Financial Statements

U.S. Department of Health and Human Services
CONSOLIDATED BALANCE SHEETS
As of September 30, 2006 and 2005
(In Millions)

	2006	2005
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 159,921	$ 99,638
Investments, Net (Note 5)	341,976	300,664
Accounts Receivable, Net (Note 6)	726	738
Anticipated Congressional Appropriations (Note 7)	-	14,272
Other (Note 10)	132	169
Total Intragovernmental	502,755	415,481
Accounts Receivable, Net (Note 6)	3,207	2,103
Cash and Other Monetary Assets (Note 4)	145	204
Inventory and Related Property, Net (Note 8)	2,322	1,614
General Property, Plant & Equipment, Net (Note 9)	4,971	4,557
Other (Note 10)	509	4,528
Total Assets	**$ 513,909**	**$ 428,487**
Stewardship PP&E (Note 33)		
Liabilities (Note 11)		
Intragovernmental		
Accounts Payable	$ 620	$ 365
Accrued Payroll and Benefits	88	69
Other (Note 15)	955	992
Total Intragovernmental	1,663	1,426
Accounts Payable	562	732
Entitlement Benefits Due and Payable (Note 12)	61,164	53,754
Accrued Grant Liability (Note 14)	3,833	3,783
Federal Employee & Veterans' Benefits (Note 13)	7,532	7,183
Accrued Payroll & Benefits	804	785
Other (Note 15)	2,867	3,296
Total Liabilities	**$ 78,425**	**$ 70,959**
Net Position		
Unexpended Appropriations - Earmarked Funds	$ 27,665	$ 6,877
Unexpended Appropriations - Other Funds	102,832	80,473
Unexpended Appropriations, Total	130,497	87,350
Cumulative Results of Operations - Earmarked Funds	304,465	271,485
Cumulative Results of Operations - Other Funds	522	(1,307)
Cumulative Results of Operations, Total	304,987	270,178
Total Net Position	**$ 435,484**	**$ 357,528**
Total Liabilities & Net Position	**$ 513,909**	**$ 428,487**

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

U. S. Department of Health and Human Services
CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2006 and 2005
(In Millions)

Responsibility Segments	2006	2005
Administration for Children and Families (ACF)	$ 47,165	$ 46,722
Administration on Aging (AoA)	1,386	1,400
Agency for Healthcare Research and Quality (AHRQ)	(280)	(297)
Centers for Disease Control and Prevention (CDC)	6,152	5,242
Centers for Medicare & Medicaid Services (CMS)	524,398	483,645
Food & Drug Administration (FDA)	1,599	1,449
Health Resources & Services Administration (HRSA)	6,180	6,787
Indian Health Service (IHS)	3,275	3,157
National Institutes of Health (NIH)	28,450	27,875
Office of the Secretary (OS)	2,183	2,159
Program Support Center (PSC)	261	(18)
Substance Abuse & Mental Health Services Administration (SAMHSA)	3,168	3,199
Net Cost of Operations	**$ 623,937**	**$ 581,320**

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

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENTS OF CHANGES IN NET POSITION
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006				2005
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**	**Consolidated Total**
Cumulative Results of Operations:					
Beginning Balances	$ 271,485	$ (1,307)	$ -	$ 270,178	$ 254,881
Adjustments (+/-) (Note 19)					
Correction of Errors (+/-)	-	-	-	-	178
Beginning balances, as adjusted	271,485	(1,307)	-	270,178	255,059
Budgetary Financing Sources:					
Other Adjustments	-	369	-	369	(5)
Appropriations Used	173,571	287,273	-	460,844	410,373
Nonexchange Revenue	198,114	247	116	198,477	186,136
Donations and Forfeitures of Cash and Cash Equivalents	32	4	-	36	56
Transfers-in/out without Reimbursement	(2,105)	861	-	(1,244)	(418)
Other Financing Sources (Non-Exchange):					
Donations and forfeitures of property	-	4	-	4	3
Transfers-in/out without reimbursement (+/-)	(1)	(26)	(2)	(29)	(46)
Imputed financing	25	406	(118)	313	342
Other (+/-)	-	(24)	-	(24)	(2)
Total Financing Sources	369,636	289,114	(4)	658,746	596,439
Net Cost of Operations (+/-)	336,656	287,285	(4)	623,937	581,320
Net Change	32,980	1,829	-	34,809	15,119
Cumulative Results of Operations	**304,465**	**522**	**-**	**304,987**	**270,178**
Unexpended Appropriations					
Beginning Balance	6,877	80,473	-	87,350	82,052
Adjustments:					
Corrections of errors	-	-	-	-	(210)
Beginning Balance, as adjusted	6,877	80,473	-	87,350	81,842
Budgetary Financing Sources					
Appropriations Received	201,231	323,104	-	524,335	420,644
Appropriations transferred in/out	-	(121)	-	(121)	241
Other Adjustments	(6,872)	(13,351)	-	(20,223)	(5,004)
Appropriations Used	(173,571)	(287,273)	-	(460,844)	(410,373)
Total Budgetary Financing Sources	20,788	22,359	-	43,147	5,508
Total Unexpended Appropriations	**27,665**	**102,832**	**-**	**130,497**	**87,350**
Net Position	**$ 332,130**	**$ 103,354**	**$ -**	**$ 435,484**	**$ 357,528**

