ultimate fertility rate[1]	1.7	1.95	2.2
Income minus expenditures (in billions)	-$8,978	-$8,829	-$8,677

[1]The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 4 demonstrates, for an increase of 0.25 in the assumed ultimate fertility rate, the projected deficit decreases by approximately $150 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative fertility rate assumptions presented in Table 4.





As Charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows over the next 16 years. In fact, higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the impacts are expected to be somewhat greater, as illustrated by the present values in Table 4.

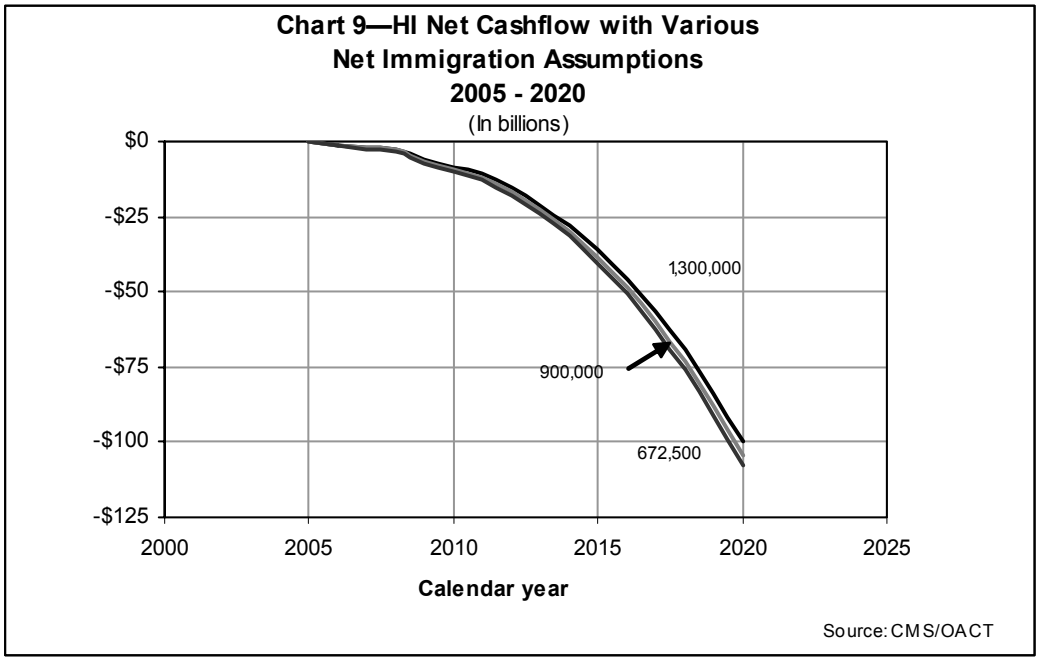
Net Immigration

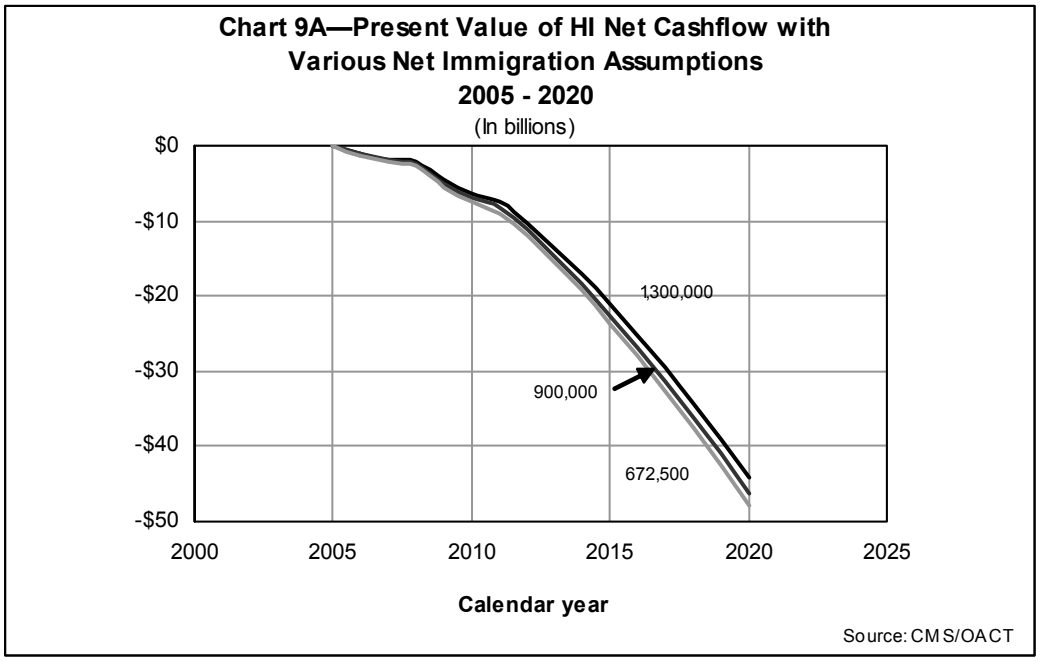
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

Table 5—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions			
Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures (in billions)	-$8,734	-$8,829	-$8,982

As shown in table 5, if the ultimate net immigration assumption is 672,500 persons, the deficit of income versus expenditures decreases by $95 billion. Similarly, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by $153 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 5.





As Charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

Real-Wage Differential

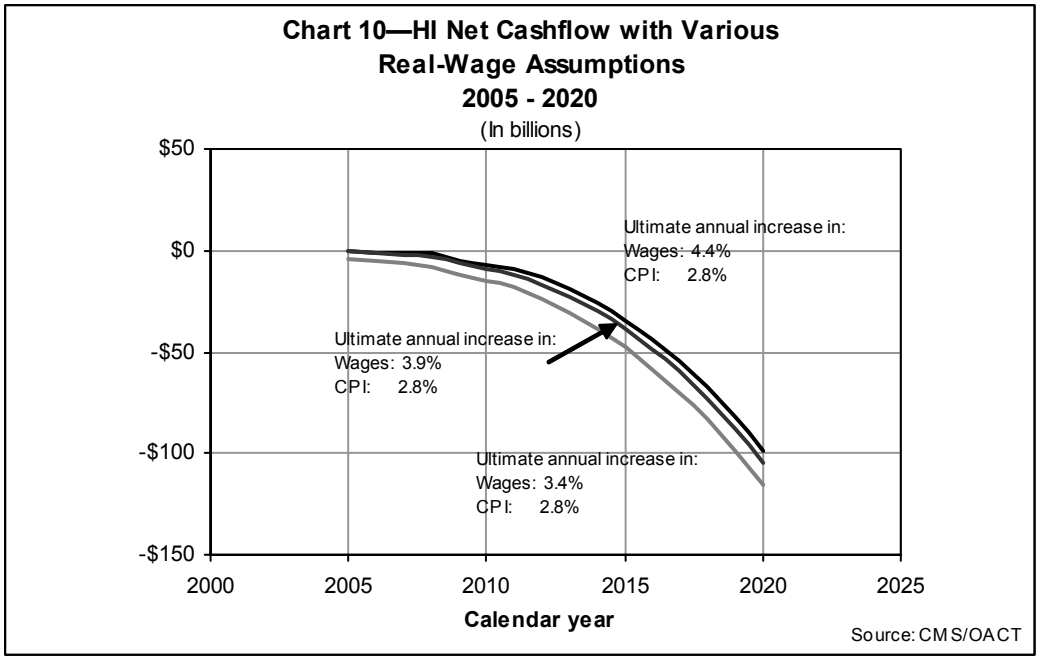
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[12] assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

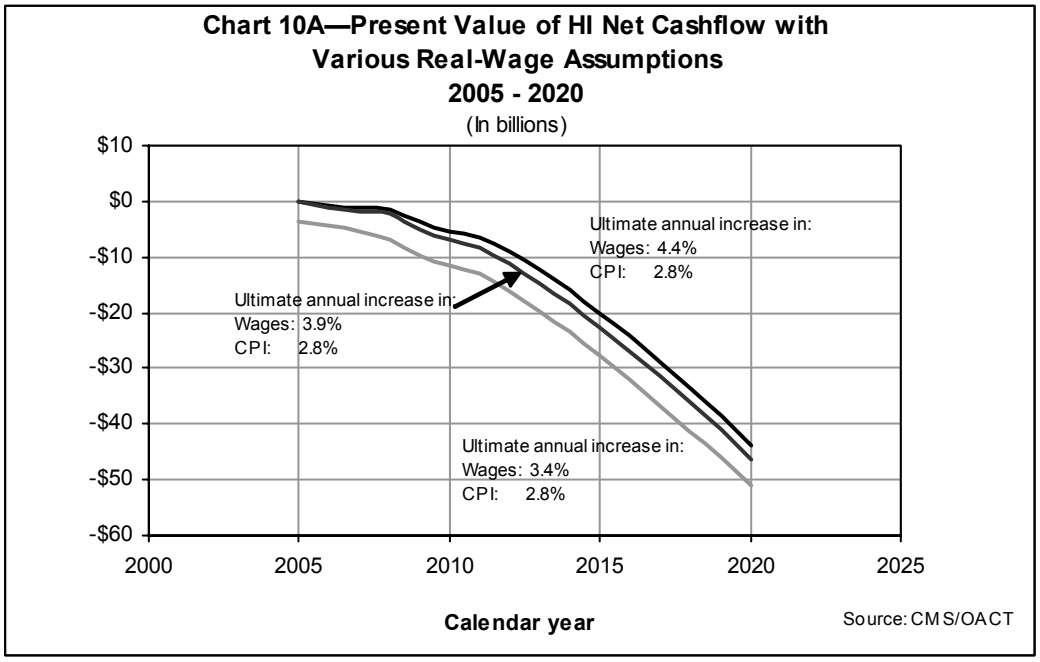
Table 6—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions			
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 -2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures (in billions)	-$8,303	-$8,829	-$9,531

As indicated in Table 6, for a half-point increase in the ultimate real-wage differential assumption, the deficit decreases by approximately $600 billion.

Charts 10 and 10A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in Table 6.

[12] The difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.





As Charts 10 and 10A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related.

