Faith-Based and Community Initiative

- Report on the participation of faith-based and community organizations in select grant programs for FY 2006. This report will include data on the amount granted to organizations and an analysis of the applicants to select grant programs.
- Implement opportunities for faith-based and community organizations to access federal, state, and local funds.
- Continue to work with Office of General Counsel and operating components to provide regulatory training for staff throughout the Department, new grantees, and outside organizations.
- Continue to explore opportunities to implement individual choice in select HHS programs.
- Continue evaluation of pilot programs to showcase results achieved by grantees in pilot programs.

Real Property Asset Management

- Develop workplace competencies by delivering to at least 60 staff a facilities management course to better implement Executive Order 13327 and Departmental and component plans and policies, to result in cost avoidance savings, better recruitment, retention, and succession plans.
- Identify and initiate disposal of excess owned and leased underutilized and non-mission critical property.
- Implement a strategy to reduce annual operating costs by 5 percent by FY 2011 ($10-$12 million cost avoidance savings per year) by linking real property operating costs to the budget decision-making process for Real Property Asset Management.
- Implement a strategy to improve the average Condition Index of the Department's portfolio to 90 by FY 2016. The ultimate goal is for all facilities to achieve a minimum Condition Index of 90 to improve the Departmental staff health and productivity.
- Transmit a complete and accurate profile of the Department's Automated Real Property Inventory System that includes disposal activity data elements to the Government-wide Federal Real Property Profile.

Research and Development Investment Criteria

- Peer-review all NIH grants competitively based on quality, relevance and performance.
- Develop replacement Government Performance and Results Act goals for the FY 2009 Congressional Justification using the R&D investment criteria.

Analysis of Financial Statements and Stewardship Information

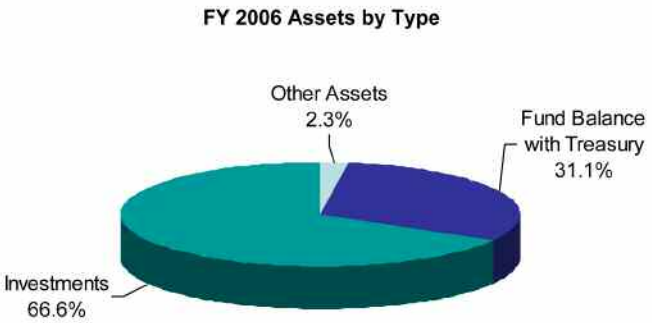
For the eighth consecutive year, HHS received an unqualified or "clean" audit opinion on its financial statements. These statements have been prepared from the Department's financial records using an accrual basis in conformity with accounting principles generally accepted in the United States and audited by the independent accounting firm of PricewaterhouseCoopers, LLP. Preparation and audit of these statements are required by the Chief Financial Officers (CFO) Act of 1990 and is part of the Department's goal to improve financial management and to produce accurate and reliable information that is useful in assessing performance and allocating resources.

Financial Condition

The Department's audited principal financial statements and notes are presented in Section III of this report. The following chart summarizes assets, liabilities, net position, and net cost of operations for FY 2005 and FY 2006 and increases/decreases from FY 2005.

FINANCIAL CONDITION *(Millions)*	FY 2006	FY 2005	Increase (Decrease)	% CHANGE
Total Assets	$ 513,909	$ 428,487	$ 85,422	19.9%
Total Liabilities	$ 78,425	$ 70,959	$ 7,466	10.5%
Net Position	$ 435,484	$ 357,528	$ 77,956	21.8%
Net Cost of Operations	$ 623,937	$ 581,320	$ 42,617	7.3%