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

U.S. Department of Health and Human Services
COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006		2005	
	Budgetary	**Non-Budgetary Credit Program Financing Accounts**	**Budgetary**	**Non-Budgetary Credit Program Financing Accounts**
Budgetary Resources:				
Unobligated Balance, Brought Forward, October 1:	$ 18,001	$ 206	$ 18,908	$ 253
Recoveries of Prior Year Unpaid Obligations				
Actual	14,481	-	11,672	-
Budget Authority				
Appropriation	948,366	4	773,208	-
Spending Authority from Offsetting Collections				
Earned				
Collected	6,741	172	6,806	27
Change in Receivables from Federal sources	(77)	-	204	-
Change in unfilled customer orders				
Advance received	37	-	1	-
Without advance from Federal sources	1,903	-	1,160	-
Expenditure Transfers from trust funds				
Actual	3,328	-	2,945	-
Subtotal	960,298	176	784,324	27
Nonexpenditure transfers, net, anticipated and actual	59	-	(87)	-
Temporarily not available pursuant to Public Law	(34,551)	-	(11,470)	-
Permanently not available (-)	(5,847)	-	(9,785)	-
Total Budgetary Resources	$ 952,441	$ 382	$ 793,562	$ 280
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 877,128	$ 4	$768,771	$ -
Reimbursable	7,587	184	6,790	74
Subtotal	884,715	188	775,561	74
Unobligated Balances – Available				
Apportioned	60,075	106	12,078	206
Exempt from apportionment	73	-	78	-
Subtotal	60,148	106	12,156	206
Unobligated Balances - Not Available	7,578	88	5,845	-
Total Status of Budgetary Resources	$ 952,441	$ 382	$ 793,562	$ 280
Change in Obligated Balance:				
Obligated Balance, Net				
Unpaid obligations, brought forward, October 1	$ 123,768	$ -	$ 117,575	$ -
Less: Uncollected customer payments from Federal sources, brought forward, October 1	5,700	-	4,007	-
Total unpaid obligated balance, net	118,068	-	113,568	-
Obligations incurred net (+/-)	884,715	188	775,561	74
Less: Gross outlays	851,874	185	757,988	74
Less: Recoveries of prior year unpaid obligations, actual	14,481	-	11,672	-
Change in uncollected customer payments from Federal sources (+/-)	1,739	-	1,299	-
Obligated Balance, Net, End of Period				
Unpaid Obligations	142,161	3	123,768	-
Less: Uncollected customer payments from Federal sources	7,327	-	5,700	-
Total, unpaid obligated balance, net, end of period	134,834	3	118,068	-
Net Outlays				
Net Outlays:				
Gross outlays	851,874	185	757,988	74
Less: Offsetting collections (-)	(10,338)	(172)	(9,715)	(27)
Less: Distributed Offsetting receipts	226,844	31	166,971	55
Net Outlays	**$ 614,692**	**$ (18)**	**$ 581,302**	**$ (8)**

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

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENTS OF FINANCING
For the Years Ended September 30, 2006 and 2005
(In Millions)

	2006	2005
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated		
Obligations Incurred	$ 884,903	$ 775,635
Less: Spending Authority from Offsetting Collections and Recoveries	26,585	22,815
Obligations Net of Offsetting Collections and Recoveries	$ 858,318	$ 752,820
Less: Offsetting Receipts	226,875	167,026
Net Obligations	$ 631,443	$ 585,794
Other Resources		
Donations and Forfeitures of Property	$ 4	$ 3
Non-Budgetary Transfers in/out Without Reimbursement	(29)	(46)
Imputed Financing From Costs Absorbed by Others	313	342
Other Non-Budgetary Resources	(24)	(2)
Net Non-Budgetary Resources Used to Finance Activities	$ 264	$ 297
Total Resources Used to Finance Activities	$ 631,707	$ 586,091
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$ (4,249)	$ 4,092
Resources That Fund Expenses Recognized in Prior Periods	15,278	15,802
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	90	24
Other	(242)	(241)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,296	1,540
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	(3,352)	(1,232)
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	$ 8,821	$ 19,985
Total Resources Used to Finance the Net Cost of Operations	$ 622,886	$ 566,106
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	$ 18	$ 31
Increase in Environmental and Disposal Liability	4	2
Upward/downward Reestimates of Credit Subsidy Expense	(56)	(40)
Increase in Exchange Revenue Receivable from the Public	(342)	679
Other	369	4,954
Accrued Entitlement Benefit Costs	-	9,470
Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods	$ (7)	$ 15,096
Components Not Requiring or Generating Resources:		
Depreciation and Amortization	$ 376	$ 218
Losses or (Gains) from Revaluation of Assets and Liabilities	13	11
Other	669	(111)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources	$ 1,058	$ 118
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	1,051	15,214
NET COST OF OPERATIONS	**$ 623,937**	**$ 581,320**

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

U.S. Department of Health and Human Services
STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2006 and Prior Base Years
(in billions)

	2006	2005 unaudited	2004 unaudited	2003 unaudited	2002 unaudited
		Estimates from Prior Years			
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 31 and 32)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	$5,685	$5,064	$4,820	$4,510	$4,408
SMI Part B	12,446	11,477	10,505	8,796	7,423
SMI Part D	7,366	7,895	7,545	0	0
Have attained eligibility age (age 65 and over)					
HI	192	162	148	128	125
SMI Part B	1,606	1,436	1,310	1,160	1,008
SMI Part D	750	817	713	0	0
Those expected to become participants (under age 15)					
HI	4,767	4,209	4,009	3,773	3,753
SMI Part B	3,562	3,658	3,514	2,817	2,402
SMI Part D	2,134	2,522	2,511	0	0
All current and future participants:					
HI	10,644	9,435	8,976	8,411	8,286
SMI Part B	17,613	16,571	15,329	12,773	10,833
SMI Part D	10,250	11,233	10,770	0	0
Actuarial present value for the 75-year projection period of estimated future cost for or on behalf of:					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	15,633	12,668	12,054	10,028	9,195
SMI Part B	12,433	11,541	10,577	8,845	7,463
SMI Part D	7,338	7,913	7,566	0	0
Have attained eligibility age (age 65 and over)					
HI	2,397	2,179	2,168	1,897	1,747
SMI Part B	1,773	1,622	1,475	1,306	1,132
SMI Part D	792	880	773	0	0
Those expected to become participants (under age 15)					
HI	3,904	3,417	3,246	2,653	2,470
SMI Part B	3,407	3,408	3,277	2,622	2,238
SMI Part D	2,121	2,440	2,431	0	0
All current and future participants:					
HI	21,934	18,264	17,468	14,577	13,412
SMI Part B	17,613	16,571	15,329	12,773	10,833
SMI Part D	10,250	11,233	10,770	0	0
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 31 and 32)					
HI	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)	$ (5,126)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Additional Information					
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 31 and 32)					
HI	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)	$ (5,126)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust fund assets at start of period					
HI	285	268	256	235	209
SMI Part B	23	19	24	34	41
SMI Part D	0	0	0	0	0
Actuarial present value for the 75-year projection of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over cost (Note 31 and 32)					
HI	$ (11,006)	$ (8,561)	$ (8,236)	$ (5,931)	$ (4,917)
SMI Part B	23	19	24	34	41
SMI Part D	0	0	0	0	0