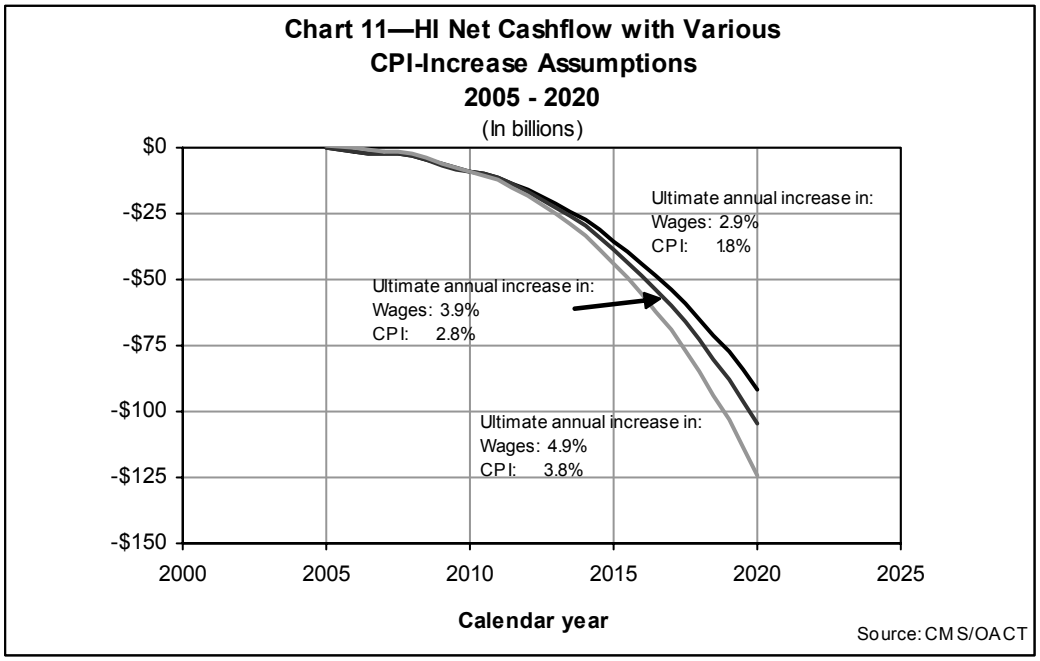
Consumer Price Index

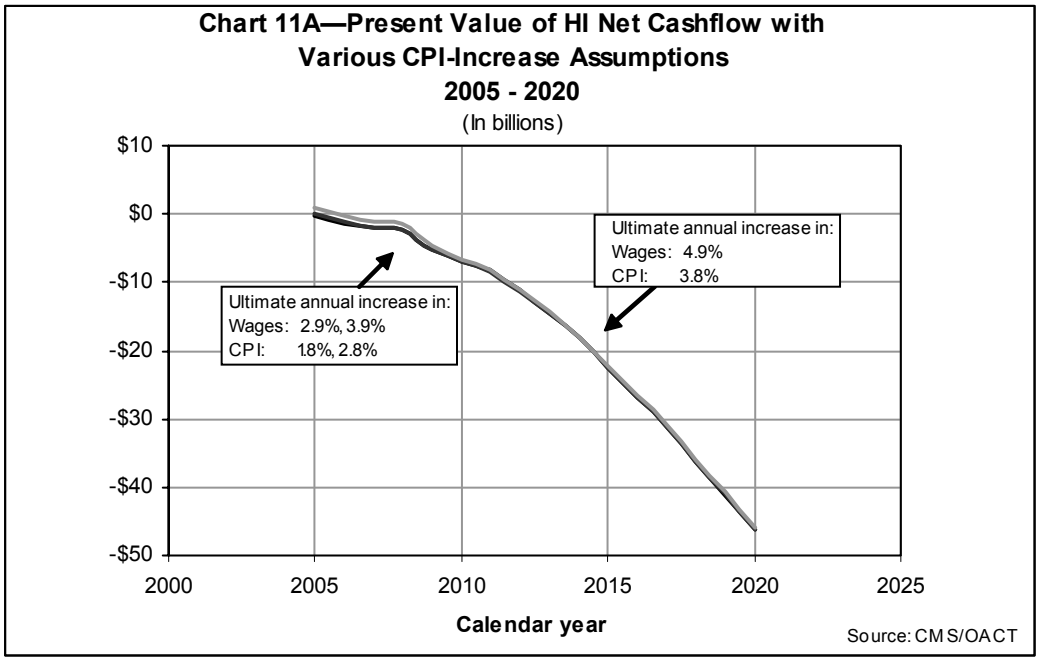
Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

Table 7—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions			
Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-$8,863	-$8,829	-$8,751

Table 7 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $34 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $78 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in Table 7.





As Charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In nominal dollars, however, a given deficit "looks bigger" under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

Real-Interest Rate

Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 5.0, 5.8, and 6.5 percent, respectively.

Table 8—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

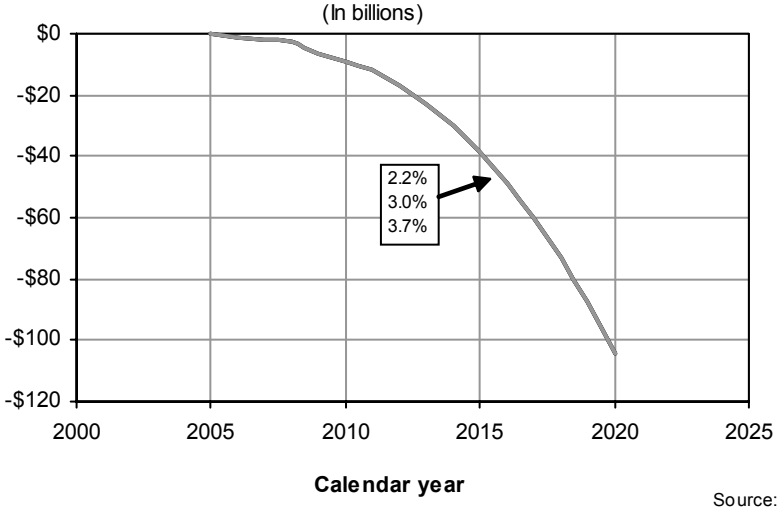
Ultimate real-interest rate	2.2 percent	3.0 percent	3.7 percent
Income minus expenditures (in billions)	-$12,075	-$8,829	-$6,544

As illustrated in Table 8, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $370 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 8.

