Financial Statements, Notes, Supplemental and Other Accompanying Information

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U.S. Department of Health and Human Services
CONSOLIDATED BALANCE SHEET
As of September 30, 2004 and 2003
(In Millions)

	2004	**Restated 2003**
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 97,667	$ 86,289
Investments, Net (Note 5)	287,886	282,350
Accounts Receivable, Net (Note 6)	573	899
Anticipated Congressional Appropriations (Note 7)	9,248	11,830
Other (Note 11)	386	350
Total Intragovernmental	$ 395,760	$ 381,718
Accounts Receivable, Net (Note 6)	2,052	2,817
Loans Receivable and Foreclosed Property, Net (Note 8)	390	387
Cash and Other Monetary Assets (Note 4)	460	843
Inventory and Related Property, Net (Note 9)	1,027	93
General Property, Plant & Equipment, Net (Note 10)	3,877	3,318
Other (Note 11)	185	85
Total Assets	**$ 403,751**	**$ 389,261**
Liabilities (Note 12)		
Intragovernmental		
Accounts Payable	$ 652	$ 271
Accrued Payroll and Benefits	64	70
Other (Note 16)	785	594
Total Intragovernmental	$ 1,501	$ 935
Accounts Payable	759	888
Entitlement Benefits Due and Payable (Note 13)	49,229	48,123
Accrued Grant Liability (Note 15)	3,755	3,752
Loan Guarantees Liabilities (Note 8)	191	362
Federal Employee & Veterans Benefits (Note 14)	7,178	6,903
Accrued Payroll & Benefits	789	718
Other (Note 16)	3,416	1,461
Total Liabilities	**$ 66,818**	**$ 63,142**
Net Position		
Unexpended Appropriations	82,052	75,385
Cumulative Results of Operations	254,881	250,734
Total Net Position	**$ 336,933**	**$ 326,119**
Total Liabilities & Net Position	**$ 403,751**	**$ 389,261**

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, 2004 and 2003
(In Millions)

	2004	**Restated 2003**
Responsibility Segments		
Administration for Children & Families (ACF)	$ 45,969	$ 47,593
Administration on Aging (AoA)	1,336	1,315
Agency for Healthcare Research & Quality (AHRQ)	(158)	311
Centers for Disease Control & Prevention (CDC)	5,114	5,406
Centers for Medicare & Medicaid Services (CMS)	451,647	416,009
Food & Drug Administration (FDA)	1,510	1,361
Health Resources & Services Administration (HRSA)	7,007	6,648
Indian Health Service (IHS)	3,362	3,048
National Institutes of Health (NIH)	26,167	22,729
Office of the Secretary (OS)	1,867	2,166
Program Support Center (PSC)	282	751
Substance Abuse & Mental Health Services Administration (SAMHSA)	3,117	3,029
Net Cost of Operations	**$ 547,220**	**$ 510,366**

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, 2004 and 2003
(In Millions)

	2004		Restated 2003	
	Cumulative Results of Operations	Unexpended Appropriations	Cumulative Results of Operations	Unexpended Appropriations
Beginning Balances	$ 250,734	$ 75,385	$ 243,859	$ 73,786
Prior period adjustments (+/-) (Note 20)	123	281	337	(84)
Beginning balances, as adjusted	$ 250,857	$ 75,666	$ 244,196	$ 73,702
Budgetary Financing Sources:				
Appropriations received	-	392,109	-	359,073
Appropriations transferred-in/out (+/-)	-	479	-	(720)
Other adjustments (rescissions, etc) (+/-)	(40)	(5,363)	309	(8,238)
Appropriations used	380,839	(380,839)	348,432	(348,432)
Nonexchange revenue	170,573	-	167,616	-
Donations and forfeitures of cash and cash equivalents	41	-	47	-
Transfers-in/out without reimbursement (+/-)	(1,185)	-	(746)	-
Other budgetary financing sources (+/-)	-	-	(2)	-
Other Financing Sources:				
Donations and forfeitures of property	3	-	-	-
Transfers-in/out without reimbursement (+/-)	665	-	899	-
Imputed financing from costs absorbed by others	339	-	339	-
Other (+/-)	9	-	10	-
Total Financing Sources	$ 551,244	$ 6,386	$ 516,904	$ 1,683
Net Cost of Operations (+/-)	547,220	-	510,366	-
Ending Balances	**$ 254,881**	**$ 82,052**	**$ 250,734**	**$ 75,385**

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, 2004 and 2003
(In Millions)

	2004		Restated 2003	
	Budgetary	**Non-Budgetary Credit Program Financing Accounts**	**Budgetary**	**Non-Budgetary Credit Program Financing Accounts**
Budgetary Resources:				
Budget Authority				
Appropriations Received	$ 700,102	$ -	$ 645,547	$ -
Borrowing authority	-	-	-	-
Contract authority	-	-	-	-
Net transfers (+/-)	498	-	(692)	-
Other	1	1	3	(1)
Unobligated Balances – Beginning of Period				
Beginning of Period	7,502	281	10,267	354
Net transfers, actual (+/-)	(19)	-	(5)	-
Anticipated Transfers balances (+/-)	-	-	-	-
Spending Authority from Offsetting Collections				
Earned				
Collected	5,492	48	4,926	147
Receivable from Federal sources	130	-	(99)	23
Change in unfilled customer orders				
Advance received	(29)	-	(129)	-
Without advance from Federal sources	775	-	984	-
Anticipated for rest of year, without advances	-	-	-	-
Transfers from trust funds	3,758	-	2,645	-
Subtotal	$ 10,126	$ 48	$ 8,327	$ 170
Recoveries of prior year obligations				
Actual	9,733	-	7,676	-
Anticipated	-	-	-	-
Temporarily not available pursuant to Public Law	(4,208)	-	(5,840)	-
Permanently not available (-)	(2,981)	-	(9,474)	-
Total Budgetary Resources	**$ 720,754**	**$ 330**	**$ 655,809**	**$ 523**
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 696,655	$ -	$ 643,188	$ -
Reimbursable	5,355	77	5,259	242
Subtotal	$ 702,010	$ 77	$ 648,447	$ 242
Unobligated Balances - Available				
Apportioned	13,049	73	2,469	-
Exempt from apportionment	98	-	85	-
Other available	-	-	-	-
Unobligated Balances - Not Available	5,597	180	4,808	281
Total Status of Budgetary Resources	**$ 720,754**	**$ 330**	**$ 655,809**	**$ 523**
Relationship of Obligations to Outlays:				
Obligated Balance, Net – Beginning of Period	$ 112,231	$ (23)	$ 104,642	$ -
Obligated Balance Transferred, Net (+/-)	476	-	-	-
Obligated Balance, Net – End of Period				
Accounts receivable (-)	(2,177)	-	(1,467)	(23)
Unfilled customer orders from Federal sources (-)	(2,356)	-	(1,588)	-
Undelivered orders	73,442	-	71,715	-
Accounts payable	44,660	-	43,571	-
Outlays				
Disbursements	690,226	54	632,256	242
Collections (-)	(8,937)	(48)	(7,401)	(147)
Subtotal	$ 681,289	$ 6	$ 624,855	$ 95
Less: Offsetting receipts	137,771	49	119,412	210
Net Outlays	**$ 543,518**	**$(43)**	**$ 505,443**	**$ (115)**

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, 2004 and 2003
(In Millions)

	2004	Restated 2003
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated		
Obligations Incurred	$702,087	$648,688
Less: Spending Authority from Offsetting Collections and Recoveries	19,907	16,172
Obligations Net of Offsetting Collections and Recoveries	$682,180	$632,516
Less: Offsetting Receipts	137,820	119,622
Net Obligations	$544,360	$512,894
Non-Budgetary Resources		
Donations and Forfeitures of Property	$3	$-
Non-Budgetary Transfers in/out Without Reimbursement	665	899
Imputed Financing From Costs Absorbed by Others	339	339
Other Non-Budgetary Resources	9	10
Net Non-Budgetary Resources Used to Finance Activities	$1,016	$1,248
Total Resources Used to Finance Activities	**$545,376**	**$514,142**
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	$1,060	$1,603
Resources That Fund Expenses Recognized in Prior Periods	12,373	11,307
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	(48)	(191)
Other	(184)	(189)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,774	616
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	2,383	2,773
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	$17,358	$15,919
Total Resources Used to Finance the Net Cost of Operations	**$528,018**	**$498,223**
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	$8	$34
Increase in Environmental and Disposal Liability	-	(1)
Upward/downward Reestimates of Credit Subsidy Expense	(87)	(84)
Increase in Exchange Revenue Receivable from the Public	2,476	1,251
Other	2,359	(974)
Liability for Unmatched SMI Premium (CMS only) (Note 7)	5,645	3,381
Accrued Entitlement Benefit Costs (CMS only)	10,039	8,987
Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods	$20,440	$12,594
Components Not Requiring or Generating Resources:		
Depreciation and Amortization	$108	$82
Losses or (Gains) from Revaluation of Assets and Liabilities	6	4
Other	(1,352)	(537)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources	$(1,238)	$(451)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	19,202	12,143
NET COST OF OPERATIONS	**$547,220**	**$510,366**

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

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2004 and 2003

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 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 eleven Agencies with diverse missions and programs. Each Agency 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 (ACF)
2. Administration on Aging (AoA)
3. Agency for Healthcare Research and Quality (AHRQ)
4. Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR)
5. Centers for Medicare & Medicaid Services (CMS)
6. Food and Drug Administration (FDA)
7. Health Resources and Services Administration (HRSA)
8. Indian Health Service (IHS)
9. National Institutes of Health (NIH)
10. Office of the Secretary (OS) – excluding PSC
11. Program Support Center (PSC)
12. Substance Abuse and Mental Health Services Administration (SAMHSA)

Even though it is under the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other Agencies 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 Agency.

The Homeland Security Act of 2002 resulted in changes to the structure of HHS in 2003. The Office of Emergency Preparedness, National Disaster Medical System, Metropolitan Medical Response System, and Strategic National Stockpile (SNS) programs were transferred from HHS to the Department of Homeland Security (DHS), and the Unaccompanied Alien Children Program was transferred to HHS from the Immigration and Naturalization Service as of March 1, 2003.

The Project BioShield Act of 2004 transferred back to HHS the Strategic National Stockpile program on August 13, 2004. Note 9, "Inventory and Related Property, Net" provides additional information on the transfer of stockpile inventory from DHS to HHS.

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 (P.L. 101-576), as amended by the Reports Consolidation Act of 2000 (P.L. 106-531), and presented in accordance with the form and content requirements contained in the Office of Management and Budget (OMB) Bulletin No. 01-09, Form and Content of Agency Financial Statements. 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' Agencies 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 Agency 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. The 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. CMS uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual methods to estimate the value of benefit payments incurred but not yet paid as of the fiscal year-end. A number of other HHS agencies also use the cash basis of accounting for some programs with an accrual adjustment made by recording year-end estimates of unpaid liabilities.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements 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.

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2004 and 2003

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.

The HHS financial statements do not report entity and non-entity assets separately on the face of the statement. Instead, entity/non-entity 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 account 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 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. An adjustment to the accrual for interest earned from July 1, 2004 to September 30, 2004 is included.

Note 5 provides additional information on Investments.

Accounts Receivable, Net
Accounts receivable consists of the amounts owed to HHS by other Federal agencies and by 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 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 amount due from organizations for civil monetary penalty not yet remitted to the Department of Justice, and 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 provides additional information on Accounts Receivable.

Loans Receivable and Loan Guarantee Liability

HHS administers guaranteed loan programs for the Health Center and for Health Education Assistance Loans (HEAL) programs. Loans receivables represent defaulted guaranteed loans, 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 the Department less the present value of related inflows.

For loan guarantees committed subsequent to October 1, 1991, guaranteed loans are reduced by an allowance for subsidy – the present value of the amounts not expected to be recovered and thus having to be subsidized by the government for loan guarantees – as required under the Federal Credit Reform Act of 1990 (FCRA). 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 subsequent to 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 provides additional information on Loans.

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 exceeds the outstanding advances to grantees, resulting in a negative balance in the "Advances to Grantees" account. Progress payments on work in process are not included in grants. HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual."

<u>Grants Not Subject to Grant Expense Accrual:</u> 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 as opposed to a reimbursable basis. Therefore, they are not subject to grant expense accrual.

<u>Grants Subject to Grant Expense Accrual:</u> For grants subject to grant expense accrual, 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 Agencies 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 cash drawdown.

Exceptions to the definition of "block" or "non-block" grants for reporting purposes are 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." In addition, Note 15 provides additional information on 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. Operating Materials and Supplies consist of pharmaceuticals, biological products, and other medical supplies used in providing medical services and conducting medical research. SNS materials are held for emergencies in response to local and national emergency. In addition, CDC maintains stockpile of vaccines to meet unanticipated needs in the cause of a national emergency.

Inventories held for sale are valued at historical cost using the first-in first-out (FIFO) cost flow assumption with the exception of the NIH, who uses the moving average cost flow assumption method. Operating materials and supplies are recorded as assets when purchased and expensed when they are consumed. Operating materials and supplies are valued at historical cost using the FIFO cost flow assumption. Stockpile materials are valued at historical cost using a specific identification cost flow assumption.

Note 9 provides additional information on Inventory and Related Property.

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 capital lease; leasehold improvements; and construction-in-progress. Other property consists of 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 2 years or greater 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, and began capitalizing the cost. The estimated useful life for internal use software was determined at 7-10 years for amortization. SFFAS No. 10 also requires that amortization begins when the asset is placed in use.

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.

Note 10 provides additional information on General Property, Plant and Equipment.

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. 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 HI 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 are those liabilities funded by available budgetary resources including: (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 are incurred when 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 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
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.

Entitlement Benefits Due and Payable
Entitlement Benefits Due and Payable represents the liability for Medicare and Medicaid for medical services incurred but not reported (IBNR) as of the balance sheet date.

Medicare IBNR
The Medicare liability is developed by the CMS Office of the Actuary (OACT) and includes (1) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but 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 FY 2004 but paid in FY 2005, and (5) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

For fiscal years 2003 and prior, CMS did not record corresponding budgetary obligations for the September 30 accrual of the liability for Medicare expenses incurred but not reported (IBNR). CMS recorded obligations when the Medicare contractors' banks actually drew on their letters-of-credit with the Federal Reserve as reimbursement for checks presented for payment. In FY 2003 OMB exempted CMS from the OMB Circular No. A-11, Preparation, Submission, and Execution of the Budget requirement to report obligations when the liability is incurred.

For FY 2004, CMS has begun obligating funds when the Medicare IBNR is recorded. This treatment complies with OMB Circular No. A-11 and results in the restatement of the FY 2003 SBR, as discussed later in this note.

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. The FY 2004 and FY 2003 estimate were developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

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

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 (OPM) 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 Corp (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.

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 liability for actual and estimated future payments for workers' compensation pursuant to FECA. FECA provides income and medical cost protection to Federal employees who were injured on the job or who have sustained a work-related occupational disease and 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 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 provides additional information on Federal Employee and Veterans' Benefits.

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 SBR 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. 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.

Aggregate non-exchange revenues consist primarily of FICA Taxes of $142,659 million and $139,934 million, SECA taxes of $10,789 million and $9,905 million, and Trust Fund investment interest of $16,574 million and $17,066 million for FY 2004 and 2003, respectively. For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the 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 Commissioner of Social Security 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 the Department 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 OPM 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. Employees and employers are each required to contribute 1.45 percent of employees' wages, with no limitation, to the Hospital Insurance Trust Fund. Self-employed individuals pay the full 2.9 percent of net income.

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.