Assets



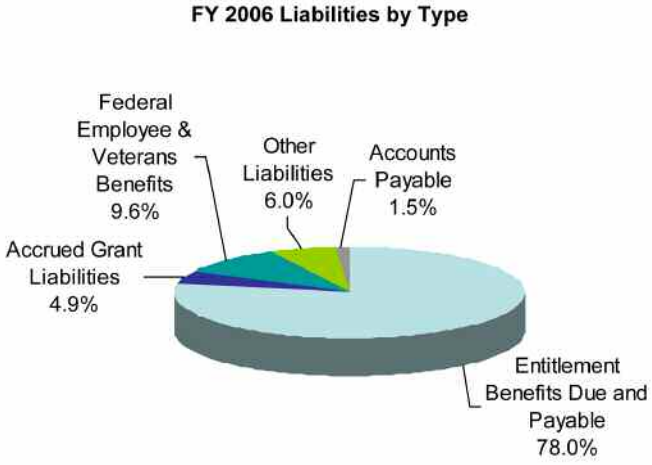
HHS assets were $513,909 million at the end of FY 2006. This represents an increase of $85,422 million, or 19.9 percent over the prior year's assets. This increase is largely attributable to increases of $60,283 million in Fund Balance with Treasury and $41,312 million in Net Investments. The increase in Fund Balance with Treasury resulted primarily from a $27,021 million increase in trust funds, which consisted of increases of $27,057 million in Hospital Insurance (HI) and Supplementary Medical Insurance (SMI), and a $36 million decrease in other trust funds. In addition, there was a $32,977 million increase in HHS appropriations. The Net Investments increase was largely related to growth in the Medicare trust funds for HI and SMI. Funds not currently needed to pay Medicare benefits and related expenses are held in the HI and SMI trust funds and invested in U.S. Treasury securities.

Fund Balance with Treasury and Net Investments together comprise 97.7 percent of total assets. Remaining assets consist of Accounts Receivable, Loans Receivable, Cash and Other Monetary Assets, Inventory and Related Property, General Property, Plant, and Equipment, and Other Assets, each less than 1 percent of total assets. An anticipated congressional appropriation of $14,272 million was reported in FY 2005 assets but was not reported in FY 2006, which accounts for a large share of the decrease from FY 2005–FY 2006.

ASSETS *(Millions)*	FY2006	FY 2005	Increase (Decrease)	% Change
Fund Balance with Treasury	$ 159,921	$ 99,638	$ 60,283	60.5%
Investments, Net	$ 341,976	$ 300,664	$ 41,312	13.7%
Other Assets	$ 12,012	$ 28,185	$ (16,173)	-57.4%
Total Assets	$ 513,909	$ 428,487	$ 85,422	19.9%

Liabilities

HHS liabilities were $78,425 million at the end of FY 2006. This represents an increase of $ 7,466 million, or 10.5 percent over the prior year's liabilities. Almost all of the entitlements represent benefits due and payable to the public from the Medicare and Medicaid insurance programs. Of the FY 2006 increase in entitlements, $7,425 million was attributed to the Medicare program. Entitlement Benefits and Federal Employee and Veterans Benefits account for 78.0 percent and 9.6 percent of total liabilities, respectively.



It is important to note that no liability has been recognized on HHS' balance sheet (nor were costs included in the Statement of Net Cost) 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, 2006. This is because Medicare is accounted for as a social insurance program rather than a pension program, consistent with Federal accounting standards.

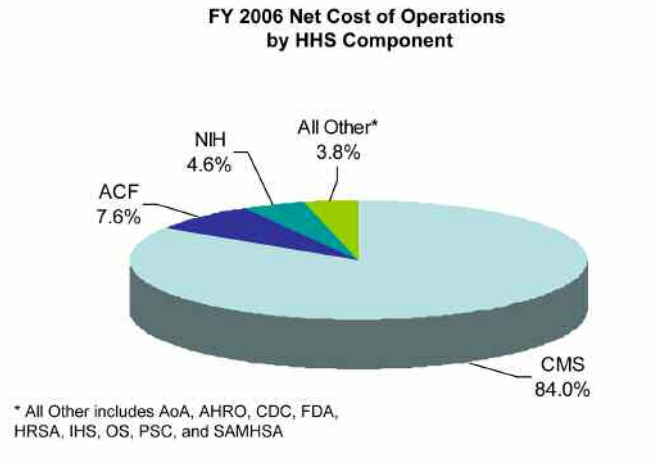
LIABILITIES *(Millions)*	FY2006	FY 2005	Increase (Decrease)	% Change
Accounts Payable	$ 1,182	$ 1,097	$ 85	7.8%
Entitlement Benefits Due and Payable	$ 61,164	$ 53,754	$ 7,410	13.8%
Accrued Grant Liabilities	$ 3,833	$ 3,783	$ 50	1.3%
Federal Employee & Veterans Benefits	$ 7,532	$ 7,183	$ 349	4.9%
Other Liabilities	$ 4,714	$ 5,142	$ -428	-8.3%
Total Liabilities	$ 78,425	$ 70,959	$ 7,466	10.5%