Chart 12—HI Net Cashflow with Various Real-Interest Rate Assumptions 2005 - 2020

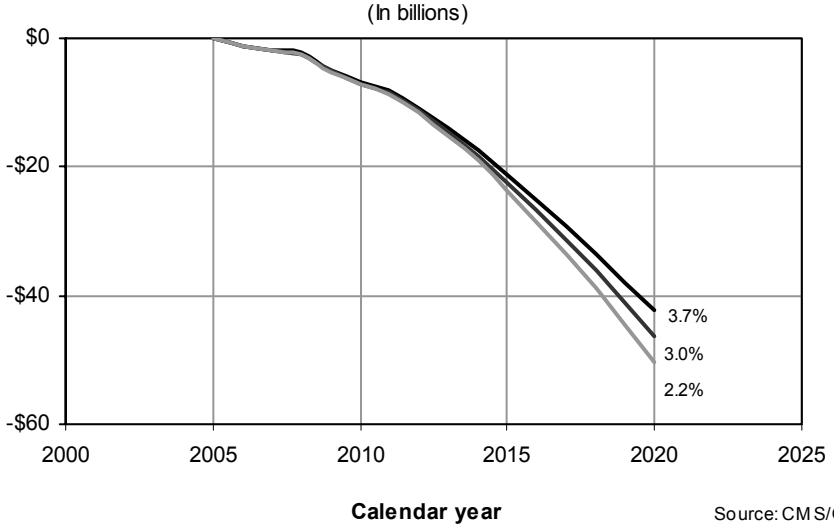
(In billions)



Source: CMS/OACT

Chart 12A—Present Value of HI Net Cashflow with Various Real-Interest Rate Assumptions 2005 - 2020

(In billions)



Source: CMS/OACT

As shown in Charts 12 and 12A, the present values of the net cashflow are more sensitive to the interest assumption than is the nominal net cashflow. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2020. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2020, 1 year later than in last year's report, due primarily to slightly higher income and slightly lower costs in 2004 than previously estimated. Despite the slight improvement, income from all sources is projected to continue to exceed expenditures for only the next 7 years and to fall short by steadily increasing amounts in 2012 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those assets, thereby adding to the draw on the Federal budget. In the absence of corrective legislation, a depleted trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries.

The HI trust fund is substantially out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require very substantial increases in revenues and/or reductions in benefits. These changes are needed in part as a result of the impending retirement of the baby boom generation.

SMI

Under current law, the SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. Because there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2005 is estimated to be sufficient to cover expenditures for that year but not to increase assets to a more adequate contingency reserve. The Part B premium and corresponding general revenue transfers will need to be increased sharply for 2006 to match projected costs and to restore Part B assets to a more adequate reserve level.

The operations of the Part D account in 2005 relate only to the transitional assistance benefit for low-income beneficiaries. No financial imbalance is anticipated, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. Potential variations in Part D costs in 2006 and later are expected to be handled through a flexible general revenue appropriations process, eliminating the need for a significant Part D contingency reserve.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. However, a critical issue for the trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily increasing demands on beneficiaries, the Federal budget, and society at large.

Medicare Overall

The projections shown in this section continue to demonstrate the need for timely and effective action to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. In its 2005 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the Nation's policy makers to take "prompt, effective, and decisive action . . . to address these challenges." It also stated: "Consideration of such reforms should occur in the relatively near future

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U.S. Department of Health and Human Services
Combining Statement of Budgetary Resources
For the Year Ended September 30, 2005
(In Millions)

	CMS			Other Agency	Agency Combined
	Medicare HI	Medicare SMI	Medicaid	Budgetary Accounts[1]	Totals
Budgetary Resources:					
1. Budget Authority	$ 197,429	$153,540	$ 178,744	$ 243,417	$ 773,130
2. Unobligated Balances – Beginning of Period	-	-	5,911	13,241	19,152
3. Spending Authority from Offsetting Collections	1	-	315	10,827	11,143
4. Recoveries of prior year obligations	16	26	9,642	1,988	11,672
5. Temporarily not available pursuant to Public Law	(11,175)	25	-	(320)	(11,470)
6. Permanently not available (-)	-	-	(2,600)	(7,185)	(9,785)
7. Total Budgetary Resources	$ 186,271	$ 153,591	$ 192,012	$ 261,968	$ 793,842
Status of Budgetary Resources:					
8. Obligations Incurred	$ 186,271	$ 153,591	$ 191,695	$ 244,078	$ 775,635
9. Unobligated Balances - Available	-	-	-	12,362	12,362
10. Unobligated Balances - Not Available	-	-	317	5,528	5,845
11. Total Status of Budgetary Resources	$ 186,271	$ 153,591	$ 192,012	$ 261,968	$ 793,842
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net – Beginning of Period	$ 16,090	$ 15,979	$ 9,315	$ 72,184	$ 113,568
13. Obligated Balance Transferred, Net (+/-)	-	-	-	-	-
14. Obligated Balance, Net – End of Period	17,733	17,580	10,635	72,120	118,068
15. Outlays	184,611	151,964	180,418	231,327	748,320
16. Less: Offsetting receipts	13,597	152,133	-	1,296	167,026
17. Net Outlays	$ 171,014	$ (169)	$ 180,418	$ 230,031	$ 581,294

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 58,373	$ 58,373	$ 45,239
AoA	1,400	1,400	1,386
AHRQ	361	361	16
CDC	7,138	7,138	5,895
CMS	138,643	138,643	133,032
FDA	2,112	2,112	1,316
HRSA	7,533	7,533	6,849
IHS	5,431	5,431	3,050
NIH	31,723	31,723	27,112
OS	4,656	4,656	2,653
PSC	948	948	304
SAMHSA	3,650	3,650	3,179
	$ 261,968	$ 261,968	$ 230,031

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the eleven HHS Agencies other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid.