Restatements

For FY 2003 and prior, CMS did not record corresponding budgetary obligations for the September 30 accrual of the liability for Medicare expenses incurred but not reported (IBNR). The CMS recorded obligations when the Medicare contractors' banks actually drew on their letters-of-credit with the Federal Reserve as reimbursement for checks presented for payment. In FY 2003, OMB exempted CMS from the OMB Circular No. A-11 requirement to report obligations when the liability is incurred. For FY 2004 CMS has begun obligating funds when the Medicare IBNR is recorded. This resulted in restatement of the FY 2003 SBR, the principal effect of which was to increase beginning obligated balances and ending balances for FY 2003 by $28,236 million and $30,339 million respectively, a corresponding reduction in Medicare Trust Fund beginning and ending balances for FY 2003, and an increase in net obligations recorded in FY 2003 of $2,103 million on the SBR and corresponding reduction of temporarily not available budgetary resources.

The Statement of Financing (SOF) has been further restated to reflect the funding of the Medicare IBNR: "Resources that fund expenses in prior periods" and "Accrued Unfunded Entitlement Benefit Costs" exclude the Medicare IBNR. The SOF Net Cost of Operations section remains unchanged. Resources used to finance items not part of the net cost of operations and components of net cost of operations that will not require or generate resources in the current period were reduced by $28,236 million and $30,339 million, respectively.

For FY 2003 and prior, CMS reported only the Medicare HI and Medicare SMI premiums collected as offsetting receipts. The transfers from the Payments to the Health Care Trust Funds (PTF) to HI and SMI were not reported. The United States Standard General Ledger (USSGL) Crosswalk for the SBR included accounts for Medicare premiums but not for the PTF transfers.

In FY 2004, the Treasury revised the USSGL crosswalk for the offsetting receipts line item of the SBR to include transfers between the general fund and trust funds. In addition, OMB revised Circular A-11, clarifying that "intrabudgetary receipts" (which includes PTF transfers) should be reported on the offsetting receipts line of the SBR. Accordingly, the offsetting receipts line of the CMS' SBR and SOF has been restated by an aggregate of $89,867 million for FY 2003. Also, previously unreported offsetting receipts for ACF, CDC, HRSA, and IHS required restating the offsetting receipts lines on the SBR and the SOF for FY 2003 by an inconsequential amount.

Contingencies
A contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible gain or loss to the Department. The uncertainty will ultimately be resolved when one or more future events occur or fail to occur. 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 provides additional information on Contingencies.

Reclassifications
The liability for Environmental and Disposal Costs is immaterial and has been reclassified to other liabilities for FY 2003 for presentation of the FY 2004 financial statements.

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 the SBR as presented in the audited financial statements. CMS reported an obligation of $1,867 million for a liability resulting from the incorrect eligibility determinations on the SBR that was not reported in FACTS II. 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 (Intra-Departmental Delegations of Authority – IDDAs).

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 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 CMS 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 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, 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 authority.

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 called the Health Care Fraud and Abuse Control (HCFAC) program or simply "Fraud and Abuse." 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.

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 which 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.

U.S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2004 and 2003

Note 2. Non-Entity Assets
Non-entity assets at September 30, 2004 and 2003 consisted of the following:

(Dollars in Millions)	2004	Restated 2003
Intragovernmental:		
Fund balance with Treasury	$ 19	$ 23
Accounts receivable	-	-
Other	-	-
Total Intragovernmental	$ 19	$ 23
Accounts receivable	$ 24	$ 82
Cash and other monetary assets	-	-
Other	-	-
Total non-entity assets	$ 43	$ 105
Total entity assets	403,708	389,156
Total Assets	$ 403,751	$ 389,261

The $19 million non-entity asset balance includes $8 million representing the collections of royalties from licenses for which a portion is paid to inventors under the Federal Technology Transfer Act, and $11 million representing tax refunds collected by the Internal Revenue Service (IRS) which was transferred to ACF for distribution to States. The majority of the $24 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 returned to Treasury due to cancelled appropriations at the end of FY 2004 and FY 2003 were approximately $600 million and $4.7 billion, respectively.

Note 3. Fund Balance with Treasury
The Fund Balance with Treasury and the status of the fund balance at September 30, 2004 and 2003 are listed below by fund type.

(Dollars in Millions)	2004	Restated 2003
Fund Balance with Treasury		
Trust Funds	$ 2,753	$ (162)
Revolving Funds	767	761
Appropriated Funds	93,530	85,151
Other Funds	617	539
Total	$ 97,667	$ 86,289
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 13,197	$ 2,461
Unavailable	(28,983)	(28,009)
Obligated Balance not yet Disbursed	113,453	111,837
Total	$ 97,667	$ 86,289

Note 3. Fund Balance with Treasury (continued)
Other Funds include balances in deposit, suspense, clearing, and related non-spending accounts.

The Unobligated Balance includes $2.9 billion, which is restricted for future use and are not apportioned for current use. An example of these funds are the ACF's Contingency Fund for State Welfare Programs, CMS' Program Management Funds, and PSC's Service and Supply Funds.

The Unobligated Unavailable negative balance is due primarily to CMS obligating $30.3 billion for Medicare IBNR that changed the amounts temporarily precluded from obligation that occur in the trust funds. The change required restatement of the FY 2003 FBWT note.

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 a Medicare Benefits account maintained at commercial banks. In order to compensate 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 balance as of September 30, 2004 was $460 million and in FY 2003 the balance was $843 million.

Note 5. Investments, Net
HHS' investments, net at September 30, 2004 and 2003 are summarized below.

	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

	2003				
(Dollars in Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Other Adjustments	Market Value Disclosure
Intragovernmental Securities					
Marketable	$20	$ -	$ 20	$ -	$ 20
Non-Marketable: Par Value	276,244	-	276,244	-	276,244
Non-Marketable: Market-based	1,989	31	2,020	-	2,020
Subtotal	$278,253	$ 31	$ 278,284	-	$ 278,284
Accrued Interest	4,066	-	4,066	-	4,066
Total, Intragovernmental	$282,319	$31	$ 282,350	$ -	$ 282,350

Note 5. Investments, Net (continued)
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 Treasury Department 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, One Day Certificates, and Non-Marketable, Market-based (MK).

Par value securities purchased by CMS are recorded at cost, interest is earned based on a statutory formula, and securities are redeemed at face value. MK securities mirroring marketable securities terms that are not traded on any securities exchange include both Non-Marketable, MK, and One Day Certificates. MKs are purchased by HRSA's Vaccine Injury Compensation Program (VICP) trust fund, the Ricky Ray Hemophilia Relief trust fund and the NIH Gift funds. The MKs are purchased at a discount or premium based on market terms and are recorded at cost. Discounts and premiums are recorded and amortized on a straight-line basis. Marketable securities purchased are recorded at cost based on market terms. Currently, securities held by the VICP will mature in fiscal years 2005 through 2009.

CMS invests in U.S. Treasury Special Issues bonds (Par value securities) that are special public obligations for exclusive purchase by the Medicare trust funds. Special issued bonds are always purchased and redeemed at face value. Certificates are short term and paid 4 1/2 percent in FY 2004 and FY 2003. The bond interest rates ranged from 3 1/2 percent to 8 3/4 percent in FY 2004 and FY 2003. The accrued interest receivable as of September 30, 2004 and 2003 was $3,988 million and $4,066 million, respectively.

Note 6. Accounts Receivable, Net
HHS' accounts receivable as of September 30, 2004 and 2003 are summarized below.

	2004								
(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net Agency Receivables Combined	Intra-Agency Eliminations	Net Agency Receivables Consolidated	Inter-Agency Eliminations	Net HHS Receivables Consol.
Intragovernmental									
Entity	$41,518	$-	$41,518	$-	$ 41,518	$(40,708)	$810	$ (237)	$ 573
Non-Entity	-	-	-	-	-	-	-	-	-
Total, Intragovernmental	$41,518	$-	$41,518	$-	$ 41,518	$(40,708)	$810	$ (237)	$ 573
With the Public									
Entity									
Medicare	$2,908	$-	$2,908	$(1,556)	$ 1,352	$-	$ 1,352	$ -	$ 1,352
Other	1,419	-	1,419	(743)	676	-	676	-	676
Non-Entity	15	83	98	(74)	24	-	24	-	24
Total, With the Public	$4,342	$83	$4,425	$(2,373)	$ 2,052	$-	$ 2,052	$ -	$ 2,052

Note 6. Accounts Receivable, Net (continued)

Restated 2003

(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net Agency Receivables Combined	Intra-Agency Eliminations	Net Agency Receivables Consolidated	Inter-Agency Eliminations	Net HHS Receivables Consol.
Intragovernmental									
Entity	$37,231	$147	$37,378	$-	$37,378	$(36,366)	$1,012	$(113)	$ 899
Non-Entity	-	-	-	-	-	-	-	-	-
Total, Intragovernmental	$37,231	$147	$37,378	$-	$37,378	$(36,366)	$1,012	$(113)	$ 899
With the Public									
Entity									
Medicare	$5,325	$-	$5,325	$(3,273)	$2,052	$-	$2,052	$-	$ 2,052
Other	1,350	-	1,350	(667)	683	-	683	-	683
Non-Entity	61	505	566	(484)	82	-	82	-	82
Total, With the Public	$6,736	$505	$7,241	$(4,424)	$2,817	$-	$2,817	$-	$ 2,817

Medicare receivables are primarily composed of both overpayments to Medicare providers, beneficiaries, physicians and suppliers as well as the repayment of claims where Medicare should be the secondary payer. The majority of the other accounts receivable with the public represent the receivable from Medicaid due to cost disallowance.

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

For Medicare receivables, CMS 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 5 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.

FY 2003 intragovernmental receivable balance, most of which represents nonexpenditure transfers-in from Bureau of Public Debt (BPD) to CMS' HI and SMI, has been restated to include benefit expenses incurred but not reported as of September 30, 2003, which were not obligated or reported in FY 2003. Likewise, the corresponding intra-agency elimination has been also restated for FY 2003.

Note 7. Anticipated Congressional Appropriation

The CMS has recorded $9,248 million in anticipated Congressional appropriations ($11,830 million in FY 2003) 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 IBNR claims as of September 30. In FY 2004, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $3,603 million ($8,449 million in FY 2003). A review of appropriation language by CMS' Office of General Counsel (OGC) 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 $3,603 million anticipated appropriation in FY 2004 ($8,449 million in FY 2003) for IBNR claims that exceed the available appropriation.

Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by 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' OACT and may be insufficient in any particular fiscal year.

In FY 2004, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30, approximately $5,573 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $72.1 million in interest on unmatched amount, leaving a cumulative liability of $5,645 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 $5,645 million anticipated appropriation in FY 2004 ($3,381 million in FY 2003) for the amount of the unmatched SMI premiums. Although the actual transfer of funds will occur in FY 2005, CMS has reported the $5,645 million as revenues earned in FY 2004.

In addition, the $5,645 million in unmatched SMI premiums is reported as other liability "requiring or generating resources in future periods" on the Consolidated Statement of Financing.

Note 8. Loan Guarantee Receivables and Liabilities

The Health Resources and Services Administration (HRSA) operates guaranteed loan programs for the Health Center and Health Education Assistance Loans (HEAL) programs. For HEAL, the HRSA guarantees the payment of both 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 bankruptcy (Chapter 11, 13, and Adversaries), default, death, or permanent disability. In the event of default, these lenders are responsible for 2 percent of the cost of each defaulted loan.

Note 8. Loan Guarantee Receivables and Liabilities (continued)
Legislation that enables the program to guarantee new loans to student borrowers expired September 30, 1998. Health Center Program (Post-1991) guarantees the loans to HRSA grantees, which are made by non-federal lenders to the health center for cost of developing and operating managed care networks or plans.

Subsidy cost, on guaranteed loans obligated beginning in FY 1992, is calculated using the net present value of projected lifetime costs and is revalued annually through the OMB Subsidy Credit Model reestimate 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 with 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. The loan's cohort year represents the year a loan was guaranteed regardless of the timing of the disbursement.

In recent years, HHS has allowed existing HEAL recipients to refinance their loans into new guaranteed loans. This allowable refinancing will end on September 30, 2004. The retirement of loans being refinanced is considered a receipt of principal and interest. This receipt is offset by the disbursement related to the newly created loan. The underlying loan, in any given cohort, is paid off in its original cohort, and a new loan is opened in the cohort in which refinancing activity occurred.

Total loans guaranteed under these programs, as of September 30, 2004 and 2003 are summarized as follows.

(Dollars in Millions)	2004		2003	
HEAL Loan Guarantees:	No. of Loans	Amount	No. of Loans	Amount
Pre-1992 loans	41,734	$331	54,026	$436
Post-1991 loans	66,815	1,697	82,944	1,880
Health Centers Loan Guarantees	12	39	7	14
Total	108,561	$ 2,067	136,977	$2,330

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 procedures in an effort to collect amounts due prior to submitting the 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 in the student's promissory notes or, in cases of judgment, court-mandated rate. Interest is accrued monthly and compounded semiannually for non-judgment cases and accrued quarterly and

Note 8. Loan Guarantee Receivables and Liabilities (continued)
compounded annually for judgment cases. Nevertheless, interest is accrued on both performing and non-performing loans.

The loans receivable at September 30, 2004 and 2003 are summarized below.

	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					
Pre-1992 Loans	-	-	-	-	-
Post-1991 Loans	4	-	4	(4)	-
Total	$ 609	$ 17	$ 626	$ (236)	$ 390

	2003				
(Dollars in Millions)	Loans, Receivable, Principal	Interest Receivable	Loans Receivable, Gross	Allowance	Loans, Receivable, Net
Defaulted Guaranteed Loans					
HEAL Loans (HRSA)					
Pre-1992 Loans	$ 490	$ 12	$ 502	$ (203)	$ 299
Post-1991 Loans	112	3	115	(27)	88
Subtotal	$ 602	$ 15	$ 617	$ (230)	$ 387
Health Centers					
Post-1991 Loans	4	-	4	(4)	-
Total	$606	$ 15	$ 621	$ (234)	$ 387

Loan guarantee liabilities:
As set forth 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. 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 3.65 percent in FY 2004 and 3.76 percent in FY 2003. This liability is adjusted each year for the change in default rates.

Note 8. Loan Guarantee Receivables and Liabilities (continued)
The loans guarantee liabilities at September 30, 2004 and 2003 are summarized below.

(Dollars in Millions)	2004	2003
Loan Guarantee Liabilities:		
HEAL Loans		
Pre-1992 Loans	$ 13	$ 15
Post-1991 Loans	172	344
Subtotal	$ 185	$ 359
Health Center		
Post-1991 Loans	6	3
Total Loan Guarantee Liabilities	$ 191	$ 362

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

(Dollars in Millions)	2004	2003
Beginning Balance, Liability for Loan Guarantees	$347	$259
Add: Subsidy Expense		
Default Costs (net of recoveries)	($3)	$ (5)
Fees and Other Collections	(15)	144
Other Subsidy Cost (death and disability)	(38)	(4)
Total Subsidy Expense	$(56)	$135
Adjustments:		
Interest Supplements	0	$(23)
Other	(64)	60
Total Adjustments	$(64)	$37
Subsidy Re-estimates		
Technical Re-estimates	$(38)	$(6)
Interest Re-estimates	(11)	(78)
Total Subsidy Re-estimates	$(49)	$(84)
Ending Balance, Liability for Loan Guarantees	$178	$347

Administrative expenses for the fiscal years reported are immaterial.

Loan guarantee subsidy expense:
The subsidy costs for the year ended September 30, 2004 is summarized as follows:

(Dollars in Millions)	2004	Restated 2003
Subsidy Expense		
Default Costs (net of recoveries)	$(3)	$(5)
Fees and Other Collections	(15)	144
Other Subsidy Cost (death and disability)	(38)	(4)
Total Subsidy Expense	$(56)	$135

Note 8. Loan Guarantee Receivables and Liabilities (continued)
The subsidy rates for post-1991 loan guarantees programs are as follows:

Loan Guarantee Programs:	Subsidy	Fees & Other Collections	Other	Total
2004				
a. Health Education Assistance Loan Program (HEAL)	16.48%			16.48%
b. Health Center Guarantee Loan Program (HCGLP)	4.68%	1%		5.68%
2003				
a. Health Education Assistance Loan Program (HEAL)	15.76%			15.76%
b. Health Center Guarantee Loan Program (HCGLP)	5.88%	1%		6.88%

Note 9. Inventory and Related Property, Net
HHS' inventory and related property, net at September 30, 2004 and 2003 are summarized below.