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

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

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U. S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2006 and 2005

Note 1. Summary of Significant Accounting Policies

Reporting Entity

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

Organization and Structure of HHS

The HHS is comprised of 11 Operating Divisions (OPDIVs) with diverse missions and programs. Each OPDIV is considered a responsibility segment representing a component 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. Although it is part of the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other OPDIVs and Federal agencies. The Agency for Toxic Substances and Disease Registry is combined with the Centers for Disease Control and Prevention for financial reporting purposes; therefore, these footnotes will refer to them as one responsibility segment. The managers of the responsibility segments report to the entity's top management directly, and its resources and results of operations can be clearly distinguished from those of other responsibility segments of the entity. The 12 responsibility segments are:

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

Basis of Accounting and Presentation

The HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P. L. 101-576), as amended by the Government

U. S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2006 and 2005

Management Reform Act of 1994, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular No. A-136 (Revised), *Financial Reporting Requirements* which, effective fiscal year (FY) 2006, supersedes OMB Bulletin 01-09, *Form and Content of Agency 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. The generally accepted accounting principles (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 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.

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 resources are consumed, without regard to the payment of cash. Budgetary accounting principles, on the other hand, are designed to recognize the obligation of funds according to legal requirements, which in many cases is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of Federal funds. The HHS OPDIVs use the cash basis of accounting for some programs with an accrual adjustment made by recording year-end estimates of unpaid liabilities.

The financial statements consolidate the balances of approximately 160 appropriations and fund accounts, and a number of accounts used for suspense, collection of receipts, and general government functions. Transactions and balances among HHS OPDIVs have been eliminated in the presentation of the Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statements of Changes in Net Position, and the Consolidated Statements of Financing. The Combined Statements of Budgetary Resources are presented on a combined basis, therefore, intra-HHS and intra-OPDIV transactions and balances have not been eliminated from these statements. Supplemental information is accumulated from the OPDIV reports, regulatory reports, and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

Unified Financial Management System

The HHS continues to streamline and integrate its financial management systems through a phased development of the Unified Financial Management System (UFMS). HHS' overarching financial management goals seek to (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that HHS resources are used appropriately, efficiently, and effectively. With UFMS, HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. The Centers for Disease Control and Prevention and the Food and Drug Administration went live with UFMS

U. S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2006 and 2005

in April 2005. Efforts continue with the scheduled implementation for the PSC and its customer OPDIVs in October 2006. Final deployment for the Indian Health Service is scheduled for October 2007.

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

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

Entity and Non-Entity Assets
Entity assets are assets that the reporting entity has authority to use in its operations, i.e., management has the authority to decide how the funds are used, or management is legally obligated to use the 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.

Entity and non-entity assets are combined into one line on the face of the balance sheet as required by OMB Circular No. A-136. The detail for non-entity assets is presented in Note 2, Non-Entity Assets.

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

Note 3, Fund Balance with Treasury, provides additional information.

Investments
Investments consist of Treasury securities including the Centers for Medicare and Medicaid Services' par value securities that represent the majority of the HHS earmarked funds carried at face value, and other securities carried at amortized cost. Section 1817 for Hospital Insurance Trust Fund (HI) and Section 1841 for Supplementary Medical Insurance Trust

U. S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2006 and 2005

Fund (SMI) of the Social Security Act require that trust investments 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. Treasury securities are issued to the earmarked fund as evidence of earmarked receipts and provide the fund with the authority to draw upon the U.S. Treasury for future authorized expenditures (although for some funds, this is subject to future appropriation). No provision is made for unrealized gains or losses on these securities since it is the Department's intent to hold investments to maturity. Interest income is compounded semiannually in June and December and is adjusted to include an accrual for interest earned from July 1 to September 30. The FASAB Statement of Federal Financial Accounting Standard, No. 27, prescribes certain disclosures concerning earmarked investments, such as the fact that cash generated from earmarked funds is used by the U.S. Treasury for general Government purposes and that upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures. Treasury securities held by an earmarked fund are an asset of the fund and a liability of the U.S. Treasury, so they are eliminated in consolidation for the U.S. Government-wide financial statements.

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

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

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

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

Direct Loans and Loan Guarantee Receivables and Liabilities
Direct Loans:
The Health Care Infrastructure Improvement Program was enacted into law as part of the Medicare Modernization Act of 2003. This loan program provides loans to hospitals or entities that are engaged in research in the causes, prevention, and treatment of cancer; and are designated as cancer centers by the National Cancer Institute, or are designated by the State legislature as the official cancer institute of the State, and such designation by the State legislature occurred prior to December 8, 2003, for payment of the capital costs of eligible

U. S. Department of Health and Human Services
Notes to the Principal Financial Statements
For the Years Ended September 30, 2006 and 2005

projects. HHS reasonably expects any loans made under this program to be forgiven as it is anticipated that the borrowers will meet the requirements for forgiveness.

Loan Guarantees:
HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loans (HEAL) programs. Loans receivable 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. The loans guarantee liabilities are valued at the present value of the cash outflows from HHS less the present value of related inflows.

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

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

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. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the “Advances to Grantees” account. An accrued grant liability occurs when the accrued grant expenses exceed the outstanding advances to grantees, resulting in a negative balance in the “Advances to Grantees” account. HHS grants are classified into two categories: “Grants Not Subject to Grant Expense Accrual” and “Grants Subject to Grant Expense Accrual.” Progress payments on work in process are not included in grants.