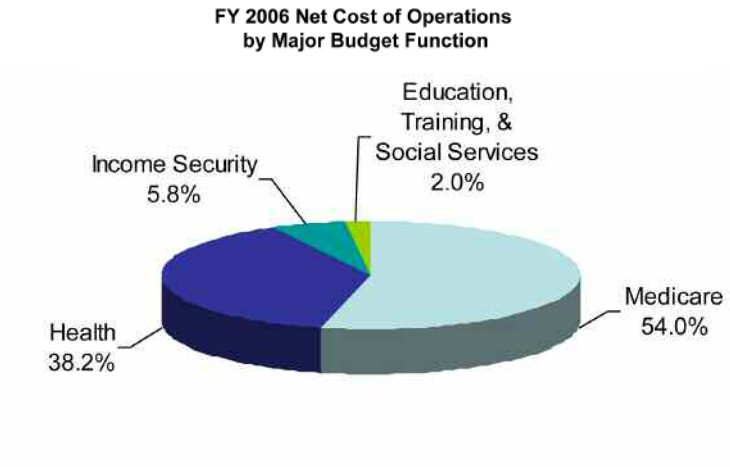
Ending Net Position

At the end of FY 2006, HHS' Net Position shown on the Consolidated Balance Sheet and the Consolidated Status of Changes to Net Position was $435,484 million, an increase of $77,956 million (21.8 percent) from the previous year. This was due to an increase of $34,809 million in cumulative results of operation and an increase of $43,147 mllion in unexpended appropriations. Net Position is the sum of cumulative net results of operation since inception and unexpended appropriations, those appropriations provided to HHS that remain unused at the end of the fiscal year.

Net Cost of Operations

HHS net costs of operations during FY 2006 was $623,937 million. This represents an increase of $42,617 million, or 7.3 percent over FY 2005 costs of more than $581,320 million. The Medicare budget function accounted for all of the $42,617 million total increase for FY 2006. HHS component gross cost for FY 2006 increased $54,492 million over FY 2005 and exchange revenues increased $11,875 million, largely due to an increase in Medicare premiums collected from beneficiaries. The largest share of increase in net costs is attributed to the Centers for Medicare & Medicaid Services, whose costs increased $40,753 million. The following two charts depict HHS' net cost of operations by HHS component and by Major Budget Function.





Budgetary Resources

The Combined Statement of Budgetary Resources provides information on how budgetary resources were made available and their status at the end of the year. Total resources of $952,823 million for FY 2006 were an increase of $158,981 million over FY 2005, a 20 percent increase. FY 2006 obligations of $884,903 million were $109,268 million over FY 2005 obligations, a 14.1 percent increase. Resources at year-end were $67,920 million of which $7,666 million was not available for expenditure. Total net outlays of $614,674 million, cash disbursed for the Department's obligations, increased $33,380 million (5.7 percent) over FY 2005 outlays. Outlays for Medicare and Medicaid combined were $49,819 million less than in FY 2005, while outlays for all other HHS programs in FY 2006 were $83,199 million more than the previous year. The greater difference was in "other" HHS programs; budgetary resources provided were 42.4 percent greater, obligations incurred increased 35.8 percent and outlays increased 36.2 percent.

Social Insurance

The Statement of Social Insurance is presented as a basic financial statement for the first time, in accordance with Statement of Federal Financial Accounting Standards No. 25, Reclassification of Stewardship Responsibilities and Eliminating the Current Services Assessments. This Statement presents the 75-year actuarial present value of the income and expenditures of the Hospital Insurance and Supplementary Medical Insurance trust funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participations. These projections are considered to be important information regarding the potential future cost of the Medicare program.