(Dollars in Millions)	2004	2003
Inventory Held for Sale:		
Inventory Held for Current Sale	$34	$ 33
Inventory Held for Repair	-	-
Total Inventory Held for Sale	$34	$33
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	$7	$7
Operating Materials and Supplies Reserved for Future Use	-	-
Total Operating Materials and Supplies	$7	$7
Stockpile Materials:		
Stockpile Materials Held for Emergency or Contingency	$986	$53
Total Stockpile Materials	$986	$53
Inventory and Related Property, Gross	$1,027	$93
Less: Allowance for Loss/Obsolescence/Spoilage	-	-
Inventory and Related Property, Net	$1,027	$93

During FY 2003, HHS transferred the Strategic National Stockpile (SNS) held for emergencies in response to local and national emergencies in the amount of $648 million to DHS, along with the related budget authority for the SNS program of $567 million. During FY 2004, these stockpile materials were transferred back from DHS to HHS in the amount of $868 million, with a corresponding budget authority of $626 million. Strategic National Stockpile materials are not for sale and are valued at their historical cost using FIFO cost flow assumption method.

Note 10. General Property, Plant and Equipment, Net
Major categories of HHS General Property, Plant and Equipment (PP&E) at September 30, 2004 and 2003 are listed below.

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Note 10. General Property, Plant and Equipment, Net (continued)

(Dollars in Millions)	Depreciation Method	Estimated Useful Lives	2004 Acquisition Cost	2004 Accumulated Depreciation	2004 Net Book Value	Restated 2003 Net Book Value
Land & Land Rights			$48	$ -	$48	$48
Construction in Progress			1,389	-	1,389	1,025
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	2,829	(1,246)	1,583	1,440
Equipment	Straight Line	3-20 Yrs	1,028	(457)	571	509
Internal Use Software	Straight Line	7-10 Years	176	(43)	133	94
Assets Under Capital Lease	Straight Line	1-20 Years	141	(26)	115	160
Leasehold Improvements	Straight Line	*Life of Lease	42	(4)	38	42
Totals			$5,653	$ (1,776)	$3,877	$3,318

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

Included in the FY 2004 Net Book Value for Internal Use Software are capitalized costs totaling approximately $1.8 million for the UFMS. The majority of the UFMS costs were appropriately transferred from Internal Use Software.

Note 11. Other Assets

Other Assets at September 30, 2004 and 2003 are comprised of the following, all of which are considered entity assets.

(Dollars in Millions)	2004	Restated 2003
Intragovernmental		
Advances to Other Federal Entities	$745	$651
Other	1	25
Agency Combined, Intragovernmental	746	676
Less: Intra-Agency Eliminations	(338)	(326)
Agency Consolidated, Intragovernmental	408	350
Less: Inter-Agency Eliminations	(22)	-
HHS Consolidated, Intragovernmental	$386	$350
With the Public		
Prepayments and Deferred Charges	$80	$72
Travel Advances & Emergency Employee Salary Advances	4	6
Other	101	7
HHS Consolidated, With the Public	$185	$85

Advances to Other Federal Entities is largely comprised of advances from the NIH institutes and centers 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 CDC to the Department of Veterans Affairs (VA) for the SNS.

Note 11. Other Assets (continued)
The Prepayments and Deferred charges represent advances to vendors outside the government for various bioterrorism projects, for example, vaccines/drugs associated with the Bio-shield program.

Note 12. Liabilities Not Covered by Budgetary Resources
HHS' liabilities not covered by budgetary resources at September 30, 2004 and 2003 are summarized below.

(Dollars in Millions)	2004	Restated 2003
Intragovernmental		
Accounts Payable	$-	$ 271
Accrued Payroll and Benefits	19	20
Other	98	151
Total Intragovernmental	$ 117	$ 442
Entitlement Benefits Due and Payable	$ 10,039	$ 8,987
Federal Employees and Veterans' Benefits	7,178	6,903
Accrued Payroll and Benefits	431	418
Other	2,822	743
Total Liabilities Not Covered by Budgetary Resources	$ 20,587	$ 17,493
Total Liabilities Covered by Budgetary Resources	46,231	45,649
Total Liabilities	$ 66,818	$ 63,142

Note 13. Entitlement Benefits Due and Payable
Entitlement Benefits Due and Payable represents benefits due and payable to the public at year-end from entitlement programs enacted by law. The largest entitlement programs in HHS are the CMS managed Medicare and Medicaid programs which comprise all of the HHS entitlement benefits due and payable.

Entitlement Benefits Due and Payable at September 30, 2004 and 2003 are summarized below.

	2004			Restated 2003		
(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	$ 29,875	$ -	$ 29,875	$ 30,339	$ -	$30,339
Medicaid	9,315	10,039	19,354	8,797	8,987	17,784
Other	-	-	-	-	-	-
Totals	$ 39,190	$10,039	$ 49,229	$ 39,136	$ 8,987	$48,123

Note 14. Federal Employee and Veterans' Benefits
HHS' Federal Employee and Veterans' Benefits at September 30, 2004 and 2003 are summarized below. These liabilities are not covered by budgetary resources.

(Dollars in Millions)	2004	2003
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 6,327	$ 6,107
PHS Commissioned Corp Post-retirement Health Benefits	582	495
Workers' Compensation Benefits (Actuarial FECA Liability)	269	301
Total, Federal Employee and Veterans' Benefits	$ 7,178	$ 6,903

PHS Commissioned Corps: HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System for approximately 5,929 active duty officers and 4,898 retiree annuitants or survivors. Authorized by Public Law 78-410, it is a defined noncontributory 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, 2004, the actuarial present value of accumulated plan pension benefits was $6,327 million of which $593 million was not vested, and the liability for medical benefits was actuarially determined to be $582 million.

Significant assumptions used by the actuary in its reports on the pension and medical programs as of September 30, 2004, were as follows: interest on Federal securities of 6.25 percent, annual basic pay scale increase of 3.75 percent, and annual inflation of 3.0 percent. Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system. HHS bases aggregate entry age normal actuarial cost method to both programs to determine their liabilities.

The following shows key valuation results as of September 30, 2004 and 2003, 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)	2004	Restated 2003
SFFAS 5 Expense		
(a) Normal Cost	$ 150	$ 138
(b) Interest Cost	404	389
(c) Ongoing Cost (a & b)	554	527
(d) Prior Service Cost & (Gains)/Losses	17	31
(e) Total Expense	$ 571	$ 558

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.

Note 14. Federal Employee and Veterans' Benefits (continued)
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 2004 and 2003 appear below.

FY 2004	FY 2003
4.883% in Year 1	3.84% in Year 1
5.235% in Year 2 and thereafter	4.85% 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 projected future benefits. These factors are also used to adjust historical payments to current year dollars. The compensation COLAs and CPIMs used in projections are as follows:

FY	COLA	CPIM
2005	2.03%	4.14%
2006	2.73%	3.96%
2007	2.40%	3.98%
2008	2.40%	3.99%
2009+	2.40%	4.02%

Note 15. Accrued Grant Liability
Grant advances are liquidated upon the grantees' reporting of expenditures on the quarterly SF-272 Report (Federal Cash Transaction Report). In many cases, HHS receives these reports several months after the grantee actually incurs the expense, resulting in an understated grant expense in the financial statements. To mitigate this, HHS developed departmentwide procedures to estimate and accrue amounts due grantees for their unreported expenses through September 30.

At fiscal year-end, the Agencies record the liability based on the estimated accrual for unreported grantees' expenses. If the amount of the collective Agency 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 "Advances to Grantees/Accrued Grant Liability".

HHS' net grant advances (liability) at September 30, 2004 and 2003 are summarized below.

	2004	2003
Grant Advances Outstanding (before year-end grant accrual)	$ 15,087	$ 14,699
Less: Estimated Accrual for Amounts Due to Grantees	(18,842)	(18,451)
Net Grant Advances (Liability)	$ (3,755)	$ (3,752)

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Note 16. Other Liabilities

HHS' other liabilities at September 30, 2004 and 2003 are summarized below.

(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 Agency Totals	$ 1,157	$ 98	$ 1,255	$ 594	$ 2,822	$ 3,416
Less: Intra-Agency Eliminations	(338)	-	(338)	-	-	-
Consolidated Agency Totals	$ 819	$ 98	$ 917	$ 594	$ 2,822	$ 3,416
Less: Inter-Agency Eliminations	(132)	-	(132)	-	-	-
Consolidated HHS Totals	$ 687	$ 98	$ 785	$ 594	$ 2,822	$ 3,416

(Dollars in Millions) Restated 2003	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	$ -	$ -	$ -	$ -	$ -	$ -
Deferred Revenue	558	-	558	547	-	547
Liabilities for Deposit Funds, Clearing Accounts and Undeposited Collections	-	-	-	3	-	3
Contingent Liabilities	-	-	-	-	320	320
Capital Lease Liability	-	91	91	81	6	87
Custodial Liabilities	-	60	60	-	-	-
Vaccine Injury Compensation Program	-	-	-	-	365	365
Environmental and Disposal Costs	-	-	-	2	37	39
Other	250	-	250	85	15	100
Combined Agency Totals	$ 808	$ 151	$ 959	$ 718	$ 743	$ 1,461
Less: Intra-Agency Eliminations	(326)	-	(326)	-	-	-
Consolidated Agency Totals	$ 482	$ 151	$ 633	$ 718	$ 743	$ 1,461
Less: Inter-Agency Eliminations	(39)	-	(39)	-	-	-
Consolidated HHS Totals	$ 443	$ 151	$ 594	$ 718	$ 743	$ 1,461

Note 16. Other Liabilities (continued)

The majority of the other liabilities include deferred revenue, contingent liabilities, and the Vaccine Injury Compensation Program (VICP). Deferred Revenue of $613 million is for the provision of goods and services. The VICP, administered by HRSA, provides compensation for vaccine-related injury or death. The $313 million VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2004.

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 2004, HRSA's actuarial contractor estimated the preliminary contingent liability to be $586 million ($318 million in FY 2003). This increase of $268 million is an actuarial estimate for ultimate liabilities as of FY 2004. These liabilities include the incurred but not reported (IBNR) amount of $194 million and the expected payouts for fiscal years 2004 to 2006 of $203 million for the Community Health Center program.

Other intragovernmental liabilities of $691 million are comprised of $344 million, which CMS owes to other Federal entities. The majority of the other intragovernmental liabilities are comprised of funds owed to Treasury from CMS. CMS owes Treasury $309 million. As of September 30, beneficiaries owe $287 million to CMS for Medicare HI and SMI premiums. When CMS collects the premiums, the revenue is credited to the HI and SMI trust funds. The remaining $22 million consists of interest on overpayments reported by Medicare contractors. CMS also owes other Federal entities $35 million for services performed through interagency agreements.

CMS routinely receives 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.

Included in other liabilities are estimated amounts for a contingent liability payable to States (to reimburse them for payments they have paid on behalf of beneficiaries) at an amount of approximately $1,867 million, 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 Program's accounts in the general fund.

Note 16. Other Liabilities (continued)
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 PP&E. The majority of the environmental and disposal costs consist of IHS' liabilities associated with surveying, testing, and remediating contaminated sites and NIH's ground water remediation project in accordance with applicable laws and regulations.

The CMS routinely processes and settles 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.

Additionally, the SSA routinely collects Medicare Part B premiums from beneficiaries who receive Old Age and Survivors and Disability Insurance (OASDI) payments. Prior to December 2002, SSA did not have procedures in place to recover Medicare premiums as death notifications were received. The Department of Health and Human Services' (HHS) Office of General Counsel (OGC) advised CMS that it has no legal obligation to repay the SSA. The OGC based its decision on the fact that SSA has no legally enforceable claim against CMS because there is no statutory provision that expressly requires CMS to reimburse the OASDI Trust Funds for prior amounts transferred to the SMI Trust Fund.

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.

Note 17. Leases
Capital Leases: HHS has entered into various capital leases with Indian 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 with 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 within 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

Note 17. Leases (continued)

During FY2003, using OMB Circular No. A-11 criteria, 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 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 under the OMB criteria are capital leases. The issue is currently under review by OMB.

A Summary of Net Assets under Capital Lease and Future Minimum Lease Payments at September 30, 2004 and 2003 follows.

(Dollars in Millions)	2004	Restated 2003
Summary of Net Assets Under Capital Lease		
Land and Building	$ 140	$ 194
Machinery and Equipment	1	1
Other	-	-
Subtotal	$ 141	$ 195
less: Accumulated Amortization	(26)	(35)
Assets Under Capital Lease	$ 115	$ 160

	2004		Restated 2003	
(Dollars in Millions)	Capital Leases	Operating Lease	Capital Leases	Operating Lease
Future Minimum Lease Payments				
Year 1	$ 12	$ 263	$ 16	$ 247
Year 2	12	260	16	257
Year 3	12	266	17	261
Year 4	12	271	17	277
Year 5	12	276	17	292
Later Years	152	463	205	612
Total Minimum Lease Payments	$ 212	$ 1,799	$ 288	$ 1,946
Less: Imputed Interest	(89)		(110)	
Total Capital Lease Liability	$ 123		$ 178	

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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 year ended September 30, 2004 and 2003 are summarized below.

	2004									Restated 2003
(Dollars in Millions)	Education Training and Social Services	Health	Medicare	Income Security	Admin. of Justice	Natural Resources/ Environment	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals	HHS Consolidated Totals
Intragovernmental										
Gross Cost	$ 181	$ 4,349	$ 511	$ 21	$ -	$ -	$ 5,062	$ (1,650)	$ 3,412	$ 3,008
Less: Earned Revenue	(13)	(2,137)	(5)	(4)	-	-	(2,159)	1,320	(839)	(652)
Net Cost, Intragovernmental	$ 168	$ 2,212	$506	$17	$ -	$ -	$ 2,903	$ (330)	$ 2,573	$ 2,356
With the Public										
Gross Cost	$ 12,135	$229,571	$301,389	$34,959	$ 1	$ 1	$ 578,056	$ -	$ 578,056	$ 537,583
Less: Earned Revenue	-	(1,262)	(32,147)	-	-	-	(33,409)	-	(33,409)	(29,573)
Net Cost, With the Public	$ 12,135	$228,309	$269,242	$34,959	$ 1	$ 1	$ 544,647	$ -	$ 544,647	$ 508,010
Totals										
Gross Cost	$ 12,316	$233,920	$301,900	$34,980	$ 1	$ 1	$ 583,118	$ (1,650)	$ 581,468	$ 540,591
Less: Earned Revenue	(13)	(3,399)	(32,152)	(4)	-	-	(35,568)	1,320	(34,248)	(30,225)
Net Cost of Operations	$ 12,303	$230,521	$269,748	$34,976	$ 1	$ 1	$ 547,550	$ (330)	$ 547,220	$ 510,366

Note 19. Exchange Revenue
HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $34.2 billion and $30.2 billion for the years ended September 30, 2004 and 2003, respectively. HHS' exchange revenue primarily consists of Medicare premiums collected from beneficiaries.

Premiums Collected are used to finance 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 HHS agencies 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. The following is a summary of the prior period adjustments as of September 30, 2004 and 2003.