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

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Grants Subject to Grant Expense Accrual: For grants subject to grant expense accrual, commonly referred to as "non-block grants," grantees draw funds (recorded as Advances to Grantees) based on their estimated cash needs. As grantees report their actual disbursements (quarterly), the amounts are recorded as expenses, and their advance balance is reduced. At year-end, the OPDIVs report both actual payments made through the third quarter and an unreported grant expenditures estimate for the fourth quarter based on historical spending patterns of the grantees. The year-end accrual estimate equals the estimate of fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash being drawn down.

Exceptions to the definition of "block" or "non-block" grants for reporting purposes are the Temporary Assistance for Needy Families program and the Child Care Development Fund program. These two programs are referred to as "block" grants but since the programs report expenses to HHS, they are treated as "non-block" grants for the estimate of the grant accrual.

HHS reports advances other than grant advances in Note 10, Other Assets and Note 14, Accrued Grant Liability, which provides additional information on the accrued grant liability.

Inventory and Related Property, Net

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

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

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

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

Note 8, Inventory and Related Property, Net, provides additional information.

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

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

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

The SFFAS No.10 also requires that amortization begin when the asset is placed in use. In April 2005, UFMS was implemented at the CDC and the Food and Drug Administration (FDA). In FY 2005, CMS began amortizing HIGLAS over ten years using the straight-line method in accordance with HHS policy for UFMS. In addition, CMS has other capitalized internal use software that is currently being amortized over a useful life of five years.

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

Additional information is provided in Note 9, General Property, Plant and Equipment, Net.

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Stewardship PP&E

Stewardship PP&E consist of heritage assets and stewardship land whose physical properties resemble those of general PP&E that are traditionally capitalized in financial statements. The valuation of these assets is difficult and matching costs for a period of time is meaningless. On July 7, 2005, SFFAS No. 29, Heritage Assets and Stewardship Land was issued. This standard requires that the balance sheet reference a note that discloses information but not an amount for Stewardship PP&E.

Note 33, Stewardship PP&E has additional information.

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 Health Insurance Trust Fund, since liabilities are only those items that are present obligations of the Government. The Department's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

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

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

Liabilities Covered by Budgetary Resources and Liabilities Not Covered by Budgetary Resources are combined on the balance sheet. The breakout of these resources is presented in Note 11, Liabilities Not Covered by Budgetary Resources; Note 12, Entitlement Benefits Due and Payable; Note 13, Federal Employee and Veterans' Benefits; and Note 15, Other Liabilities.

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

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

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

Medicare
The Medicare liability is developed by the Office of the Actuary of the Centers for Medicare and Medicaid Services and includes (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in FY 2006 but paid in FY 2007, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers. The Medicare Advantage liability includes amounts incurred related to risk adjustments and other estimates.

Medicaid
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 September 30, 2006, estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Note 12, Entitlement Benefits Due and Payable, provides additional information.

Federal Employee and Veterans' Benefits
Most HHS employees participate in either the Civil Service Retirement System (CSRS) – a defined benefit plan, or the Federal Employees Retirement System (FERS) – a defined benefit and contribution plan. For employees covered under CSRS, the Department

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contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. A primary feature of FERS is that it offers a Thrift Savings Plan (TSP) into which the Department automatically contributes one percent of employee pay and matches employee contributions up to an additional four percent of pay.

The U.S. Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS or FERS assets, accumulated plan benefits, or unfunded liabilities applicable to Federal employees. Therefore, HHS does not recognize any liability on its balance sheet for pensions, other retirement benefits, and other post-employment benefits with the exception of Commissioned Corps (see below). HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and an 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 a liability for actual and estimated future payments for workers' compensation pursuant to the Federal Employees Compensation Act (FECA). FECA provides income and medical cost protection (1) to Federal employees who were injured on the job or who have sustained a work-related occupational disease and (2) to beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by the Department of Labor (DOL), which pays valid claims and subsequently bills the employing Federal agency. The FECA liability consists of two components – the actual claims paid by DOL but not yet disbursed, and the estimated liability for future benefit payments as a result of past events, such as death, disability, and medical costs.

Note 13, Federal Employee and Veterans' Benefits, provides additional information.

Revenue and Financing Sources

The Department receives the majority of funding needed to support its programs through Congressional appropriation and through reimbursement for the provision of goods or services to other Federal agencies. The United States Constitution prescribes that no money may be expended by a Federal agency unless and until funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by the Department.

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Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

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

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

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

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

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

Imputed Financing Sources. In certain instances, operating costs of HHS are paid out of funds appropriated to other Federal agencies. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management, and certain legal judgments against HHS are paid from the Judgment Fund maintained by Treasury. When

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costs that are identifiable to HHS and directly attributable to the Department's operations are paid by other agencies, the Department recognizes these amounts as imputed costs of HHS, and at the same time, this amount is recognized as an imputed financing source on the Consolidated Statement of Changes in Net Position.

Other Financing Sources. Medicare's HI program, or Medicare Part A, is financed through the HI trust fund, whose revenues come primarily from the Medicare portion of payroll and from self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and under the Self-Employment Contribution Act (SECA). The Medicare payroll tax rate is 2.9 percent of annual wages. Contribution rates are discussed under Exchange and Non-Exchange Revenue. Medicare's Supplemental Medical Insurance (SMI) program, or Medicare Part B, is financed primarily by general fund appropriations (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries. Premium payments from Medicare beneficiaries are matched approximately three to one by Congressional appropriations.

Aggregate non-exchange revenues consist primarily of FICA taxes of $168,564 million and $157,702 million, SECA taxes of $11,829 million and $11,252 million, and Trust Fund investment interest of $17,142 million and $16,484 million for FY 2006 and FY 2005, respectively.

Contingencies

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

Note 22, Contingencies, provides additional information.

Reclassifications

Certain reclassifications were made to the presentation of the September 30, 2005 financial statements and footnotes to improve their comparability with the September 30, 2006 statements and footnotes. These reclassifications were made in compliance with the form and content prescribed by the OMB Circular No. A-136.