U.S. Department of Health and Human Services
Condensed Balance Sheet
Franchise and Intra-Governmental Support Revolving Funds
As of September 30, 2005
(In Millions)

	HHS Service and Supply Fund	NIH Service and Supply Fund	Combined Totals
Assets			
Fund Balance with Treasury	$ 71	$ 371	$ 442
Accounts Receivable, Net	154	3	157
Property, Plant and Equip, Net	14	159	173
Other Assets	10	10	20
Total Assets	$ 249	$ 543	$ 792
Liabilities			
Accounts Payable	$ 82	$ 96	$ 178
Other Liabilities	16	304	320
Total Liabilities	$ 98	$ 400	$ 498
Net Position			
Cumulative Results of Operations	$ 151	$ 143	$ 294
Total Liabilities and Net Position	$ 249	$ 543	$ 792

U.S. Department of Health and Human Services
Condensed Statement of Net Cost
Franchise and Intra-Governmental Support Revolving Funds
For the Year Ended September 30, 2005
(In Millions)

Program/Business Line	Gross Costs	Less: Earned Revenue	Net Costs
HHS Service and Supply Fund			
Administrative Operations Services	$ 100	$ (106)	$ (6)
Financial Management Service	47	(54)	(7)
Human Resources Service	54	(50)	4
Federal Occupational Health	192	(185)	7
Strategic Acquisitions Services	79	(58)	21
Human Resource Centers	46	(49)	(3)
Total	$ 518	$ (502)	$ 16
NIH Service and Supply Fund			
Research Support	$ 938	$ (921)	$ 17
Total	$ 938	$ (921)	$ 17

The Program Support Center (PSC), a component of the Office of the Secretary, manages the HHS Service and Supply Fund. The PSC provides support services to federal agencies on a competitive, "service-for-fee" basis. Services and products are available in the areas of Acquisitions, Finance, Medical Supply Operation, Health Services, Personnel and Payroll and Support Services. Major customers are other HHS Operating Divisions and components of many federal agencies including Departments of Defense, Education, Housing and Urban Development, Interior, Energy, Labor, State, Transportation, Treasury and other independent federal organizations.

The NIH Research Support provides administrative services, which include facilities management, supply stores, printing and reproduction, medical arts and photography, procurement, and a wide range of other research support services. The Information Technology (IT) reported under Research Support includes the regional data processing center, which sells computing services and programming services and enterprise IT software development. Instrumentation Services reported under Research Support include biomedical fabrication and instrumentation activities which entails creating highly technical bioengineering structures. The Animal Services reported under Research Support entails purchasing, housing and feeding animals used in research. Major customers of NIH are the Research Institutes and Centers and for computer services, the Department of Defense.

U.S. Department of Health and Human Services
Deferred Maintenance
For the Years Ended September 30, 2005 and 2004

Deferred maintenance is maintenance that was not performed when it should have been, was scheduled and not performed, or was delayed for a future period. Maintenance is the act of keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components and other activities needed to preserve the asset so that it continues to provide acceptable services and achieves its expected life. Maintenance does not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance expense is recognized as incurred. The Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration all use the condition assessment survey for all classes of property. The Indian Health Service uses two types of surveys to assess installations – annual general inspections and deep look surveys.

Category of Asset	Condition	Cost to Return to Acceptable Condition 2005	2004
General PP&E			
Buildings	2 - 4	$ 961	$ 915
Equipment	2 - 4	8	8
Other Structures	2 - 4	25	37
Total		$ 994	$ 960

Asset Condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A “fair” or 3 rating is considered acceptable operating condition. Although PP&E categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of “fair” or above may still report necessary costs to return them to acceptable condition.

U.S. Department of Health and Human Services
Intragovernmental Transactions - Assets
For the Year Ended September 30, 2005
(In Millions)

Agency	TFM Dept Code	Fund Bal. w/ Treasury	Investments	Accounts Receivable	Other
Dept of Agriculture	12			3	-
Dept of Commerce	13			10	15
Dept of Defense	17,215,797			39	-
Dept of Education	91			3	-
Dept of Energy	89			4	-
Dept of the Interior	14			1	-
Dept of Justice	15			5	-
Dept of Labor	16			1	-
Dept of State	19			2	-
Dept of Transportation	69			1	-
Dept of the Treasury	20	99,638	300,664	3	14,273
Dept of Veterans Affairs	36			159	153
Agency for International Development	72			5	-
Environmental Protection Agency	68			27	-
Dept of Homeland Security	70			9	-
General Services Admin	47			2	-
National Aeronautics & Space Admin	80			2	-
National Science Foundation	49			1	-
Social Security Admin	28			1	-
RRB	60			454	-
All other Federal agencies		-	-	6	-
Total		$ 99,638	$ 300,664	$ 738	$ 14,441