(Dollars in Millions)	2004	Restated 2003
Increases (Decreases) to Equity		
Correction of Errors	$ 404	$ 373
Change in Accounting Principles	-	-
Departmental Adjustments to Beginning Net Position	-	(120)
Total	$ 404	$ 253

Departmental Adjustments to Beginning Net Position represent audit adjustments booked in the final HHS Agency statements but not in time to be included in the HHS Department statements. In FY 2003 an additional $14 million net position adjustment related to prior year intra-HHS eliminations is included in the departmental adjustment. These adjustments are top-side, department-level adjustments that are not included in the Agency level statements. Therefore, the Department must enter an adjustment to Beginning Net Position to reflect HHS' true beginning net position balance on a consolidated basis.

Note 21. Custodial Activity

ACF 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 2004, receipts amounted to $1,489 million ($1,532 million for FY 2003) and outlays amounted to $1,480 million ($1,516 million for FY 2003).

FDA's 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 2004 were $51 million ($398.5 million for FY 2003). CMP collections are immediately forwarded to the Department of the Treasury and cannot be used for FDA operations.

Note 22. Federal Matching Contribution

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 $58.70 from October 2003 through December 2003 and $66.60 from January 2004 through September 2004. Premiums collected from beneficiaries totaled $30.3 billion in FY 2004 ($26.8 billion in FY 2003) and were matched by an $96.7 billion ($84.3 billion in FY 2003) 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. 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.

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 $1,047 million and $1,017 million (restated) as of September 30, 2004 and 2003, respectively.

Note 24. Apportionment Categories of Obligations Incurred

Obligations incurred by apportionment categories at September 30, 2004 and 2003 are summarized below:

	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

Note 24. Apportionment Categories of Obligations Incurred (continued)

	Restated 2003		
(Dollars in Millions)	Direct	Reimbursable	Totals
Category A	$ 89,897	$ 4,986	$ 94,883
Category B	549,294	515	549,809
Exempt from apportionment	3,997	-	3,997
Total Obligations Incurred	$ 643,188	$ 5,501	$ 648,689

The FY 2003 Category A direct obligation has been restated from $103,721 million to $89,897 million and Category B direct obligation has been restated from $533,545 million to $549,294 million, increasing direct obligations by $1,925 million. In addition, certain amounts reported in FY 2003 as Category B representing the Medicare benefit payments are being reported as exempt in FY 2004 as a result of OMB's change in apportionment requirements. Medicare benefit payment obligations are exempt from apportionment in FY 2004.

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. OMB has exempted CMS from the Circular No. A-11 requirement to report the recoveries of prior year obligations separately on the SF-133. Therefore, recoveries of prior year obligations have not been reported separately within the financial statements.

Note 25. Legal Arrangements Affecting Use of Unobligated Balances

Unobligated balances consist of appropriated funds, revolving funds, management funds, trust funds, NIH's 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 5 subsequent years. Revolving funds are no year funds without any time limit. The NIH Management fund is available for two fiscal years. The trust funds are also no year funds without time limits. NIH's CRADA funds are available for the performance of the contractual agreement.

FDA has a Contingency Fund that was established in FY 1983 whereby funds are to be used for unusual direct costs of product emergencies (i.e., Tylenol incident, Breast Implant Hotline, etc.). Two rules were set for this fund: (1) only for emergency costs exceeding $100 thousand over the normal budget and (2) any use has to be specifically apportioned and approved by OMB. During FY 2003, FDA requested and was approved by OMB to utilize the balance of this account ($1.2 million) in support of food safety and security activities, including testing methodologies, reagents and chemical supplies. FDA did not request additional resources for this account in FY 2004. FDA received $151.1 million in funding in FY 2002, to remain available until expended, to support Counter Terrorism projects. FDA's focus is in three key areas: food safety, safe and effective medical products, and physical security. The amount obligated for counter terrorism projects through FY 2003 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" calls 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 SFFAS No. 7 calls 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 2006 President's Budget, with actual numbers for FY 2004, has not yet been published, and therefore no comparisons can be made between FY 2004 amounts presented in the SBR with amounts reported in the 'actual' column of the President's Budget. The FY 2006 President's Budget is expected to be released in February 2005, and may be obtained from the OMB website http://www.whitehouse.gov/omb/budget or the Government Printing Office (GPO).

The Budget of the United States Government, FY 2005 – Appendix for the HHS, was used as the reference for the Total Budgetary Resources amount and the Federal Programs by Agency and the Account in Chapter 27 of the FY 2005 Analytical Perspectives was used as the reference for the Net Outlays (less Offsetting Receipts) amount in the following reconciliation of the SBR to the U.S. Budget for FY 2003.

The reconciliation is disclosed in the following table:

(Dollars in Millions)	2003	
	Budgetary Resources	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$ 656,332	$ 505,328
Unobligated Balances – Not Available	(5,089)	
Other	1,742	18
Budget of the U.S. Government	$ 652,985	$ 505,346

For the budgetary resources reconciliation, the amount used from the U.S. Budget was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the SBR and not the U.S. Budget is the budgetary resources that are not available. The Other line in the table above includes restated budgetary resources for FY 2003, timing differences, and the difference in offsetting collections reported between the SBR and the U.S. Budget. The FY 2003 SBR did not include the CMS intrabudgetary receipts on line 16, offsetting receipts, of the SBR. After receiving a memo from OMB that addressed the proper reporting of offsetting receipts, HHS revised the reporting of offsetting receipts to conform to the latest guidance. As a result, the FY 2003 SBR was restated to reflect the correct reporting of the interfund transfers on line 16 as offsetting receipts.

Note 26. Explanation of Differences Between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government (continued)
For fiscal years 2003 and prior, CMS reported only the HI and SMI premiums collected as offsetting receipts. The transfers from PTF to HI and SMI were not reported. As a result, duplication of CMS outlays in the PTF outlays and the HI and SMI outlays. The USSGL crosswalk for the SBR included accounts for Medicare premiums but not for the PTF transfers. Also, the OMB Circular No. A-11 did not provide definitive support as to whether PTF transfers should be reported on this line.

In FY 2004, the USSGL revised the SBR crosswalk for offsetting receipts to include transfers between the general fund and trust funds. In addition, OMB revised Circular No. A-11, clarifying that "intrabudgetary receipts" (which includes PTF transfers) should be reported on the offsetting receipts line. Accordingly, CMS has restated the FY 2003 offsetting receipts to include PTF transfers to HI and SMI. (The offsetting receipts line of the Statement of Financing has been similarly restated). Including PTF transfers as offsetting receipts eliminates the duplication in outlays and reconciles CMS' total net outlays to the *Budget of the U.S. Government*.

ACF, CDC, HRSA, and IHS restated the offsetting receipts that were not included in the FY 2003 SBR. The amounts were $1.1 billion, $l million, $210 million and $37 million respectively. NIH reported $9 million on line 16 of the SBR. The offsetting receipts for NIH are composed of the proprietary receipts from the public for CRADA. For CRADA the $16 million cash collected is recorded as deferred revenue and revenue is recognized at the time the expenses are incurred.

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.

Note 28. Permanent Indefinite Appropriations

The HHS permanent indefinite appropriations are open ended as it relates to the period of availability and the dollar amount. These appropriations must have both the budget authority available for the use for a specific purpose, without current year action by Congress once the appropriation has been established. Indefinite authority means that the dollar amount is unknown at the time the authority is granted.

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
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

Note 29. Adjustments to Beginning Balance of Budgetary Resources
During FY 2003, FDA accelerated the billing and collection of FY 2004 advanced fees from the drug industry. The fees collected in advance were unavailable in FY 2003 and did not become available until the beginning of FY 2004 after the passage of the FDA appropriation. The collection of these advances is authorized by the Prescription Drug User Fee Act of 1992 (PDUFA) 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, P.L. 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 2004. This resulted in a $139 million difference in the ending unobligated balance for FY 2003 and the beginning unobligated balance for FY 2004.

U.S. Department of Health and Human Services
Stewardship Property, Plant, and Equipment
For the Year Ended September 30, 2004

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

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

Asset Descriptions	Number of Sites	Total Square Footage	Federal Hectares	Total Hectares
Heritage Assets	2	2,295	1 (4+/- acres)	1 (4+/- acres)
Indian Trust Lands	78	N/A	424.7 (1,049 acres)	424.7 (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				34	254
Oklahoma City				1	2
Phoenix	1	2,295		13	19
Portland				3	1
Tucson				5	12
Total IHS	2	2,295	< 1.82	78	424

U.S. Department of Health and Human Services
Investment in Human Capital
For the Year Ended September 30, 2004

RESPONSIBILITY SEGMENT PROGRAM	2004	2003	2002	2001	2000
ACF					
Administration on Developmental Disabilities	$9	$10	$6	$6	$8
NIH					
Research Training and Career Development	1,696	1,405	1,248	1,118	871
Totals	**$1,705**	**$1,415**	**$1,254**	**$1,124**	**$879**

"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. For September FY 2004 and September FY 2003, grants awarded totaled $9 million and $10 million respectively.

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, 2004

Responsibility Segments	2004 Basic	2004 Applied	2004 Develop-Mental	2004 Total	2003 Total	2002 Total	2001 Total	2000 Total	Grand Total
ACF		$21		$21	$24	$29	$32	$30	$136
AHRQ		170		170	163	150	127	95	705
CDC		549		549	557	533	557	505	2,701
FDA *		26	2	28	32	29	26	26	141
HRSA		16		16	16	16	16	15	79
NIH	14,220	9,480		23,700	21,359	19,058	16,007	14,690	94,814
Totals	**$14,220**	**$10,262**	**$2**	**$24,484**	**$22,151**	**$19,815**	**$16,765**	**$15,361**	**$98,576**

*FDA restated its FY 2003 amount by 1.

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.

HIV/AIDS prevention, Infectious Diseases, Chronic Disease Prevention, and Occupational Safety and Health 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, 2004

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost 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 account within the SMI trust fund will handle the transactions for this new benefit. 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 in CMS's financial 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 is 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 *2004 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 CMS Office of the Actuary (410-786-6386). The report is also available online at www.cms.hhs.gov/publications/ trusteesreport/default.asp.

Actuarial Projections for Medicare

Cash flow in Nominal Dollars

Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cash flow 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 the mind can comprehend in today's experience.

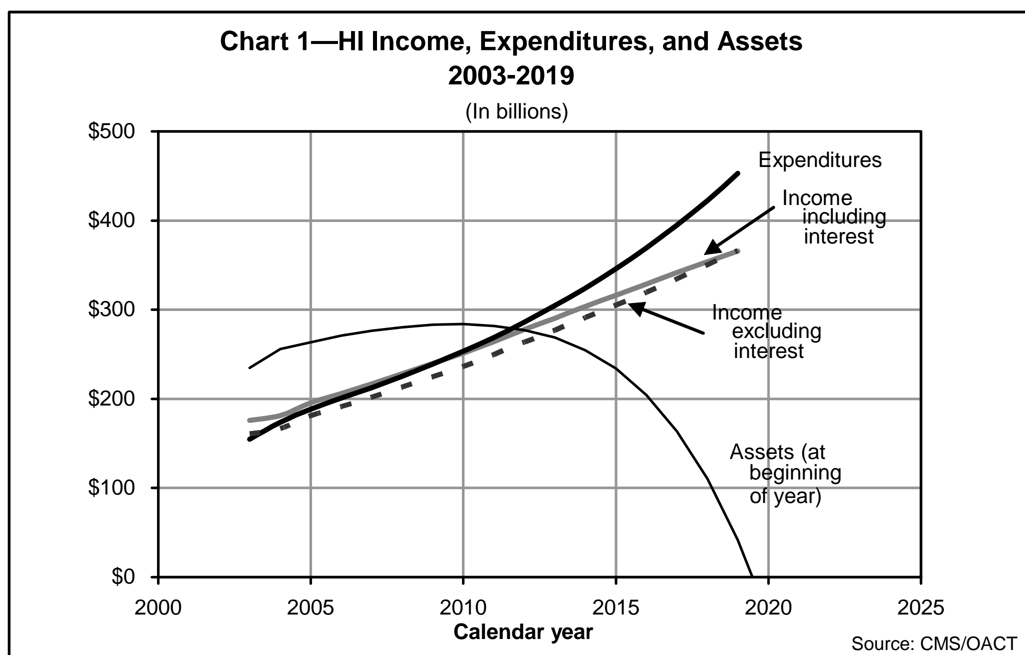
For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2019. Estimates for SMI Parts B and D are presented 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 taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 16 years.

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

The estimates also include expenditures attributable to these current and future workers, in addition to current beneficiaries.



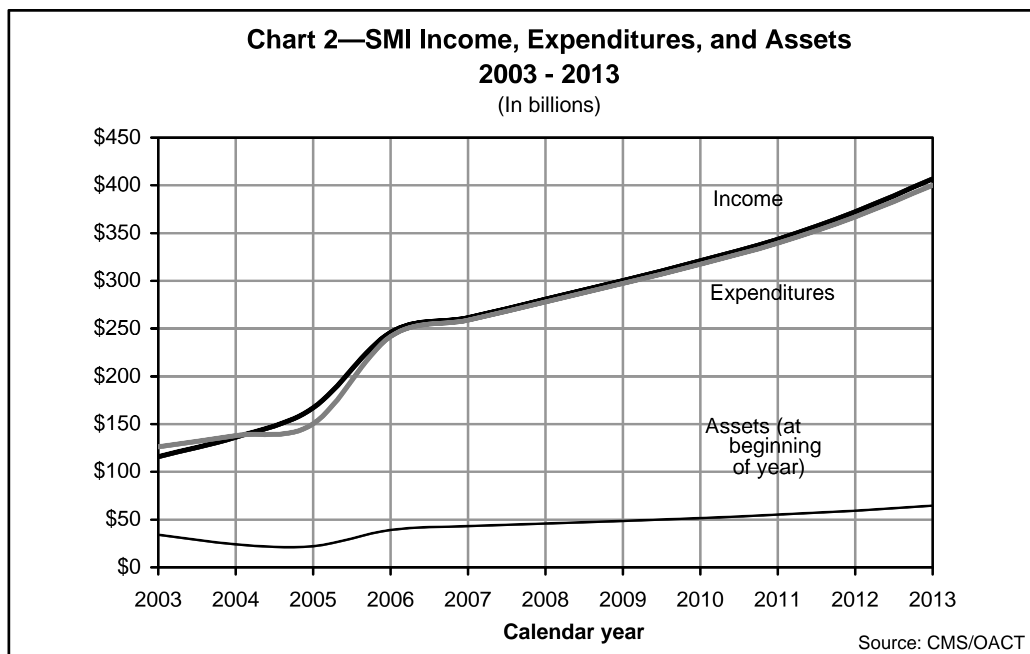
As Chart 1 shows, under the intermediate assumptions HI expenditures would begin to exceed income including interest in 2010 and income excluding interest in 2004. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the trust fund would start redeeming trust fund assets; in 2019, the assets would be depleted—seven years earlier than estimated in the 2003 Trustees Report. For the first time since the 1999 Trustees Report, 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 ten 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 2019, 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 at all based on payroll taxes but instead on 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. 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.



Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, and interest earned on the U.S. Treasury securities held by the trust fund.[2] Chart 2 displays only total income; it does not represent income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[3] Expenditures include benefit payments as well as administrative expenses.

As Chart 2 indicates, SMI income is very close to expenditures. As noted earlier, this is due to 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.