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

Earmarked Funds
Effective FY 2006, FASAB SFFAS No. 27, *Identifying and Reporting Earmarked Funds*, defines earmarked funds and requires that they be shown separately from all other funds on the Statement of Changes in Net Position, as well as in the Net Position section of the Balance Sheet. The HHS adopted FASAB SFFAS No. 27 effective October 1, 2005. Earmarked funds are defined as those financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time; are required by statute to be used for designated activities, benefits or purposes; and must be accounted for separately from the Government's general revenues. "Fund" in this statement's definition of earmarked funds refers to a "fiscal and accounting entity with a self-balancing set of accounts recording cash and other financial resources, together with all related liabilities and residual equities or balances, and changes therein, which are segregated for the purpose of carrying on specific activities or attaining certain objectives in accordance with special regulations, restrictions, or limitations." Whether the appropriation is provided by authorizing legislation or annual appropriations acts, the cumulative results of operations arising from earmarked funds is reserved or restricted to the designated activity, benefit or purpose. The SFFAS 27 does not allow restating of the FY 2005 reported amounts. The standard also requires that condensed information on assets, liabilities and costs for earmarked funds be disclosed (see Note 30). An earmarked fund may be classified in the unified budget as a trust, special or public enterprise fund. Examples of HHS earmarked funds include the HI trust fund that is used to process claims associated with Part A benefits and the SMI trust fund that is used to process claims associated with Part B benefits.

Note 30, Earmarked Funds provides additional information.

Medicare Hospital Insurance (HI) Trust Fund
The Medicare Hospital Insurance Trust Fund is authorized by Title XVIII of the Social Security Act. Medicare contractors are paid by HHS 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 HHS payments to managed care plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Treasury. This trust fund has permanent indefinite budgetary authority.

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Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under FICA and SECA. Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The HI is financed primarily by these 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 related expenses are held by the HI Trust Fund, and invested in U. S. Treasury securities.

Medicare Supplementary Medical Insurance (SMI) Trust Fund

The Medicare Supplementary Medical Insurance Trust Fund is authorized by Title XVIII of the Social Security Act. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end-stage renal disease treatment providers, rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The HHS payments to managed care plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. This trust fund has permanent indefinite budgetary authority. The SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and 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. Funds not currently needed to pay benefits and related expenses are held by the SMI Trust Fund, and invested in U. S. Treasury securities.

Medicare Prescription Drug Benefit – Part D

The Medicare Prescription Drug Benefit – Part D, established by the Medicare Modernization Act of 2003, became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Plans, and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards as well as helps those with limited income and resources. Under demonstration authority, Medicare will reimburse States who paid prescription drug costs for dual eligibles who had difficulty accessing Part D benefits at the very outset of the Part D program. Since FY 2004, the Transitional Assistance and Drug Discount Card Programs have provided credits and discounts toward prescription drug coverage for certain eligible beneficiaries; however, with the implementation of Medicare Part D, these programs were phased out in FY 2006. The

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Part D is considered part of the SMI trust fund and is reported in the Medicare column of financial statements where required.

Medicare and Medicaid Integrity Program (MIP)
The Health Insurance Portability and Accountability Act (*Public Law 104-191*) established the MIP and codified the program integrity activities previously known as "payment safeguards." This account is also referred to as the Health Care Fraud and Abuse Control program or simply "Fraud and Abuse." To safeguard the Medicare system, the HHS 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.

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) which represents a substantial milestone in HHS' strategy to detect and prevent Medicaid fraud and abuse in the program's history. The Medicaid MIP is also funded by the HI trust fund.

Medicaid
Medicaid, the health care program for low-income Americans, is administered by HHS in partnership with the states. Grant awards limit the funds that can be drawn by the states to cover current expenses. The grant awards, which are prepared at the beginning of each quarter and are amended as necessary, are an estimate of the HHS 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 HHS for the difference between approved expenses reported for the period and grant awards previously issued. Medicaid is financed by general funds and is not classified as "earmarked."

State Children's Health Insurance Program (SCHIP)
The SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The grant award to the individual State is prepared before the end of the fiscal year in an amount equal to the annual allotment. Under Section 2104 of the Act, allotments are available for 3 fiscal years, referred to as the "period of availability." At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HHS for the difference between approved expenses reported for the period and the grant awards previously issued.

Statement of Social Insurance
The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program

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participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions. This projected potential future income and expenditures under current law is not included in the accompanying Balance Sheets, Statements of Net Cost, Changes in Net Position, Budgetary Resources, or Financing.

The Medicare financial projections are developed based on numerous assumptions and are inherently subject to substantial uncertainty. This uncertainty arises from the likelihood of future changes in general economic, regulatory, and market conditions, as well as other more specific future events and contingencies that cannot be reliably anticipated, particularly over more distant timeframes such as the 75-year projection period used for the SOSI. Most of these future conditions and events are beyond our control. Future income and expenditures under current law will be affected by variation in demographic trends (birth rates, mortality rates, and immigration), general economic trends (wage growth, inflation, interest rates, labor force participation, and unemployment), and health-specific trends (growth in the utilization and intensity of health care services, and increases in medical care prices). Recent historical trends in health care have often varied dramatically; consequently, such projections can only indicate the level of expenditures that would occur under current law based on trend assumptions that are considered reasonable from today's viewpoint. Actual future expenditures are likely to differ significantly from the projections shown in the SOSI. Further, it is likely that Congress will pass legislation from time to time modifying the provisions of the Medicare program. Such legislation could also result in differences between actual future income and expenditures from those amounts projected under current law in the accompanying SOSI.

The additional information on the SOSI of actuarial present values of estimated future income (excluding interest) less expenditures plus assets at the start of the period is presented for purposes of additional analysis and is not a required part of the financial statements.

Notes 31 and 32, Statement of Social Insurance Disclosures provides additional information.

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Note 2. Non-Entity Assets

Non-entity assets at September 30, 2006, and 2005, consisted of the following:

(Dollars in Millions)	2006	2005
Intragovernmental:		
Fund Balance with Treasury	$ 26	$ 23
Accounts receivable	-	-
Other	-	-
Total Intragovernmental	26	23
Accounts receivable	14	14
Cash and other monetary assets	-	-
Other	-	-
Total Non-Entity Assets	40	37
Total Entity Assets	513,869	428,450
Total Assets	$ 513,909	$ 428,487

The $26 million non-entity asset Fund Balance with Treasury includes: $15 million of Federal tax refunds collected by the Internal Revenue Service for delinquent child support payments that were transferred to ACF for distribution to the states; $9 million in NIH collections of royalties from licenses for which a portion is paid to inventors under the Federal Technology Transfer Act; and $2 million representing CDC withholdings for state payroll deductions, collections of interest, and other miscellaneous receipts. The $14 million accounts receivable represents CMS' receivables for interest and penalties.