Medicare Trust Funds

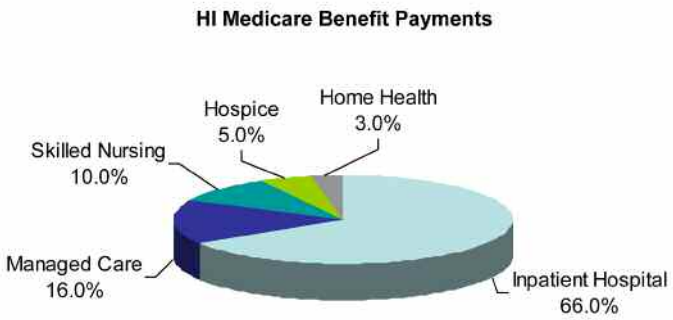
The analysis of financial statements shows that the Medicare program is by far the largest of all HHS programs. Following is a summary discussion of Medicare trust funds.

At the end of FY 2006, approximately $339,545 million ($306,100 million for Hospital Insurance and $33,445 million for Supplementary Medical Insurance trust funds) or 100 percent of HHS investments were in U.S. Treasury securities to support the Medicare trust funds. Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Medicare is a combination of three programs: HI, SMI, and Medicare Advantage. Since 1966 Medicare enrollment has increased from 19 million to approximately 43 million beneficiaries.

In December 2003, the President signed legislation to improve and modernize the Medicare program, including the addition of a drug benefit (Part D). The Medicare Prescription Drug program represents the largest change to the Medicare program since its enactment in 1965.

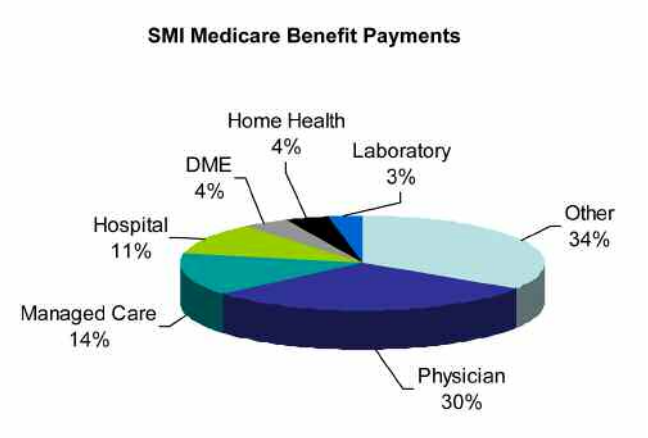
Hospital Insurance

HI or Medicare Part A, usually is provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for in-patient hospital, skilled nursing home, home health, hospice care, and managed care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and relate expenses and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.



Based on estimates from the Mid-Session Review of the FY 2007 President's Budget, inpatient hospital spending accounted for 66 percent of HI benefit outlays. Managed Care spending comprised 16 percent of total HI outlays. During HY 2006, HI benefit outlays grew by 2.4 percent. The HI benefit outlays are projected to increase by 0.8 percent to $4,360 per enrollee.

As reported in the Required Supplementary Information section of this report, HI income, including interest, continued to exceed expenditures; however, excluding interest, expenditures were slightly greater in 2006. Under the intermediate assumptions, expenditures would begin to exceed income in 2010 when including the interest as income. 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; by the end of 2018, the assets would be depleted—2 years earlier than estimated in the 2005 Trustees Report. For the third year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.



Under the Trustees' intermediate set of assumptions, and as displayed in the Statement of Social Insurance, the HI trust fund will incur an actuarial deficit of nearly $11,290 billion ($11.3 trillion) over the 75-year projection period, as compared to $8,829 billion ($8.8 trillion) in the FY 2005 financial report. In order to bring the HI trust fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions to benefits would be required.