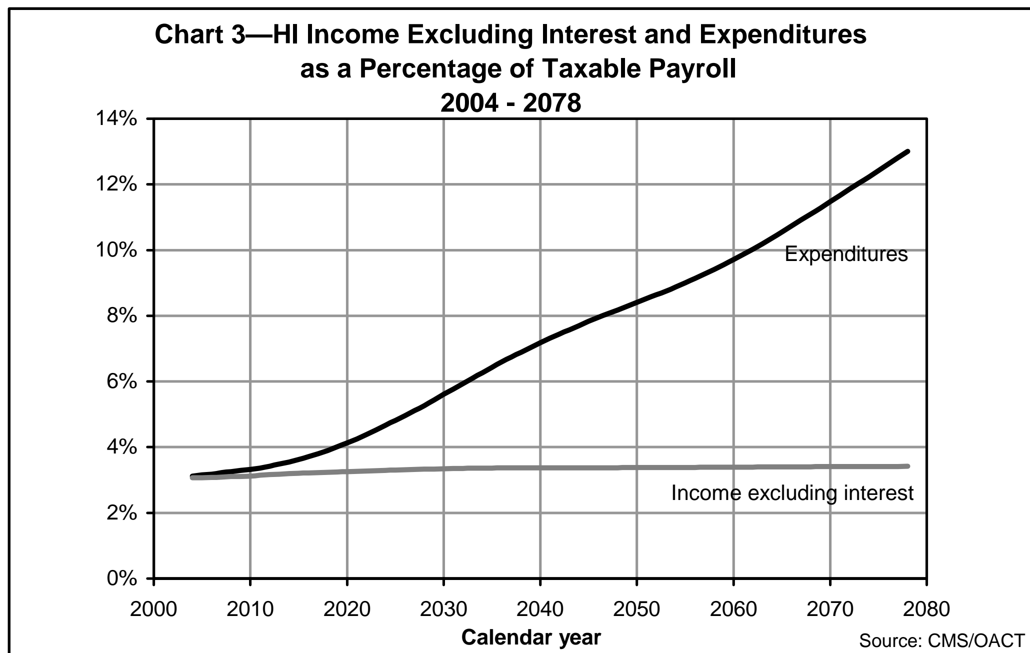
[2] In the financial statements for CMS, Medicare income and expenditures are shown from a "trust fund perspective." All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual *Financial Report of the United States Government*, also known as the 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.

[3] Interest income is generally about three percent of total SMI income.

HI Cash flow 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 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.



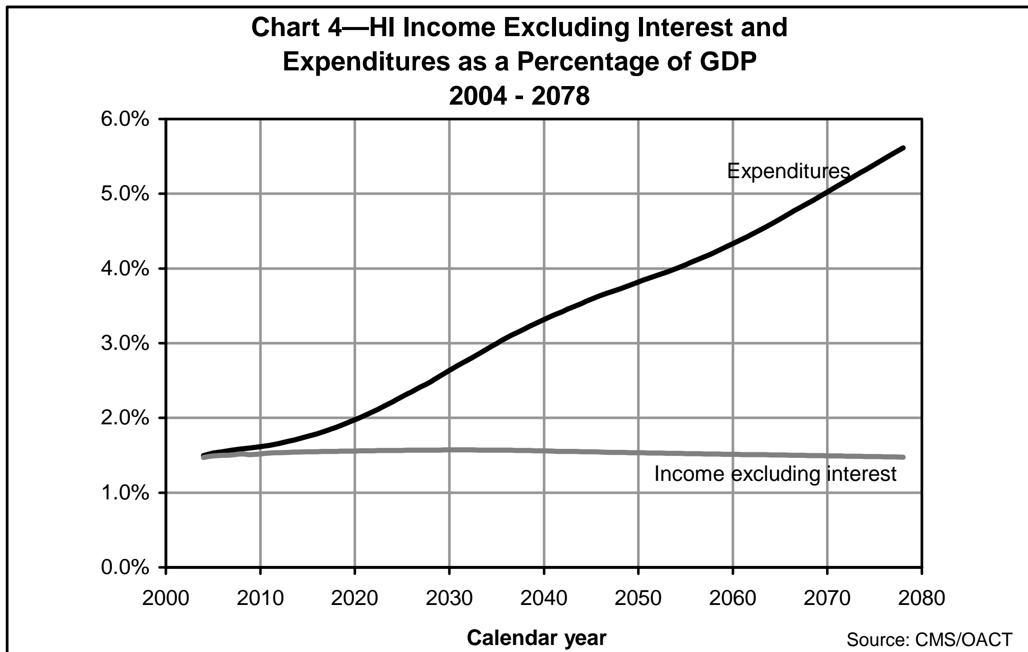
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll will remain constant at 2.9 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become 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 Cash flow 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 2003, the expenditures were $154.6 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.

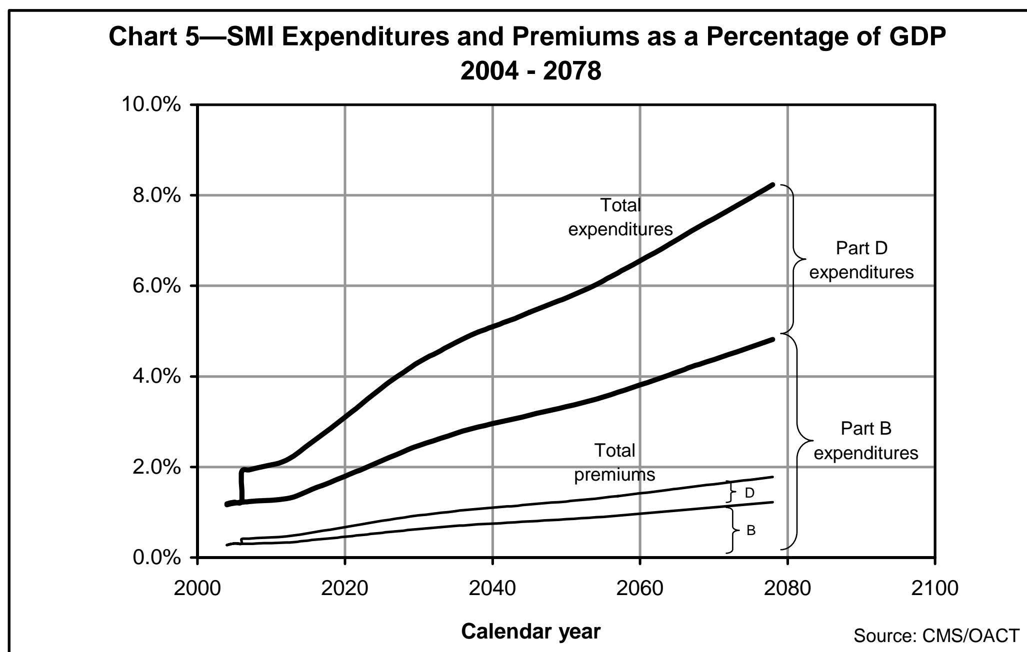


SMI

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 past and 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 assumptions.

Under the intermediate assumptions, annual SMI expenditures would grow from about one percent of GDP in 2003 to two percent of GDP in 2006 with the commencement of the general prescription drug coverage. Then, within 20 years, they would grow to four percent of GDP and to more than eight percent by the end of the projection period.

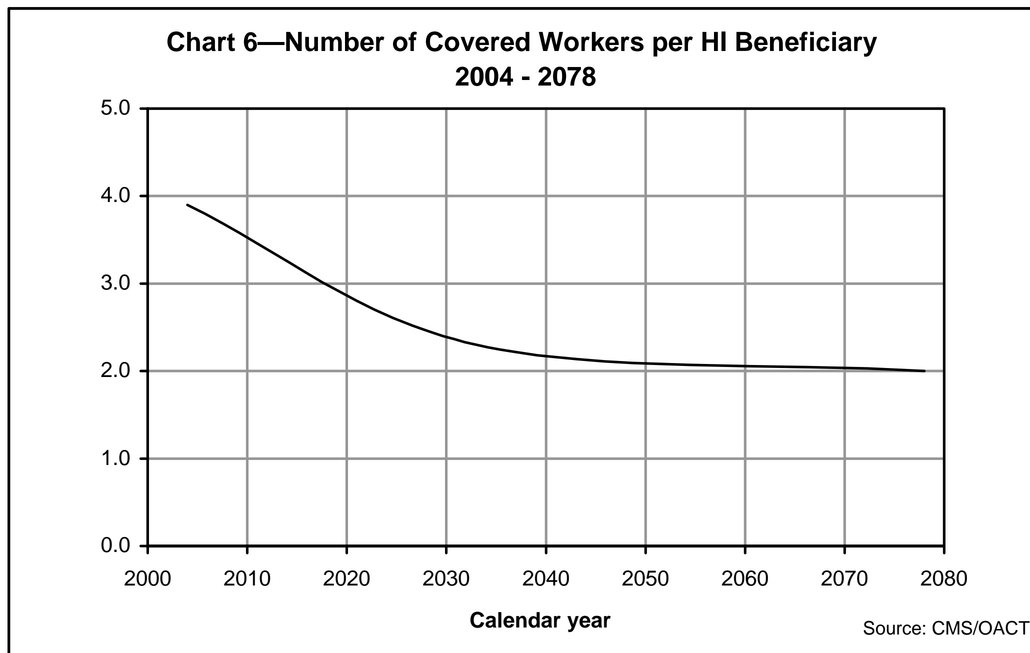


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least five percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate.

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 2003, 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 2078.



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 cash flow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income.

Table 1—Actuarial Present Values of Hospital Insurance and Supplementary Medical Insurance Revenues and Expenditures: 75-year Projection as of January 1, 2004

(In billions)

	HI					SMI[2] Part B					SMI[2] Part D				
	2004	2003	2002	2001	2000	2004	2003	2002	2001	2000	2004	2003	2002	2001	2000
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)	$4,820	$4,510	$4,408	$4,136	$3,757	$10,505	$8,796	$7,423	$7,378	$6,109	$7,545	—	—	—	—
Have attained eligibility age (age 65 and over)	148	128	125	113	97	1,310	1,160	1,008	1,032	934	713	—	—	—	—
Those expected to become participants (under age 15)	4,009	3,773	3,753	3,507	3,179	3,514	2,817	2,402	2,370	1,616	2,511	—	—	—	—
All current and future participants	8,976	8,411	8,286	7,757	7,033	15,329	12,773	10,833	10,780	8,659	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)	12,054	10,028	9,195	8,568	6,702	10,577	8,845	7,463	7,415	6,094	7,566	—	—	—	—
Have attained eligibility age (age 65 and over)	2,168	1,897	1,747	1,693	1,681	1,475	1,306	1,132	1,159	1,051	773	—	—	—	—
Those expected to become participants (under age 15)	3,246	2,653	2,470	2,225	1,349	3,277	2,622	2,238	2,206	1,514	2,431	—	—	—	—
All current and future participants	17,468	14,577	13,412	12,487	9,732	15,329	12,773	10,833	10,780	8,659	10,770	—	—	—	—
Actuarial present value[1] of estimated future income (excluding interest) less expenditures	-8,492	-6,166	-5,126	-4,730	-2,700	0	0	0	0	0	0	—	—	—	—
Trust fund assets at start of period	256	235	209	177	141	24	34	41	44	45	0	—	—	—	—
Assets at start of period plus actuarial present value[1] of estimated future income (excluding interest) less expenditures	-8,236	-5,931	-4,917	-4,553	-2,558	24	34	41	44	45	0	—	—	—	—

[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 2 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 covers 75 years, a period that covers most of their 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 on the previous page, the HI trust fund has an actuarial deficit[4] of more than $8.2 trillion over the 75-year projection period, as compared to more than $5.9 trillion in the 2003 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.[5]

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 cash flow projections, they nonetheless pose a serious financial problem for the HI trust fund.

A figure as large as $8.2 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 $272 trillion in the 2004 Trustees Report. Thus, the $8.2 trillion deficit represents approximately 3.0 percent of future taxable payroll.

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, 2004. 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 nonexchange 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.

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 2004. In practice, a number of specific assumptions are made for each of the different types of service

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

[5] As noted in footnote 2, 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 2078 would exceed the present value of projected SMI premium and State transfer revenue alone by $19.5 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 $28.1 trillion. This *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.

provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the utilization, volume, 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

				Annual percentage change in:						
							Per beneficiary cost[3]			Real-
	Fertility	Net	Real-wage			Real		SMI		interest
	rate[1]	immigration	differential[2]	Wages	CPI	GDP	HI	B	D	rate[4]
2004	2.02	1,175,000	2.4	3.6	1.2	4.4	6.5	7.0	—	3.2
2005	2.01	1,150,000	2.8	4.3	1.5	3.6	5.6	6.5	—	3.3
2010	2.00	1,025,000	1.3	4.1	2.8	2.6	3.9	3.8	6.5	3.1
2020	1.97	950,000	1.1	3.9	2.8	1.8	4.1	5.4	6.4	3.0
2030	1.95	900,000	1.1	3.9	2.8	1.8	5.6	5.2	4.9	3.0
2040	1.95	900,000	1.1	3.9	2.8	1.8	5.9	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	5.0	3.0
2070	1.95	900,000	1.1	3.9	2.8	1.8	5.4	5.1	5.1	3.0
2078	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 CPI.
[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 recent experience. 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 cash flows.[6] The assumptions varied are the fertility rate, net immigration, real-wage differential, CPI, real-interest rate, and health care cost factors.[7]

For this analysis, the intermediate economic and demographic assumptions in the *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s 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, 2004 and are based on estimates of income and expenditures during the 75-year projection period.

[6] 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.

[7] 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.

Charts 7 through 12 show the net annual HI cash flow in nominal dollars and the present value of this net cash flow for each assumption varied. In most instances, the charts depicting the estimated net cash flow indicate that, after increasing in the early years, net cashflow decreases steadily through 2019 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.

Fertility Rate

Table 3 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.

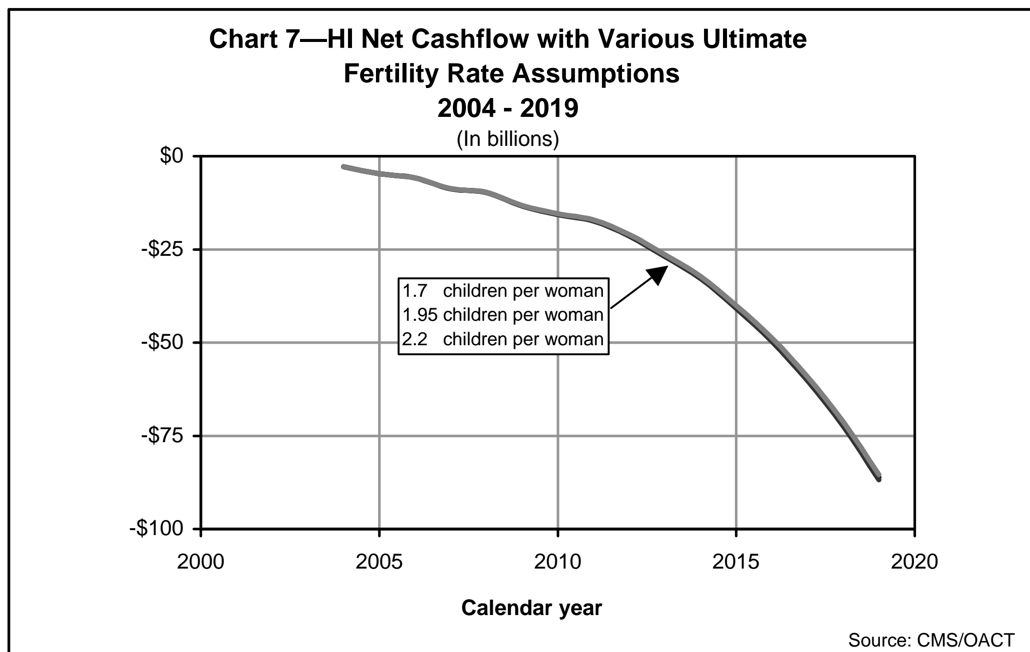
Table 3—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

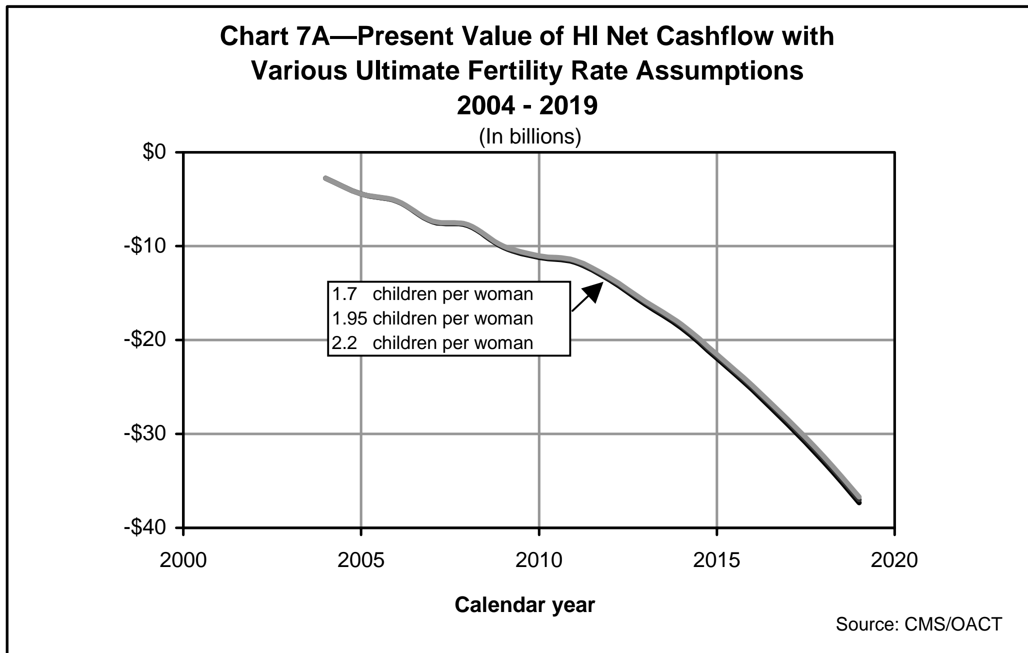
Ultimate fertility rate[1]	1.7	1.95	2.2
Income minus expenditures (in billions)	-$8,639	-$8,492	-$8,350

[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 3 indicates, for an increase of 0.25 in the assumed ultimate fertility rate, the projected deficit of income over expenditures decreases by approximately $150 billion.