U.S. Department of Health and Human Services
Intragovernmental Transactions - Liabilities
For the Year Ended September 30, 2005
(In Millions)

Agency	TFM Dept Code	Accounts Payable	Accrued Payroll & Benefits	Other
Dept of Commerce	13	2	-	-
Dept of Defense	17,215,797	12	-	87
Dept of Housing & Urban Development	86	-	-	2
Dept of Justice	15	-	-	7
Dept of Labor	16	-	24	-
Dept of the Treasury	20	-	9	485
Dept of Veterans Affairs	36	-	-	4
Environmental Protection Agency	68	-	-	148
Dept of Homeland Security	70	1	-	-
General Services Admin	47	52	-	91
Office of Personnel Mgmt	24	-	36	-
Social Security Admin	28	296	-	-
All other Federal agencies		2	-	168
Total		$ 365	$ 69	$ 992

U.S. Department of Health and Human Services
Intragovernmental Transactions - Revenues & Expenses
For the Year Ended September 30, 2005
(In Millions)

Agency	TFM Dept Code	Earned Revenue	Gross Cost	Non-exchange Revenue	
				Transfers-In	Transfers-Out
Dept of Agriculture	12	9	(11)	-	-
Dept of Commerce	13	16	(104)	-	-
Dept of Defense	17,215,797	305	(239)	-	-
Dept of Education	91	14	(145)	-	-
Dept of Energy	89	29	(72)	-	-
Dept of Housing & Urban Development	86	8	-	-	-
Dept of the Interior	14	4	(170)	-	-
Dept of Justice	15	28	(137)	-	-
Dept of Labor	16	59	(29)	-	-
Dept of State	19	4	(86)	-	-
Dept of Transportation	69	2	(2)	-	-
Dept of the Treasury	20	102	(361)	420	(62)
Dept of Veterans Affairs	36	184	(166)	-	-
Agency for International Development	72	25	(7)	-	-
Environmental Protection Agency	68	23	(6)	-	-
Dept of Homeland Security	70	172	(17)	-	-
General Services Admin	47	6	(707)	-	-
National Aeronautics & Space Admin	80	5	-	-	-
National Science Foundation	49	2	(17)	-	-
Nuclear Regulatory Commission	31	1	-	-	-
Office of Personnel Mgmt	24	-	(1,097)	-	-
Small Business Admin	73	6	(1)	-	-
Social Security Admin	28	13	(53)	3	(1,239)
RRB	60	-	-	477	(7)
All other Federal agencies		68	(108)	-	(10)
Total		$ 1,085	$ (3,535)	$ 900	$ (1,318)

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U.S. Department of Health and Human Services
Consolidating Balance Sheet by Budget Function
As of September 30, 2005
(In Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Admin. of Justice	Natural Resources & Environment	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)									
Intragovernmental									
Fund Balance with Treasury (Note 3)	$ 6,478	$ 68,763	$ 1,669	$ 22,713	$ -	$ 15	$ 99,638	$ -	$ 99,638
Investments, Net (Note 5)	-	2,220	298,444	-	-	-	300,664	-	300,664
Accounts Receivable, Net (Note 6)	14	689	42,150	1	-	-	42,854	(42,116)	738
Anticipated Congressional Appropriation (Note 7)	-	9,099	5,173	-	-	-	14,272	-	14,272
Other (Note 11)	1	538	-	-	-	-	539	(370)	169
Total Intragovernmental	$ 6,493	$ 81,309	$ 347,436	$ 22,714	$ -	$ 15	$ 457,967	$ (42,486)	$ 415,481
Accounts Receivable, Net (Note 6)	-	289	1,814	-	-	-	2,103	-	2,103
Loans Receivable and Foreclosed Property (Note 8)	-	379	-	-	-	-	379	-	379
Cash and Other Monetary Assets (Note 4)	-	-	204	-	-	-	204	-	204
Inventory and Related Property, Net (Note 9)	-	1,614	-	-	-	-	1,614	-	1,614
General Property, Plant & Equipment, Net (Note 10)	4	4,187	366	-	-	-	4,557	-	4,557
Other (Note 11)	-	(17)	4,166	-	-	-	4,149	-	4,149
Total Assets	**$ 6,497**	**$ 87,761**	**$ 353,986**	**$ 22,714**	**$ -**	**$ 15**	**$ 470,973**	**$ (42,486)**	**$ 428,487**
Liabilities (Note 12)									
Intragovernmental									
Accounts Payable	$ 11	$ 200	$ 42,178	$ 4	$ -	$ -	$ 42,393	$ (42,028)	$ 365
Accrued Payroll and Benefits	1	64	4	-	-	-	69	-	69
Other (Note 16)	-	1,042	408	-	-	-	1,450	(458)	992
Total Intragovernmental	$ 12	$ 1,306	$ 42,590	$ 4	$ -	$ -	$ 43,912	$ (42,486)	$ 1,426
Accounts Payable	17	703	-	12	-	-	732	-	732
Entitlement Benefits Due and Payable (Note 13)	-	20,355	33,399	-	-	-	53,754	-	53,754
Accrued Grant Liability (Note 15)	750	2,254	-	777	-	2	3,783	-	3,783
Loan Guarantees Liability (Note 8)	-	158	-	-	-	-	158	-	158
Federal Employee and Veterans Benefits (Note 14)	4	7,170	9	-	-	-	7,183	-	7,183
Accrued Payroll and Benefits	16	718	49	2	-	-	785	-	785
Other (Note 16)	-	1,207	1,919	13	-	(1)	3,138	-	3,138
Total Liabilities	**$ 799**	**$ 33,871**	**$ 77,966**	**$ 808**	**$ -**	**$ 1**	**$ 113,445**	**$ (42,486)**	**$ 70,959**
Net Position									
Unexpended Appropriations	5,710	52,858	6,873	21,909	-	-	87,350	-	87,350
Cumulative Results of Operations	(12)	1,032	269,147	(3)	-	14	270,178	-	270,178
Total Net Position	$ 5,698	$ 53,890	$ 276,020	$ 21,906	$ -	$ 14	$ 357,528	$ -	$ 357,528
Total Liabilities and Net Position	**$ 6,497**	**$ 87,761**	**$ 353,986**	**$ 22,714**	**$ -**	**$ 15**	**$ 470,973**	**$ (42,486)**	**$ 428,487**