Note 3. Fund Balance with Treasury

The Fund Balance with Treasury (FBWT) and the status of the fund balance as of September 30, 2006, and 2005, are listed below by fund type.

(Dollars in Millions)	2006	2005
Fund Balance with Treasury		
Trust Funds	$ 28,985	$ 1,964
Revolving Funds	896	757
Appropriated Funds	129,292	96,315
Other Funds	748	602
Total	$ 159,921	$ 99,638

Status of Fund Balance with Treasury

	2006	2005
Unobligated Balance		
Available	$ 60,254	$ 12,362
Unavailable	7,666	5,845
Obligated Balance not yet Disbursed	134,837	117,876
Non-Budgetary FBWT	(42,836)	(36,445)
Total	$ 159,921	$ 99,638

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

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The Unobligated Balance includes $2.2 billion for September 30, 2006 and $2.1 billion for September 30, 2005, which is restricted for future use and is not apportioned for current use. The $2.2 billion and the $2.1 billion reported for September 30, 2006 and September 30, 2005 respectively, include restricted amounts for the ACF Contingency Fund for State Welfare Programs, the CMS Program Management and State Grants and Demonstrations, the HRSA Federal Interest Subsidies for Medical Facilities Guarantee and Loan Fund, and the PSC Service and Supply Funds.

The Non-Budgetary FBWT negative balances reported for September 30, 2006 and 2005 are due primarily to CMS Medicare trust funds temporarily precluded from obligation.

Note 4. Cash and Other Monetary Assets

Cash and Other Monetary Assets consist primarily of the time account balances at the Medicare contractors' commercial banks. CMS uses the "Checks Paid Letter-of-Credit" method for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against Medicare Benefits Accounts maintained at commercial banks. To compensate the commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest bearing time accounts. The interest foregone by CMS on these time accounts is used to reimburse the commercial banks for the service. The account balances as of September 30, 2006 and 2005 were $145 million and $204 million, respectively.

Note 5. Investments, Net

HHS' investments as of September 30, 2006 and 2005, are summarized below:

	2006			
(Dollars in Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 29	$ -	$ 29	$ 29
Non-Marketable: Par Value	335,247	-	335,247	335,247
Non-Marketable: Market-based	2,383	7	2,390	2,390
Subtotal	337,659	7	337,666	337,666
Accrued Interest	4,310	-	4,310	4,310
Total, Intragovernmental	$ 341,969	$ 7	$ 341,976	$ 341,976

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

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

The HHS cash receipts collected for the invested funds, consisting primarily of Hospital Insurance and Supplementary Medical Insurance trust funds (earmarked funds), are deposited into the Treasury. Treasury securities are issued to the earmarked fund as evidence of earmarked receipts and provide the fund with the authority to draw upon the U.S. Treasury for future authorized expenditures (although for some funds, this is subject to future appropriation). When the earmarked fund redeems its Treasury securities to make expenditures, the U.S. Treasury will finance those expenditures in the same manner that it finances all other expenditures. Treasury securities held by earmarked funds are an asset of the fund and a liability of the U.S. Treasury, so they are eliminated for the consolidated U.S. Government-wide financial statements. The Treasury does not set aside assets to pay future expenditures for earmarked funds. When the securities are redeemed to make expenditures, Treasury will finance the expenditures out of accumulated cash balances raised by taxes or other receipts, by issuing public securities, by repaying less debt, or by curtailing other expenditures.

Par value securities purchased by the CMS are recorded at cost; interest is earned based on a statutory formula; and securities are redeemed at face value. CMS invests in U.S. Treasury Special Issue bonds (Par Value securities) that are special public obligations for exclusive purchase by the Medicare trust funds. Sections 1817 (for Hospital Insurance) and 1841 (for Supplemental Medical Insurance) of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury.

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Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The Medicare bonds paid from 3.5 percent to 7.375 percent from October 1, 2005, to September 30, 2006, and 3.5 percent to 8.125 percent from October 1, 2004, to September 30, 2005. The One Day Certificates are short-term and paid between 4.75 percent and 5.25 percent from October 1 to September 30 in 2006 and 4.125 percent from October 1 to September 30 in 2005.

The HRSA invests in One Day Certificates, Market- Based Notes and Market-Based Bills. MK securities purchased by HRSA mirror marketable securities terms that are not traded on any securities exchange; these include Non-Marketable, MK, and One Day Certificates. MKs are purchased by HRSA's Vaccine Injury Compensation Program (VICP) trust fund. Discounts and premiums are recorded and amortized on a straight-line basis. Currently, securities held by the VICP will mature in fiscal years 2007 through 2011. The Market-Based Notes paid from 3.00 percent to 6.25 percent from October 1, 2005 to September 30, 2006, and from 1.625 percent to 6.25 percent from October 1, 2004 to September 30, 2005. One Day Certificates paid from 3.36 percent to 5.34 percent from October 1, 2005 to September 30, 2006 and from 1.71 percent to 3.17 percent from October 1, 2004 to September 30 2005.