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





As Charts 7 and 7A indicate, the fertility rate assumption has only a negligible impact on projected HI cash flows 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 changes are somewhat greater, as illustrated by the present values in Table 3.

Net Immigration

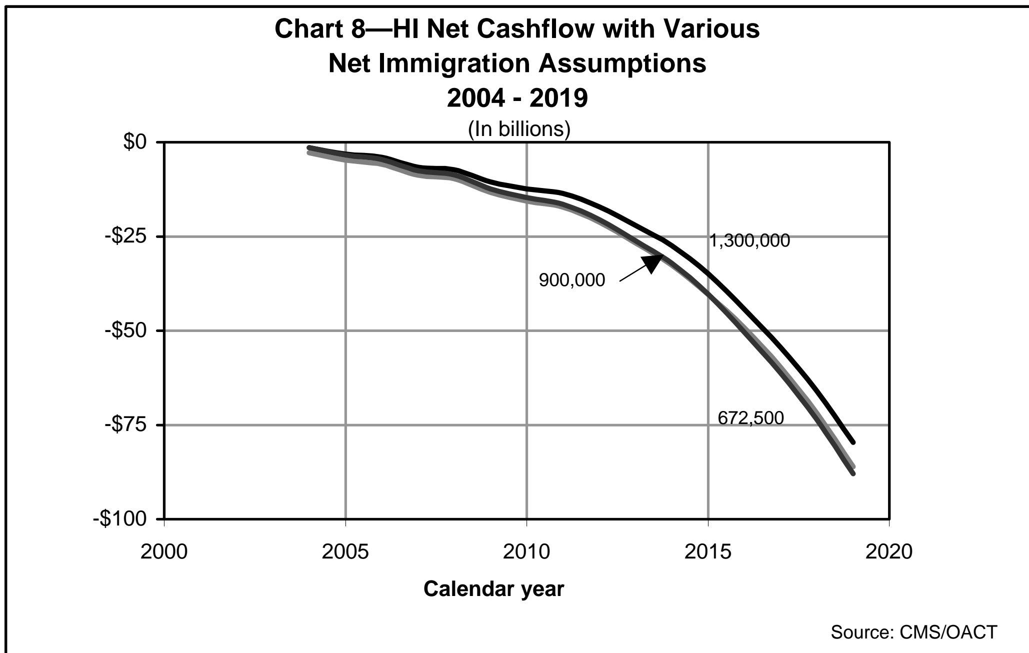
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

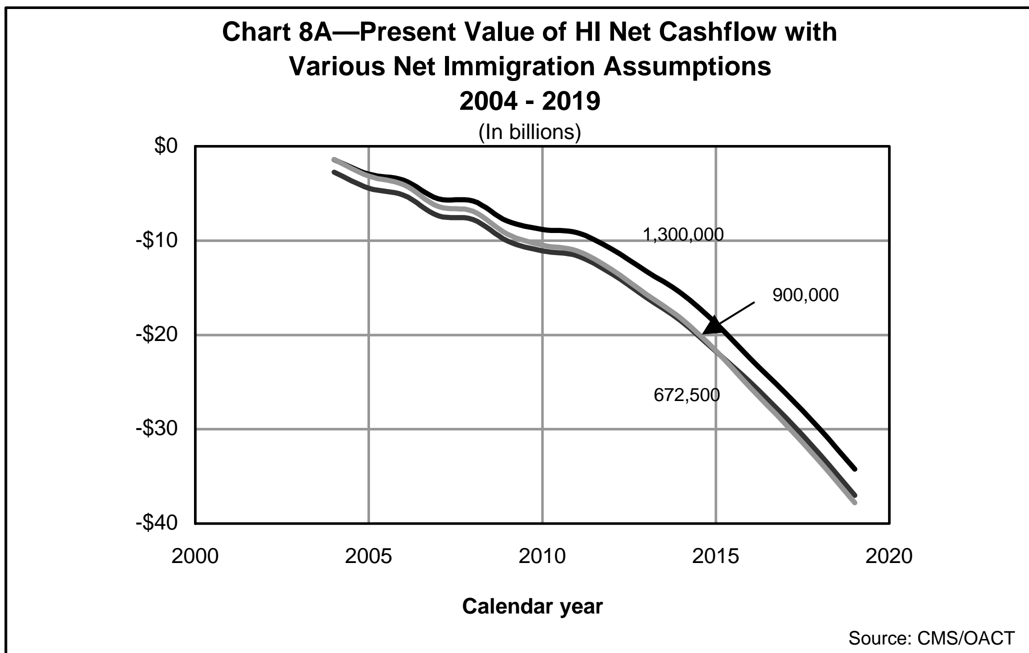
Table 4—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures (in billions)	-$8,299	-$8,492	-$8,525

As shown in Table 4, if the ultimate net immigration assumption is 672,500 persons, the deficit of income over expenditures decreases by $193 billion. On the other hand, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases less, by $33 billion.

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





As Charts 8 and 8A 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, while in the long term, the opposite occurs as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

Real-Wage Differential

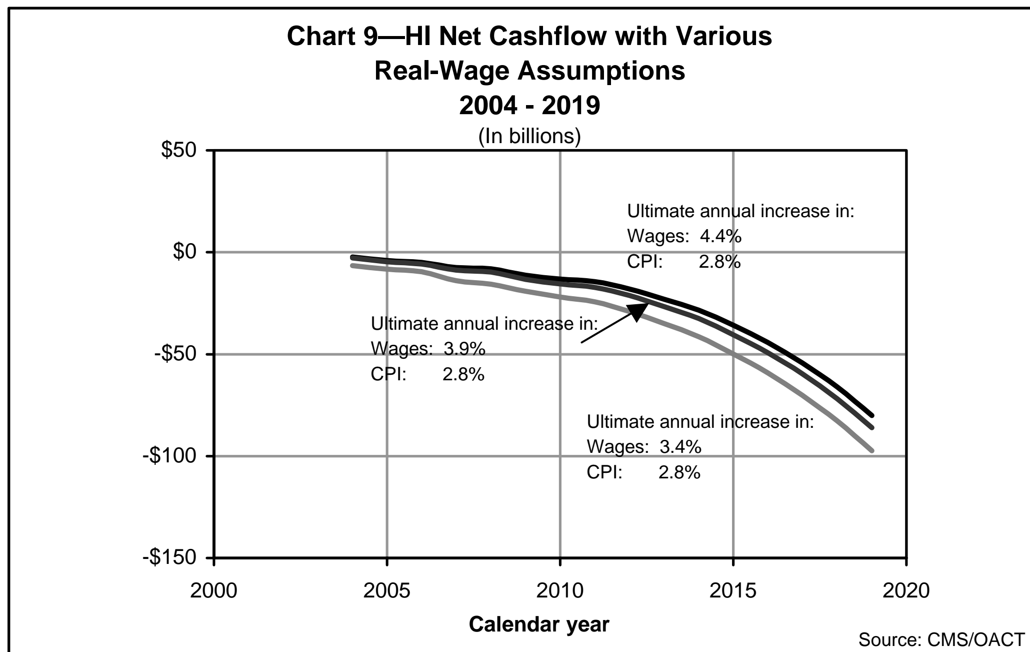
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[8] assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

Table 5—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

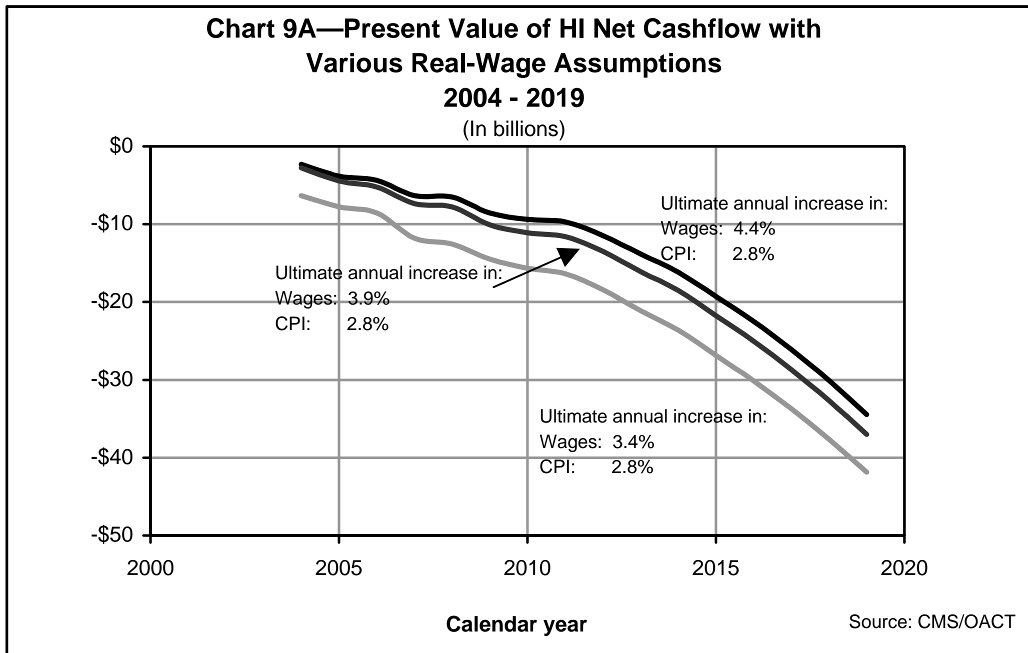
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 -2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures (in billions)	-$9,155	-$8,492	-$7,974

As indicated in Table 5, for a half-point increase in the ultimate real-wage differential assumption, the deficit of income over expenditures decreases by approximately $500 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in Table 5.



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



As Charts 9 and 9A 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

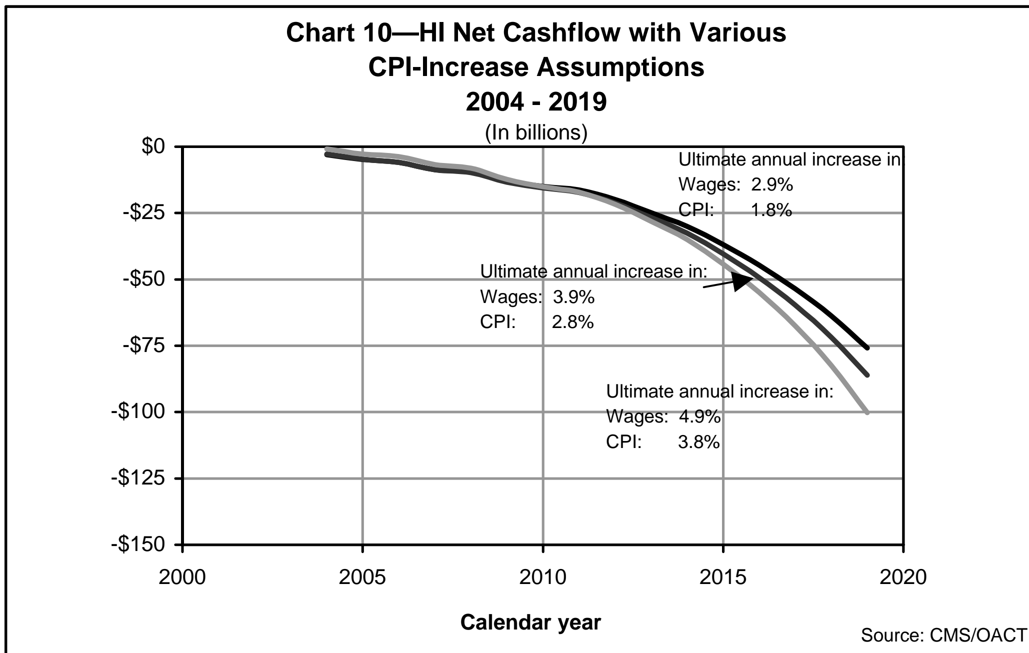
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

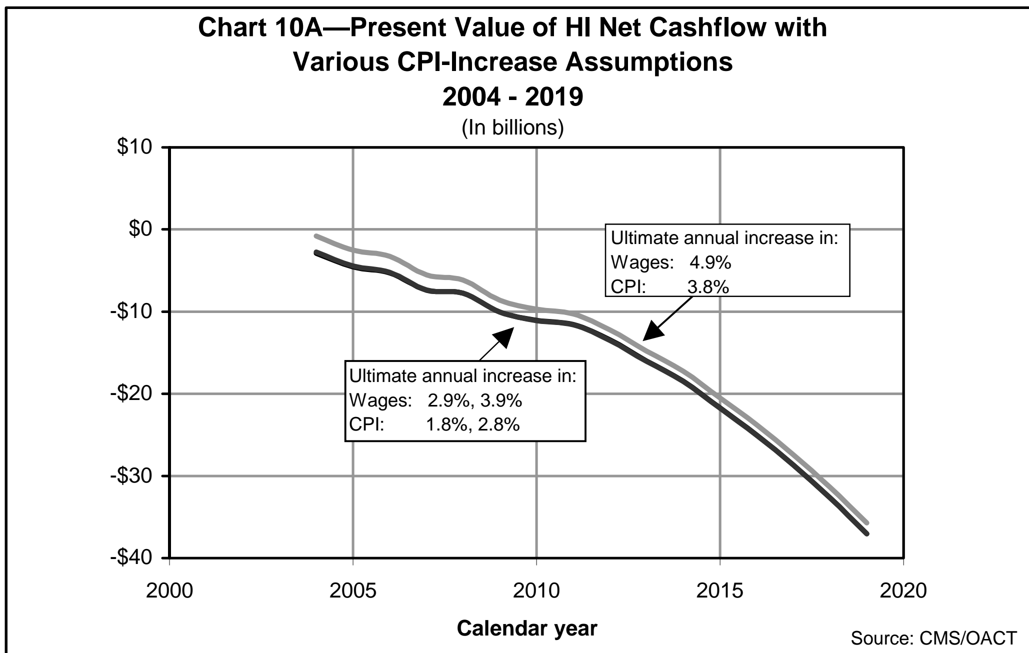
Table 6—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-$8,525	-$8,492	-$8,316

Table 6 shows that if the ultimate CPI-increase assumption is 1.8 percent, the deficit of income over expenditures increases by only $33 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases more, by $176 billion.