Supplementary Medical Insurance

SMI, or Medicare Part B and Medicare Part D, is available to nearly all people age 65 and over, the disabled, and people with end-stage renal disease who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated therapy, Medicare prescription drug discount care enrollment fees, managed care, prescription drug expenses for Transitional Assistance beneficiaries, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 94 percent of HI enrollees elect to enroll in SMI.

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by the monthly premiums. As with Part A, funds not needed to pay benefits and related expenses are held in the SMI trust fund and invested in U.S. Treasury securities.

Based on estimates from the Mid-Session Review of the President's Budget, SMI benefit outlays grew by 30 percent during FY 2006. Physician services accounted for approximately 30 percent of SMI benefit outlays. During FY 2006, the SMI benefit outlays were projected to increase 28.3 percent to $4,860 per enrollee.

As reported in the Required Supplementary Information section of this report, SMI income, which includes interest on U.S. securities, is very close to expenditures, which include benefit payments as well as administrative expenses. This is because SMI funding differs fundamentally from HI. SMI Parts B and D is not based on payroll taxes, but rather on a combination of monthly beneficiary premiums and income from the U.S. Treasury. Both are established annually to cover the following year's expenditures, thus B and D accounts are automatically in financial balance every year, regardless of future economic and other conditions.

Under the Trustees' intermediate set of assumptions, and as displayed in the Statement of Social Insurance, the SMI situation over the 75-year period is entirely different from HI projections due to the financing explained above. The projected future expenditures for Part B will be $17,613 billion ($17.6 trillion) and Part D expenditures will be $10,250 billion ($10.3 trillion). This compares to FY 2005 projections of $16,571 billion ($16.6 trillion) and $11,233 billion ($11.2 trillion). A substantial level of uncertainty surrounds these projections pending the availability of sufficient data, especially on Part D expenditures, to help establish a trend baseline. Also, the reader must take into consideration that estimates have been made on the assumption that the trust fund will continue to operate without change in current law.

Limitations of the Principal Financial Statements

The principal financial statements in Section III of this report have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of 31 U.S.C. 3515 (b). While the statements have been prepared from the books and records of HHS in accordance with generally accepted accounting principles (GAAP) for Federal entities and the formats prescribed by the Office of Management and Budget, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records. The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity.

Systems, Controls, and Legal Compliance

The Department's overall goals for its financial management systems focus on ensuring effective internal controls, systems integration, and timely and reliable financial and performance data for reporting. One of the Department's immediate priorities is to address weaknesses that are identified in audits, evaluations, and assessments of it financial management controls, systems, and processes.

Systems

A cornerstone to improving HHS management practices is the Department's ability to maintain management systems, processes, and controls that ensure financial accountability; provide useful management information; and meet requirements of Federal laws, regulations, and guidance. HHS seeks to comply with a variety of Federal financial management systems requirements, including those articulated by the Federal Managers' Financial Integrity Act (FMFIA), the Chief Financial Officers Act, the Government Management Reform Act, the Clinger-Cohen Act of 1996, the Federal Financial Management Improvement Act (FFMIA), as well as the Office of Management and Budget (OMB) Circular No. A-127, Financial Management Systems. This section includes an overview of HHS' current key systems and the Department's implementation of a Unified Financial Management System (UFMS).

System Goals and Strategies

The HHS will use Oracle Federal Financials as the foundation for integrating financial management across the Department. Through UFMS, HHS seeks to establish a unified approach for enhancing financial management performance by eliminating duplication, streamlining processes, and establishing a common information technology (IT) infrastructure across the enterprise. In addition, it seeks to retain a clean audit opinion and meet the standards for success in getting to green under the President's Management Agenda initiative "Improved Financial Performance."

HHS' existing enterprise architecture for financial management in the Department consists of disparate, decentralized reporting systems, which are mainframe-based, rely on a mix of manual and automated processes, and are supported by varying functional and technical practices among component agencies. Since HHS and its supporting components implemented these systems, both the executive and legislative branches of the Federal Government have implemented statutes and regulations to enhance accountability and results through improved financial management. Central agencies such as OMB and the Department of the Treasury, and the Federal Accounting Standards Advisory Board have issued financial management policies, standards, and other mandates that require improvements in Federal financial management systems.