U.S. Department of Health and Human Services
Consolidating Balance Sheet by Operating Division
As of September 30, 2005
(In Millions)

	ACF	AoA	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Consolidated Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intragovernmental															
Fund Balance with Treasury (Note 3)	$ 28,624	$ 567	$ 66	$ 4,859	$ 20,789	$ 779	$ 5,923	$ 1,491	$ 29,938	$ 3,821	$ 132	$ 2,649	$ 99,638	$ -	$ 99,638
Investments, Net (Note 5)	-	-	-	-	298,444	-	2,202	-	18	-	-	-	300,664	-	300,664
Accounts Receivable, Net (Note 6)	15	-	18	16	454	15	25	26	4	233	151	13	970	(232)	738
Anticipated Congressional Appropriation (Note 7)	-	-	-	-	14,272	-	-	-	-	-	-	-	14,272	-	14,272
Other (Note 11)	1	-	-	77	-	-	1	2	-	91	-	1	173	(4)	169
Total Intragovernmental	28,640	567	84	4,952	333,959	794	8,151	1,519	29,960	4,145	283	2,663	415,717	(236)	415,481
Accounts Receivable, Net (Note 6)	-	-	-	6	1,884	75	1	117	11	1	6	2	2,103	-	2,103
Loans Receivable and Foreclosed Property (Note 8)	-	-	-	-	-	-	379	-	-	-	-	-	379	-	379
Cash and Other Monetary Assets (Note 4)	-	-	-	-	204	-	-	-	-	-	-	-	204	-	204
Inventory and Related Property, Net (Note 9)	-	-	-	175	-	-	-	6	8	1,415	10	-	1,614	-	1,614
General Property, Plant & Equipment, Net (Note 10)	4	-	1	861	392	332	2	818	2,055	78	14	-	4,557	-	4,557
Other (Note 11)	-	-	-	1	4,201	-	-	-	2	(55)	-	-	4,149	-	4,149
Total Assets	**$ 28,644**	**$ 567**	**$ 85**	**$ 5,995**	**$ 340,640**	**$ 1,201**	**$ 8,533**	**$ 2,460**	**$ 32,036**	**$ 5,584**	**$ 313**	**$ 2,665**	**$ 428,723**	**$ (236)**	**$ 428,487**
Liabilities (Note 12)															
Intragovernmental															
Accounts Payable	$ 14	$ 1	$ 3	$ 1	$ 324	$ 12	$ 59	$ 17	$ 12	$ 44	$ 8	$ 14	$ 509	$ (144)	$ 365
Accrued Payroll and Benefits	1	-	-	11	4	11	2	8	26	-	5	1	69	-	69
Other (Note 16)	-	-	40	87	433	75	79	148	100	-	-	122	1,084	(92)	992
Total Intragovernmental	$ 15	$ 1	$ 43	$ 99	$ 761	$ 98	$ 140	$ 173	$ 138	$ 44	$ 13	$ 137	$ 1,662	$ (236)	$ 1,426
Accounts Payable	26	2	14	30	-	8	28	41	419	58	77	29	732	-	732
Entitlement Benefits Due and Payable (Note 13)	-	-	-	-	53,754	-	-	-	-	-	-	-	53,754	-	53,754
Accrued Grant Liability (Note 15)	1,444	83	13	124	-	(3)	394	14	1,564	126	-	24	3,783	-	3,783
Loan Guarantees Liability (Note 8)	-	-	-	-	-	-	158	-	-	-	-	-	158	-	158
Federal Employee and Veterans Benefits (Note 14)	4	-	1	19	10	20	32	79	59	21	6,918	20	7,183	-	7,183
Accrued Payroll and Benefits	17	1	4	75	54	85	29	121	301	62	29	7	785	-	785
Other (Note 16)	13	-	(1)	31	1,926	206	779	112	57	16	-	(1)	3,138	-	3,138
Total Liabilities	**$ 1,519**	**$ 87**	**$ 74**	**$ 378**	**$ 56,505**	**$ 414**	**$ 1,560**	**$ 540**	**$ 2,538**	**$ 327**	**$ 7,037**	**$ 216**	**$ 71,195**	**$ (236)**	**$ 70,959**
Net Position															
Unexpended Appropriations	27,137	482	2	4,717	14,706	145	4,951	1,358	27,435	3,900	38	2,479	87,350	-	87,350
Cumulative Results of Operations	(12)	(2)	9	900	269,429	642	2,022	562	2,063	1,357	(6,762)	(30)	270,178	-	270,178
Total Net Position	$ 27,125	$ 480	$ 11	$ 5,617	$ 284,135	$ 787	$ 6,973	$ 1,920	$ 29,498	$ 5,257	$ (6,724)	$ 2,449	$ 357,528	$ -	$ 357,528
Total Liabilities and Net Position	**$ 28,644**	**$ 567**	**$ 85**	**$ 5,995**	**$ 340,640**	**$ 1,201**	**$ 8,533**	**$ 2,460**	**$ 32,036**	**$ 5,584**	**$ 313**	**$ 2,665**	**$ 428,723**	**$ (236)**	**$ 428,487**