Charts 10 and 10A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in Table 6.





As Charts 10 and 10A 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

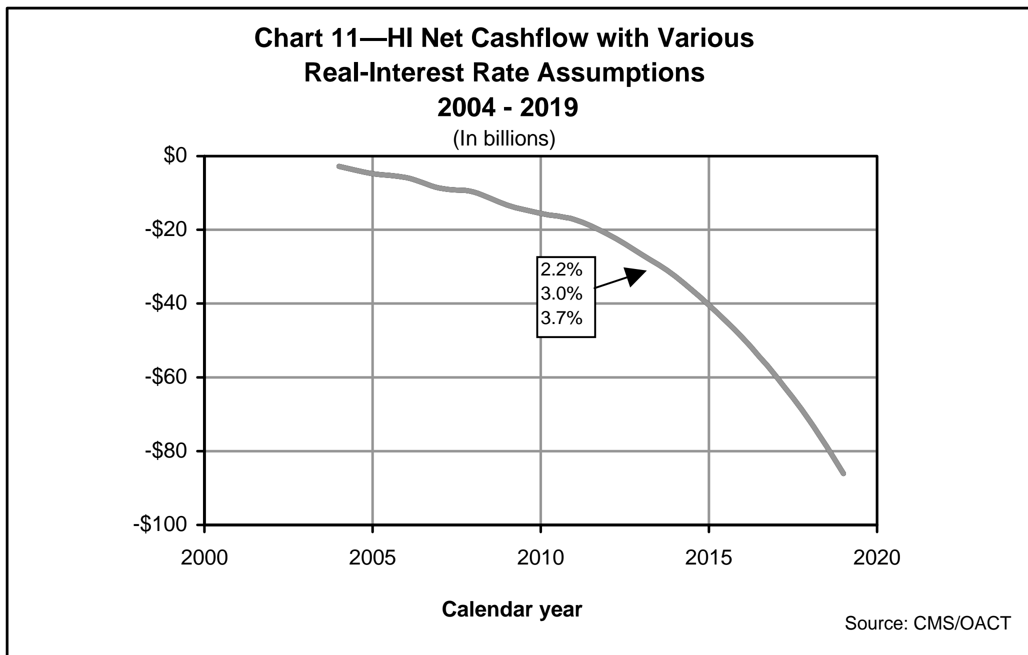
Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate annual yields of 5.0, 5.8, and 6.5 percent, respectively.

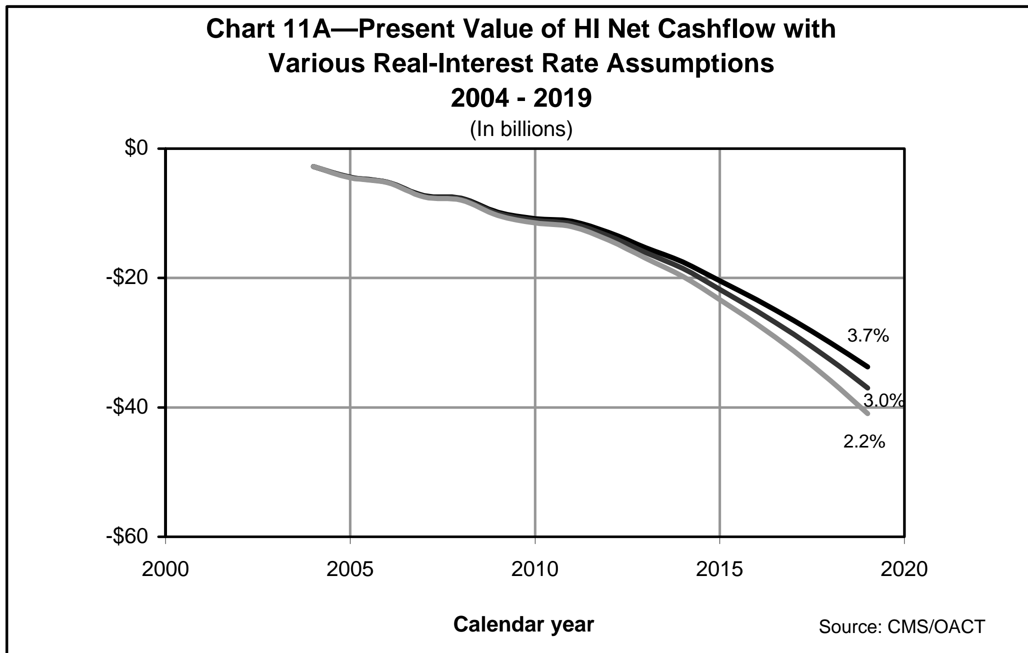
Table 7—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.2 percent	3.0 percent	3.7 percent
Income minus expenditures (in billions)	-$12,231	-$8,492	-$6,054

As illustrated in Table 7, for an increase of 0.1 in the ultimate real-interest rate percentage, the deficit of income over expenditures decreases by approximately $400 billion.

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





As shown in Charts 11 and 11A, 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 2019. 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), with the result being that the overall net present value is smaller.

Health Care Cost Factors

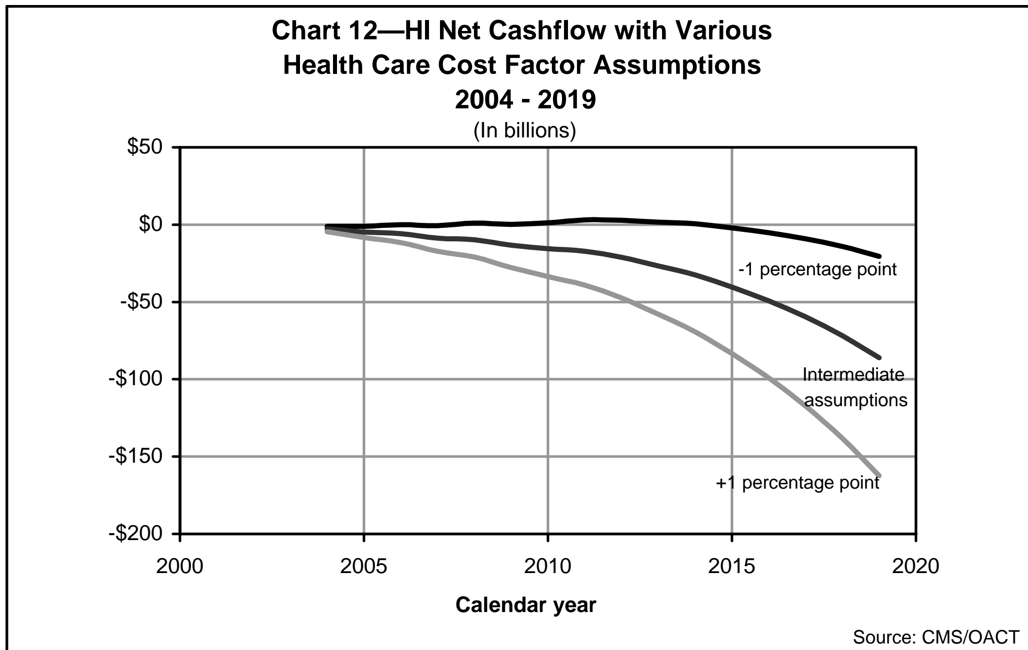
Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, 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.

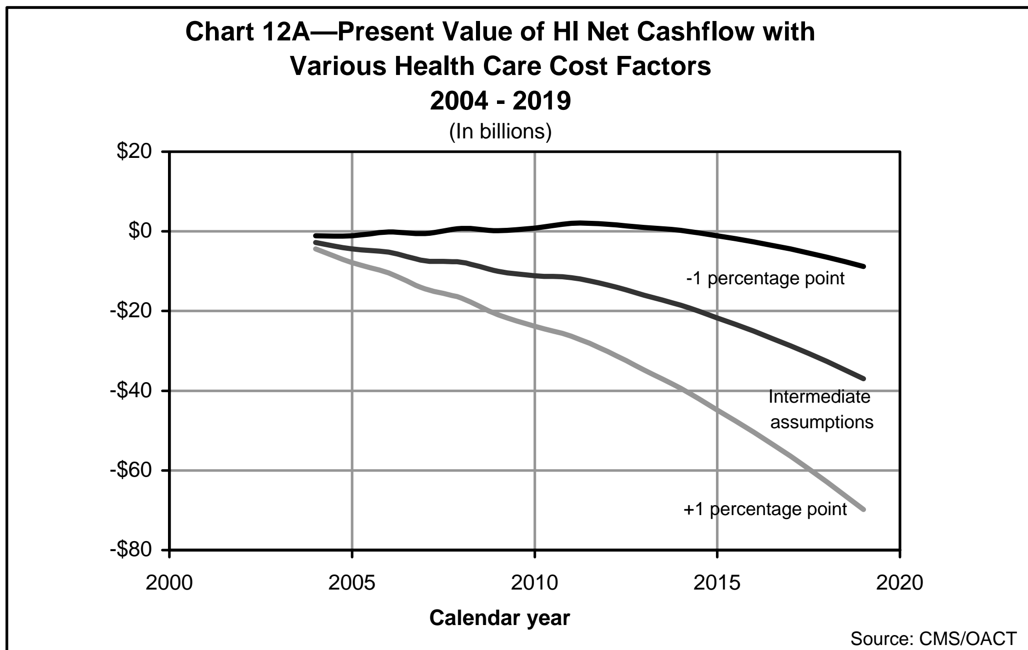
Table 8—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	-$2,990	-$8,492	-$17,531

Table 8 indicates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income over expenditures decreases by $5,502 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 $9,039 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in Table 8.





This assumption has a dramatic impact on projected HI cashflow. The assumptions analyzed thus far have affected both HI income and costs. However, 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 12 and 12A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Trust Fund Finances and Sustainability

HI

The financial status of the HI trust fund has deteriorated significantly compared with last year's estimates; asset exhaustion is projected to occur in 2019 under current law compared to 2026. This change results primarily from the 2003 legislation and from higher HI expenditures and lower payroll tax revenues in 2003 than expected (and associated assumption adjustments). Under the Medicare Trustees' intermediate assumptions, income from all sources is projected to continue to exceed expenditures for the next 6 years but to fall short by steadily increasing amounts in 2010 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 2004, along with a portion of account assets, is estimated to be sufficient to cover expenditures for that year and to maintain a minimally adequate contingency reserve. The Part B premium and corresponding general revenue transfers will need to be increased sharply for 2005 to match projected costs and to restore Part B assets to a more adequate reserve level.

The operations of the Part D account in 2004 and 2005 will relate only to the transitional assistance benefit for low-income beneficiaries. No financial imbalance is likely, 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 will necessitate an adequate asset balance.

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 and society at large.

Medicare Overall

The projections shown in this section continue to demonstrate the need for the Administration and the Congress 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 their 2004 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." They also stated: "Consideration of such reforms should occur in the relatively near future."

U.S. Department of Health and Human Services
Combining Statement of Budgetary Resources
For the Year Ended September 30, 2004
(In Millions)

	CMS			Other	
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Totals
Budgetary Resources:					
1. Budget Authority	$ 179,760	$123,676	$ 181,546	$ 215,620	$ 700,602
2. Unobligated Balances – Beginning of Period	-	-	-	7,764	7,764
3. Spending Authority from Offsetting Collections	-	-	168	10,006	10,174
4. Recoveries of prior year obligations	-	-	7,527	2,206	9,733
5. Temporarily not available pursuant to Public Law	(13,941)	10,020	-	(287)	(4,208)
6. Permanently not available (-)	-	-	-	(2,981)	(2,981)
7. Total Budgetary Resources	$ 165,819	$ 133,696	$ 189,241	$ 232,328	$ 721,084
Status of Budgetary Resources:					
8. Obligations Incurred	$ 165,819	$ 133,696	$ 183,330	$ 219,242	$ 702,087
9. Unobligated Balances - Available	-	-	5,884	7,336	13,220
10. Unobligated Balances - Not Available	-	-	27	5,750	5,777
11. Total Status of Budgetary Resources	$ 165,819	$ 133,696	$ 189,241	$ 232,328	$ 721,084
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net – Beginning of Period	$ 16,235	$ 16,404	$ 8,797	$ 70,772	$ 112,208
13. Obligated Balance Transferred, Net (+/-)	-	-	-	476	476
14. Obligated Balance, Net – End of Period	16,090	15,979	9,315	72,185	113,569
15. Outlays	165,964	134,121	175,117	206,093	681,295
16. Less: Offsetting receipts	11,547	125,078	-	1,195	137,820
17. Net Outlays	$ 154,417	$ 9,043	$ 175,117	$ 204,898	$ 543,475

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 51,012	$ 51,012	$ 44,916
AoA	1,387	1,387	1,351
AHRQ	356	356	73
CDC	6,474	6,474	5,526
CMS	119,823	119,823	109,884
FDA	1,916	1,916	1,378
HRSA	7,600	7,600	6,723
IHS	4,422	4,422	3,049
NIH	31,014	31,014	25,669
OS	3,917	3,917	2,901
PSC	918	918	317
SAMHSA	3,489	3,489	3,111
	$ 232,328	$ 232,328	$ 204,898

[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, 2004
(In Millions)

	HHS Service and Supply Fund	NIH Service and Supply Fund	Combined Totals
Assets			
Fund Balance with Treasury	$ 38	$ 316	$ 354
Accounts Receivable, Net	163	4	167
Property, Plant and Equip, Net	15	170	185
Other Assets	22	14	36
Total Assets	$ 238	$ 504	$ 742
Liabilities			
Accounts Payable	$ 61	$ 47	$ 108
Other Liabilities	18	282	300
Total Liabilities	$ 79	$ 329	$ 408
Net Position			
Cumulative Results of Operations	$ 159	$ 175	$ 334
Total Liabilities and Net Position	$ 238	$ 504	$ 742

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, 2004
(In Millions)

Program/Business Line	Gross Costs	Less: Earned Revenue	Net Costs
HHS Service and Supply Fund			
Administrative Operations Services	$ 199	$ (183)	$ 16
Financial Management Service	45	(59)	(14)
Human Resources Service	80	(81)	(1)
Federal Occupational Health	179	(171)	8
Total	$ 503	$ (494)	$ 9
NIH Service and Supply Fund			
Research Support	$ 760	$ (793)	$ (33)
Total	$ 760	$ (793)	$ (33)

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, “fee-for-service” 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 agencies 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, 2004 and 2003

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	
		2004	2003
General PP&E			
Buildings	2 - 4	$ 915	$ 618
Equipment	2 - 4	8	8
Other Structures	2 - 4	37	37
Total		$ 960	$ 663

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, 2004
(In Millions)

Agency	TFM Dept Code	Fund Bal. w/ Treasury	Investments	Accounts Receivable	Other
Dept of Agriculture	12			3	-
Dept of Commerce	13			6	35
Dept of Defense	17,215,797			35	-
Dept of Education	91			4	-
Dept of Energy	89			1	-
Dept of Housing & Urban Development	86			2	-
Dept of the Interior	14			1	-
Dept of Justice	15			3	-
Dept of Labor	16			1	-
Dept of State	19			3	-
Dept of Transportation	69			1	-
Dept of the Treasury	20	97,667	287,886	13	9,248
Dept of Veterans Affairs	36			9	352
Agency for International Development	72			3	-
Environmental Protection Agency	68			39	-
Dept of Homeland Security	70			14	-
General Services Admin	47			3	-
National Aeronautics & Space Admin	80			1	-
National Science Foundation	49			1	-
Nuclear Regulatory Commission	31			-	-
Office of Personnel Mgmt	24			-	-
Small Business Admin	73			-	-
Social Security Admin	28			1	-
RRB	60			421	-
All other Federal agencies		-	-	8	(1)
Total		$ 97,667	$ 287,886	$ 573	$ 9,634