Marketable securities purchased by the National Institutes of Health gift funds are recorded at cost based on market terms and are invested in interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

Note 6. Accounts Receivable, Net

HHS' accounts receivable as of September 30, 2006 and 2005 are summarized below:

	2006							
(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 978	$ -	$ -	$ 978	$ -	$ 978	$ (252)	$ 726
Non-Entity	-	-	-	-	-	-	-	-
Total, Intragovernmental	$ 978	$ -	$ -	$ 978	$ -	$ 978	$ (252)	$ 726
With the Public								
Entity								
Medicare	$ 4,784	$ -	$ -	$ 4,784	$ (1,919)	$ 2,865	$ -	$ 2,865
Other	590	2	1	593	(265)	328	-	328
Non-Entity	9	43	-	52	(38)	14	-	14
Total, With the Public	$ 5,383	$ 45	$ 1	$ 5,429	$ (2,222)	$ 3,207	$ -	$ 3,207

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	2005							
(Dollars in Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 970	$ -	$ -	$ 970	$ -	$ 970	$ (232)	$ 738
Non-Entity	-	-	-	-	-	-	-	-
Total, Intragovernmental	$ 970	$ -	$ -	$ 970	$ -	$ 970	$ (232)	$ 738
With the Public								
Entity								
Medicare	$ 3,322	$ -	$ -	$ 3,322	$ (1,508)	$ 1,814	$ -	$ 1,814
Other	465	-	69	534	(259)	275	-	275
Non-Entity	12	44	-	56	(42)	14	-	14
Total, With the Public	$ 3,799	$ 44	$ 69	$ 3,912	$ (1,809)	$ 2,103	$ -	$ 2,103

The Hospital Insurance (HI) Trust Fund accrues a receivable from the Railroad Retirement Board (RRB) for amounts transferred through a financial interchange between the HI Trust Fund and RRB. The financial interchange is intended to place the HI trust fund in the same position it would have been had railroad employment been covered by the Federal Insurance Contributions Act. Of the Intragovernmental Accounts Receivable, net as of September 30, 2006 and 2005, $473 million and $454 million were owed by the RRB, respectively.

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

For Medicare receivables, the 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 five years. The Medicaid accounts receivable has been recorded at a net realizable amount based on historic analysis of actual recoveries and the rate of disallowances found in favor of the states.

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

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Note 7. Anticipated Congressional Appropriation

In FY 2006, Congress provided the CMS with sufficient appropriation amounts to cover the entire Medicaid IBNR liability and the matching of SMI premiums from the general fund. Therefore, no Anticipated Congressional Appropriation exists for FY 2006.

As of September 30, 2005, the HHS recorded $14,272 million in anticipated Congressional appropriations to cover liabilities incurred by the Medicaid program and the Payments to the Health Care Trust Funds, as discussed below:

Medicaid

Beginning in FY 1996, HHS accrued an expense and liability for Medicaid IBNR as of September 30. In FY 2005, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $9,099 million. A review of appropriation language by the Office of General Counsel 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, HHS recorded a $9,099 million anticipated appropriation in FY 2005 for IBNR claims that exceeded 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 and the method 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 the Office of the Actuary (OACT) and can be insufficient in any particular fiscal year. In FY 2005, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30, approximately $5,107 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $65 million in interest on the unmatched amount, leaving a cumulative liability of about $5,173 million owed to SMI. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, HHS recorded a $5,173 million anticipated appropriation in FY 2005 for the amount of the unmatched SMI premiums. Although the actual transfer of funds occurred in FY 2006, HHS reported the $5,173 million as revenues earned in FY 2005.

In addition, the $5,173 million in unmatched SMI premiums is reported as a liability "requiring or generating resources in future periods" on the Consolidated Statement of Financing.

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Note 8. Inventory and Related Property, Net

HHS' inventory and related property, net at September 30, 2006 and 2005 are summarized below:

(Dollars in Millions)	2006	2005
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 19	$ 19
Inventory Held for Repair	-	-
Total Inventory Held for Sale	19	19
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	4	5
Operating Materials and Supplies Reserved for Future Use	-	-
Total Operating Materials and Supplies	4	5
Stockpile Materials:		
Stockpile Materials Held for Emergency or Contingency	2,299	1,590
Total Stockpile Materials	2,299	1,590
Inventory and Related Property, Gross	2,322	1,614
Less: Allowance for Loss/Obsolescence/Spoilage	-	-
Inventory and Related Property, Net	$ 2,322	$ 1,614

On August 13, 2004, the Department of Homeland Security transferred Strategic National Stockpile (SNS) materials to HHS as required by the Project BioShield Act of 2004. These materials are not available for sale and are maintained to respond to local and national emergencies. The stockpile materials maintained are primarily SNS and are valued at $2,029 million as of September 30, 2006.

Note 9. General Property, Plant and Equipment, Net

Major categories of HHS General Property, Plant and Equipment (PP&E) at September 30, 2006 and 2005 are listed below:

			2006			2005
(Dollars in Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value	Net Book Value
Land & Land Rights	-	-	$ 48	$ -	$ 48	$ 48
Construction in Progress	-	-	718	-	718	723
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,179	(1,458)	2,721	2,472
Equipment	Straight Line	3-20 Yrs	1,281	(620)	661	679
Internal Use Software	Straight Line	5-10 Yrs	863	(179)	684	487
Assets Under Capital Lease	Straight Line	1-20 Yrs	141	(38)	103	110
Leasehold Improvements	Straight Line	*Life of Lease	43	(7)	36	38
Totals			$ 7,273	$ (2,302)	$ 4,971	$ 4,557

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

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Included in the September 30, 2006 and 2005, Net Book Value for Internal Use Software are Unified Financial Management System capitalized costs totaling approximately $10 million for FY 2006 and $13 million for FY 2005.

Note 10. Other Assets

Other assets as of September 30, 2006 and 2005 are comprised of the following, all of which are considered entity assets:

(Dollars in Millions)	2006	2005
Intragovernmental		
Advances to Other Federal Entities	$ 499	$ 538
Prepayments & Deferred Charges	-	-
Other	1	1
OPDIV Combined, Intragovernmental	500	539
Less: Intra-OPDIV Eliminations	(365)	(366)
OPDIV Consolidated, Intragovernmental	135	173
Less: Inter-OPDIV Eliminations	(3)	(4)
HHS Consolidated, Intragovernmental	$ 132	$ 169
With the Public		
Prepayments and Deferred Charges	$ -	$ 4,044
Travel Advances & Emergency Employee Salary Advances	139	5
Other	370	479
HHS Consolidated, With the Public	$ 509	$ 4,528

Advances to other Federal entities is largely comprised of advances from the NIH to the NIH Service and Supply Fund and the Management Fund for financing the NIH Business System and the NIH Clinical Center, as well as advances from the CDC and the Office of the Secretary to the Department of Veterans Affairs for Strategic National Stockpile items.