U. S. Department of Health and Human Services
Supplemental Statement of Net Cost
For the Years Ended September 30, 2005 and 2004
(In Millions)

	2005			
	Agency Consolidated	Inter-Agency Eliminations		HHS Consolidated
Responsibility Segments	Totals	Costs (-)	Earned/Exchange Revenues (+) [1]	Totals
ACF	$ 46,680	$ (12)	$ 54	$ 46,722
AoA	1,400	(4)	4	1,400
AHRQ	9	(321)	15	(297)
CDC	5,510	(391)	123	5,242
CMS	483,402	(8)	251	483,645
FDA	1,378	(20)	91	1,449
HRSA	6,700	(65)	152	6,787
IHS	3,140	(34)	51	3,157
NIH	27,348	(146)	673	27,875
OS	2,308	(357)	208	2,159
PSC	362	(407)	27	(18)
SAMHSA	3,266	(110)	43	3,199
Net Cost of Operations	$ 581,503	$ (1,875)	$ 1,692	$ 581,320

	2004			
	Agency Consolidated	Inter-Agency Eliminations		HHS Consolidated
Responsibility Segments	Totals	Costs (-)	Earned/Exchange Revenues (+) [1]	Totals
ACF	$ 45,940	$ (5)	$ 34	$ 45,969
AoA	1,340	(7)	3	1,336
AHRQ	80	(250)	12	(158)
CDC	5,295	(297)	116	5,114
CMS	451,457	(2)	192	451,647
FDA	1,466	(41)	85	1,510
HRSA	6,920	(51)	138	7,007
IHS	3,351	(32)	43	3,362
NIH	25,748	(129)	548	26,167
OS	2,183	(404)	88	1,867
PSC	636	(375)	21	282
SAMHSA	3,134	(57)	40	3,117
Net Cost of Operations	$ 547,550	$ (1,650)	$ 1,320	$ 547,220

[1]Eliminations for non-exchange revenue are reported in the Statement of Changes in Net Position

U.S. Department of Health and Human Services
Consolidating Statement of Net Cost By Budget Function
For the Year Ended September 30, 2005
(In Millions)

Responsibility Segments:	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations Cost (-)	Intra-HHS Eliminations Revenue	HHS Consolidated Totals
ACF	$ 11,215	$ -	$ -	$ 35,465	$ 46,680	$ (12)	$ 54	$ 46,722
AoA	1,400	-	-	-	1,400	(4)	4	1,400
AHRQ	-	9	-	-	9	(321)	15	(297)
CDC	-	5,510	-	-	5,510	(391)	123	5,242
CMS	-	187,689	295,713	-	483,402	(8)	251	483,645
FDA	-	1,378	-	-	1,378	(20)	91	1,449
HRSA	-	6,700	-	-	6,700	(65)	152	6,787
IHS	-	3,140	-	-	3,140	(34)	51	3,157
NIH	-	27,348	-	-	27,348	(146)	673	27,875
OS	-	2,308	-	-	2,308	(357)	208	2,159
PSC	-	362	-	-	362	(407)	27	(18)
SAMHSA	-	3,266	-	-	3,266	(110)	43	3,199
Net Cost of Operations	**$ 12,615**	**$ 237,710**	**$ 295,713**	**$ 35,465**	**$ 581,503**	**$ (1,875)**	**$ 1,692**	**$ 581,320**

U.S. Department of Health and Human Services
Gross Cost and Exchange Revenuee
For Year Ended September 30, 2005
(In Millions)

Responsibility Segments	Intragovernmental						With the Public		HHS Consolidated
	Gross Cost			Less: Exchange Revenue				Less: Exchange	Net Cost of
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated	Gross Cost	Revenue	Operations
ACF	$ 187	$ (22)	$ 165	$ 38	$ (64)	$ (26)	$ 46,531	$ -	$ 46,722
AoA	19	(4)	15	4	(4)	-	1,385	-	1,400
AHRQ	48	(321)	(273)	318	(15)	303	279	-	(297)
CDC	748	(392)	356	522	(124)	398	5,297	13	5,242
CMS	600	(8)	592	11	(251)	(240)	521,122	38,309	483,645
FDA	541	(20)	521	24	(91)	(67)	1,207	346	1,449
HRSA	392	(77)	315	126	(164)	(38)	6,525	91	6,787
IHS	431	(34)	397	198	(51)	147	3,633	726	3,157
NIH	3,515	(2,207)	1,308	2,299	(2,734)	(435)	26,223	91	27,875
OS	907	(594)	313	914	(445)	469	2,319	4	2,159
PSC	133	(417)	(284)	499	(37)	462	741	13	(18)
SAMHSA	220	(110)	110	155	(43)	112	3,201	-	3,199
Totals	**$ 7,741**	**$ (4,206)**	**$ 3,535**	**$ 5,108**	**$ (4,023)**	**$ 1,085**	**$ 618,463**	**$ 39,593**	**$ 581,320**

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