U.S. Department of Health and Human Services
Intragovernmental Transactions - Liabilities
For the Year Ended September 30, 2004
(In Millions)

Agency	TFM Dept Code	Accounts Payable	Accrued Payroll & Benefits	Other
Dept of Agriculture	12	-	-	-
Dept of Commerce	13	-	-	-
Dept of Defense	17,215,797	7	-	38
Dept of Education	91	-	-	6
Dept of Energy	89	-	-	-
Dept of Housing & Urban Development	86	-	-	2
Dept of the Interior	14	-	-	-
Dept of Justice	15	-	-	9
Dept of Labor	16	-	18	-
Dept of State	19	-	-	-
Dept of Transportation	69	-	-	-
Dept of the Treasury	20	-	7	322
Dept of Veterans Affairs	36	-	-	1
Agency for International Development	72	-	-	4
Environmental Protection Agency	68	-	-	127
Dept of Homeland Security	70	-	-	63
General Services Admin	47	20	-	99
National Aeronautics & Space Admin	80	-	-	-
National Science Foundation	49	-	-	-
Nuclear Regulatory Commission	31	-	-	-
Office of Personnel Mgmt	24	-	39	-
Small Business Admin	73	-	-	-
Social Security Admin	28	620	-	-
RRB	60	-	-	-
All other Federal agencies		5	-	114
Total		$ 652	$ 64	$ 785

U.S. Department of Health and Human Services
Intragovernmental Transactions - Revenues & Expenses
For the Year Ended September 30, 2004
(In Millions)

Agency	TFM Dept Code	Earned Revenue	Gross Cost	Non-exchange Revenue	
				Transfers-In	Transfers-Out
Dept of Agriculture	12	13	(11)	-	-
Dept of Commerce	13	9	(51)	-	-
Dept of Defense	17,215,797	157	(59)	(147)	-
Dept of Education	91	10	(70)	-	-
Dept of Energy	89	39	(61)	-	-
Dept of Housing & Urban Development	86	8	-	-	-
Dept of the Interior	14	5	(187)	-	-
Dept of Justice	15	27	(134)	315	-
Dept of Labor	16	56	(30)	-	-
Dept of State	19	9	(81)	-	-
Dept of Transportation	69	3	(17)	-	-
Dept of the Treasury	20	15	(345)	41	(76)
Dept of Veterans Affairs	36	42	(321)	-	-
Agency for International Development	72	25	(22)	-	-
Environmental Protection Agency	68	37	(5)	-	-
Dept of Homeland Security	70	301	(1)	-	-
General Services Admin	47	6	(686)	-	-
National Aeronautics & Space Admin	80	5	-	-	-
National Science Foundation	49	1	(18)	-	-
Nuclear Regulatory Commission	31	1	-	-	-
Office of Personnel Mgmt	24	1	(1,135)	-	-
Small Business Admin	73	1	-	-	-
Social Security Admin	28	10	(41)	3	(1,741)
RRB	60	-	-	435	(6)
All other Federal agencies		58	(137)	-	(9)
Total		$ 839	$ (3,412)	$ 647	$ (1,832)

U.S. Department of Health and Human Services
Consolidating Balance Sheet by Budget Function
As of September 30, 2004
(In Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Admin. of Justice	Natural Resources & Environ	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)									
Intragovernmental									
Fund Balance with Treasury (Note 3)	$ 6,498	$ 72,223	$ 2,543	$ 16,385	$ 2	$ 16	$ 97,667	$ -	$ 97,667
Investments, Net (Note 5)	-	2,094	285,792	-	-	-	287,886	-	287,886
Accounts Receivable, Net (Note 6)	2	532	40,982	2	-	-	41,518	(40,945)	573
Anticipated Congressional Appropriation (Note 7)	-	3,603	5,645	-	-	-	9,248	-	9,248
Other (Note 11)	1	744	1	-	-	-	746	(360)	386
Total Intragovernmental	$ 6,501	$ 79,196	$ 334,963	$ 16,387	$ 2	$ 16	$ 437,065	$ (41,305)	$ 395,760
Accounts Receivable, Net (Note 6)	-	699	1,353	-	-	-	2,052	-	2,052
Loans Receivable and Foreclosed Property (Note 8)	-	390	-	-	-	-	390	-	390
Cash and Other Monetary Assets (Note 4)	-	-	460	-	-	-	460	-	460
Inventory and Related Property, Net (Note 9)	-	1,027	-	-	-	-	1,027	-	1,027
General Property, Plant & Equipment, Net (Note 10)	4	3,761	111	-	-	1	3,877	-	3,877
Other (Note 11)	-	110	75	-	-	-	185	-	185
Total Assets	**$ 6,505**	**$ 85,183**	**$ 336,962**	**$ 16,387**	**$ 2**	**$ 17**	**$ 445,056**	**$ (41,305)**	**$ 403,751**
Liabilities (Note 12)									
Intragovernmental									
Accounts Payable	$ 14	$ 159	$ 41,314	$ -	$ -	$ -	$ 41,487	$ (40,835)	$ 652
Accrued Payroll and Benefits	1	60	3	-	-	-	64	-	64
Other (Note 16)	-	935	320	-	-	-	1,255	(470)	785
Total Intragovernmental	$ 15	$ 1,154	$ 41,637	$ -	$ -	$ -	$ 42,806	$ (41,305)	$ 1,501
Accounts Payable	21	732	-	6	-	-	759	-	759
Entitlement Benefits Due and Payable (Note 13)	-	19,354	29,875	-	-	-	49,229	-	49,229
Accrued Grant Liability (Note 15)	591	2,266	-	896	-	2	3,755	-	3,755
Loan Guarantees Liability (Note 8)	-	191	-	-	-	-	191	-	191
Federal Employee and Veterans Benefits (Note 14)	5	7,164	9	-	-	-	7,178	-	7,178
Accrued Payroll and Benefits	17	725	47	-	-	-	789	-	789
Other (Note 16)	-	1,313	2,092	11	-	-	3,416	-	3,416
Total Liabilities	**$ 649**	**$ 32,899**	**$ 73,660**	**$ 913**	**$ -**	**$ 2**	**$ 108,123**	**$ (41,305)**	**$ 66,818**
Net Position									
Unexpended Appropriations	5,878	52,950	7,750	15,474	-	-	82,052	-	82,052
Cumulative Results of Operations	(22)	(666)	255,552	-	2	15	254,881	-	254,881
Total Net Position	$ 5,856	$ 52,284	$ 263,302	$ 15,474	$ 2	$ 15	$ 336,933	$ -	$ 336,933
Total Liabilities and Net Position	**$ 6,505**	**$ 85,183**	**$ 336,962**	**$ 16,387**	**$ 2**	**$ 17**	**$ 445,056**	**$ (41,305)**	**$ 403,751**

U.S. Department of Health and Human Services
Consolidating Balance Sheet by Operating Division
As of September 30, 2004
(In Millions)

	ACF	AoA	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Consolidated Totals	Inter-Agency Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intragovernmental															
Fund Balance with Treasury (Note 3)	$ 22,307	$ 578	$ 82	$ 4,728	$ 26,570	$ 671	$ 5,966	$ 1,443	$ 28,751	$ 3,855	$ 97	$ 2,619	$ 97,667	$ -	$ 97,667
Investments, Net (Note 5)	-	-	-	-	285,792	-	2,077	-	17	-	-	-	287,886	-	287,886
Accounts Receivable, Net (Note 6)	4	-	8	30	421	8	67	24	4	82	157	5	810	(237)	573
Anticipated Congressional Appropriation (Note 7)	-	-	-	-	9,248	-	-	-	-	-	-	-	9,248	-	9,248
Other (Note 11)	1	-	-	209	1	3	11	1	-	182	-	-	408	(22)	386
Total Intragovernmental	22,312	578	90	4,967	322,032	682	8,121	1,468	28,772	4,119	254	2,624	396,019	(259)	395,760
Accounts Receivable, Net (Note 6)	-	-	-	2	1,905	15	3	115	5	-	6	1	2,052	-	2,052
Loans Receivable and Foreclosed Property (Note 8)	-	-	-	-	-	-	390	-	-	-	-	-	390	-	390
Cash and Other Monetary Assets (Note 4)	-	-	-	-	460	-	-	-	-	-	-	-	460	-	460
Inventory and Related Property, Net (Note 9)	-	-	-	116	-	-	-	9	12	868	22	-	1,027	-	1,027
General Property, Plant & Equipment, Net (Note 10)	4	-	-	682	120	320	1	779	1,895	61	15	-	3,877	-	3,877
Other (Note 11)	-	-	-	2	101	-	-	-	2	80	-	-	185	-	185
Total Assets	**$ 22,316**	**$ 578**	**$ 90**	**$ 5,769**	**$ 324,618**	**$ 1,017**	**$ 8,515**	**$ 2,371**	**$ 30,686**	**$ 5,128**	**$ 297**	**$ 2,625**	**$ 404,010**	**$ (259)**	**$ 403,751**
Liabilities (Note 12)															
Intragovernmental															
Accounts Payable	$ 14	$ 1	$ 6	$ 5	$ 624	$ 17	$ 48	$ 11	$ 8	$ 29	$ 1	$ 15	$ 779	$ (127)	$ 652
Accrued Payroll and Benefits	1	-	-	7	3	9	2	11	23	3	5	-	64	-	64
Other (Note 16)	-	-	19	91	344	1	95	127	62	115	-	63	917	(132)	785
Total Intragovernmental	$ 15	$ 1	$ 25	$ 103	$ 971	$ 27	$ 145	$ 149	$ 93	$ 147	$ 6	$ 78	$ 1,760	$ (259)	$ 1,501
Accounts Payable	26	1	13	222	-	62	36	40	238	33	60	28	759	-	759
Entitlement Benefits Due and Payable (Note 13)	-	-	-	-	49,229	-	-	-	-	-	-	-	49,229	-	49,229
Accrued Grant Liability (Note 15)	1,404	83	14	154	-	(3)	370	8	1,488	220	-	17	3,755	-	3,755
Loan Guarantees Liability (Note 8)	-	-	-	-	-	-	191	-	-	-	-	-	191	-	191
Federal Employee and Veterans Benefits (Note 14)	4	1	1	19	10	20	32	78	58	21	6,914	20	7,178	-	7,178
Accrued Payroll and Benefits	16	1	3	91	51	103	27	136	279	45	30	7	789	-	789
Other (Note 16)	11	(1)	(1)	6	2,104	177	876	86	160	-	(1)	(1)	3,416	-	3,416
Total Liabilities	**$ 1,476**	**$ 86**	**$ 55**	**$ 595**	**$ 52,365**	**$ 386**	**$ 1,677**	**$ 497**	**$ 2,316**	**$ 466**	**$ 7,009**	**$ 149**	**$ 67,077**	**$ (259)**	**$ 66,818**
Net Position															
Unexpended Appropriations	20,858	494	7	4,508	16,422	322	5,106	1,294	26,506	3,992	38	2,505	82,052	-	82,052
Cumulative Results of Operations	(18)	(2)	28	666	255,831	309	1,732	580	1,864	670	(6,750)	(29)	254,881	-	254,881
Total Net Position	$ 20,840	$ 492	$ 35	$ 5,174	$ 272,253	$ 631	$ 6,838	$ 1,874	$ 28,370	$ 4,662	$ (6,712)	$ 2,476	$ 336,933	$ -	$ 336,933
Total Liabilities and Net Position	**$ 22,316**	**$ 578**	**$ 90**	**$ 5,769**	**$ 324,618**	**$ 1,017**	**$ 8,515**	**$ 2,371**	**$ 30,686**	**$ 5,128**	**$ 297**	**$ 2,625**	**$ 404,010**	**$ (259)**	**$ 403,751**

U. S. Department of Health and Human Services
Supplemental Statement of Net Cost
For the Years Ended September 30, 2004 and 2003
(In Millions)

	2004			
	Agency	Inter-Agency Eliminations		HHS
	Consolidated		Earned/Exchange	Consolidated
Responsibility Segments	Totals	Costs (-)	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

	Restated 2003			
	Agency	Inter-Agency Eliminations		HHS
	Consolidated		Earned/Exchange	Consolidated
Responsibility Segments	Totals	Costs (-)	Revenues (+) [1]	Totals
ACF	$ 47,615	$ (31)	$ 9	$ 47,593
AoA	1,317	(2)	-	1,315
AHRQ	217	(9)	103	311
CDC	5,279	(92)	219	5,406
CMS	416,198	(193)	4	416,009
FDA	1,409	(83)	35	1,361
HRSA	6,707	(87)	28	6,648
IHS	3,109	(88)	27	3,048
NIH	23,057	(423)	95	22,729
OS	2,023	(64)	207	2,166
PSC	543	(17)	225	751
SAMHSA	3,034	(30)	25	3,029
Net Cost of Operations	$ 510,508	$ (1,119)	$ 977	$ 510,366

[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 Years Ended September 30, 2004
(In Millions)

Responsibility Segments:	Education, Training, & Social Services	Health	Medicare	Income Security	Admin of Justice	Natural Resources & Environment	Agency Combined Totals	Intra-HHS Eliminations Cost (-)	Intra-HHS Eliminations Revenue	HHS Consolidated Totals
ACF	$ 10,963	$ -	$ -	$ 34,976	$ 1	$ -	$ 45,940	$ (5)	$ 34	$ 45,969
AoA	1,340	-	-	-	-	-	1,340	(7)	3	1,336
AHRQ	-	80	-	-	-	-	80	(250)	12	(158)
CDC	-	5,294	-	-	-	1	5,295	(297)	116	5,114
CMS	-	181,709	269,748	-	-	-	451,457	(2)	192	451,647
FDA	-	1,466	-	-	-	-	1,466	(41)	85	1,510
HRSA	-	6,920	-	-	-	-	6,920	(51)	138	7,007
IHS	-	3,351	-	-	-	-	3,351	(32)	43	3,362
NIH	-	25,748	-	-	-	-	25,748	(129)	548	26,167
OS	-	2,183	-	-	-	-	2,183	(404)	88	1,867
PSC	-	636	-	-	-	-	636	(375)	21	282
SAMHSA	-	3,134	-	-	-	-	3,134	(57)	40	3,117
Net Cost of Operations	**$ 12,303**	**$ 230,521**	**$ 269,748**	**$ 34,976**	**$ 1**	**$ 1**	**$ 547,550**	**$ (1,650)**	**$ 1,320**	**$ 547,220**

U.S. Department of Health and Human Services
Gross Cost and Exchange Revenue
For the Year Ended September 30, 2004
(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	$ 197	$ (12)	$ 185	$ 18	$ (41)	$ (23)	$ 45,761	$ -	$ 45,969
AoA	13	(7)	6	7	(3)	4	1,334	-	1,336
AHRQ	35	(250)	(215)	241	(12)	229	286	-	(158)
CDC	839	(311)	528	587	(130)	457	5,048	5	5,114
CMS	554	(2)	552	5	(192)	(187)	483,114	32,206	451,647
FDA	528	(41)	487	36	(85)	(49)	1,284	310	1,510
HRSA	391	(58)	333	81	(145)	(64)	6,693	83	7,007
IHS	412	(32)	380	51	(43)	8	3,716	726	3,362
NIH	3,220	(1,914)	1,306	2,002	(2,333)	(331)	24,585	55	26,167
OS	425	(415)	10	356	(99)	257	2,114	-	1,867
PSC	120	(385)	(265)	480	(31)	449	1,020	24	282
SAMHSA	162	(57)	105	129	(40)	89	3,101	-	3,117
Totals	**$ 6,896**	**$ (3,484)**	**$ 3,412**	**$ 3,993**	**$ (3,154)**	**$ 839**	**$ 578,056**	**$ 33,409**	**$ 547,220**