As of September 30, 2006, the Centers for Medicare and Medicaid Services had $124 million ($102 million in FY 2005) in Other Assets representing advances made to various contractors and vendors. Medicare Advantage plans were issued an advance payment on September 30, 2005, in the amount of $4,099 million for services that were provided in October 2005. No such advance payment was necessary for FY 2006.

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Note 11. Liabilities Not Covered by Budgetary Resources
HHS' liabilities not covered by budgetary resources at September 30, 2006 and 2005 are summarized below:

(Dollars in Millions)	2006	2005
Intragovernmental		
Accounts Payable	$ -	$ -
Accrued Payroll and Benefits	27	21
Other	526	169
Total Intragovernmental	553	190
Entitlement Benefits Due and Payable	-	9,470
Federal Employees and Veterans' Benefits	7,532	7,183
Accrued Payroll and Benefits	458	453
Other	1,889	2,581
Total Liabilities Not Covered by Budgetary Resources	10,432	19,877
Total Liabilities Covered by Budgetary Resources	67,993	51,082
Total Liabilities	$ 78,425	$ 70,959

Note 12. Entitlement Benefits Due and Payable
Entitlement Benefits Due and Payable represent benefits due and payable to the Public at year-end from entitlement programs enacted by law. The Medicare and Medicaid programs are the largest entitlement programs in HHS and comprise all of the HHS Entitlement Benefits Due and Payable.

Entitlement Benefits Due and Payable at September 30, 2006 and 2005, are summarized in the following schedule:

	2006			2005		
(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	$ 40,824	$ -	$ 40,824	$ 33,399	$ -	$ 33,399
Medicaid	19,182	-	19,182	10,635	9,470	20,105
Other	1,158	-	1,158	250	-	250
Totals	$ 61,164	$ -	$ 61,164	$ 44,284	$ 9,470	$ 53,754

Medicare benefits payable consists of a $36,628 million estimate ($32,884 million in FY 2005) by the Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2006. The liability represents (a) an estimate of claims incurred that may or

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may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 2006 that were paid in 2007 and (e) an estimate of retroactive settlements of cost reports.

The Retiree Drug Subsidy (RDS) consists of a $2,377 million estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2006. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

Medicare Advantage and Prescription Drug Program benefits payable consist of a $1,683 million estimate for amounts owed to plans relating to risk and other payment related adjustments. Under the Medicare Modernization Act, certain Medicare payments to private Part D insurance plans are ultimately based on the individual claims experiences for each plan enrollee. In particular, Medicare reinsurance amounts are payable if an enrollee's total "true out-of-pocket costs" exceed $3,600 in 2006. Similarly, beneficiaries who have additional assistance through the Medicare low-income subsidy program qualify for payment of much of their Part D cost-sharing liability; the ultimate amount of such assistance will depend on each such beneficiary's individual cost experience.

For administrative practicality, Part D plans are paid an estimated average monthly amount per enrollee for reinsurance and a corresponding estimated average amount per LIS enrollee for cost sharing. These monthly payments are based on the plans' estimates of such costs, as included in their actuarial bid submissions to CMS. The bids are prepared by a qualified and credentialed actuary and reviewed by the OACT for reasonableness prior to the start of the plan year. Following the end of the plan year, when complete data on enrollees' use of prescription drugs are available, Medicare and the Part D plans will reconcile the estimated monthly payments with the actual experience, and a payment adjustment will be made—either from the program to the plan or vice-versa, as necessary to balance each account.

In practice, it is probable that some plans will have underestimated the average reinsurance and/or LIS cost-sharing amounts, and other plans will have overestimated these amounts. From an actuarial standpoint, it is reasonable to expect that the plans' expectations would be about right on average, with the overpayments to some plans tending to offset the underpayments to others. In the absence of actual plan data for the complete year, however, there is no way to reasonably estimate the aggregate amount of overpayments and the aggregate amount of underpayments for either the reinsurance or the LIS cost-sharing subsidies. In practice, each such aggregate amount could be substantial, and the net difference between them could also be very significant.

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Thus, because this is the initial year of the prescription drug program and actual data have not been received and reviewed, at this time HHS cannot reasonably estimate financial statement accrual amounts for Part D reinsurance and low-income cost sharing that it will ultimately owe plans. Nor can HHS reasonably estimate such amounts that other Part D plans will owe HHS. These amounts can only be determined with any degree of certainty when the final reconciliations of the 2006 plan year data are performed, which will take place in 2007.

Moreover, because the aggregate amounts payable or receivable at calendar year-end cannot be reasonably estimated, it is not possible to estimate a reliable accrual for the end of the fiscal year. The monthly payments of estimated reinsurance and LIS cost-sharing liabilities are determined as simple averages of the annual amounts. It is reasonable to expect that the cumulative payments at any point during the calendar year would not exactly match the cumulative actual incurred amounts, because the timing of the latter is not uniform throughout the year. However, since the ultimate annual amount cannot be reasonably estimated at this time, it is similarly not possible to reasonably estimate September 30th (or other intermediate) accruals.

A potential gain contingency in the Medicare Advantage and Prescription Drug Program consists of amounts due to HHS resulting from risk and other payment related adjustments. However, these amounts have not been finalized as of year end.

Undocumented aliens consist of a $170 million estimate ($250 million in FY 2005) of emergency health services furnished by providers to eligible aliens but not paid as of September 30, 2006. As part of the MMA, Section 1011, Congress mandated HHS directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act related to undocumented aliens.

The HHS implemented the State to Plan Reconciliation Demonstration project under the authority of Section 402 of the Social Security Amendments of 1967 in order to ensure appropriate care continuation for dual eligibles and other low-income subsidy entitled beneficiaries. The liability of $136 million relating to the demonstration project represents estimated amounts to be paid to States for costs incurred in assisting dual eligible beneficiaries to transition to the Medicare Part D Prescription Drug Benefit. A potential gain contingency exists relating to the State to Plan Reconciliation Demonstration project that represents amounts expected to be recovered from the Part D plans for Medicaid and State Pharmaceutical Assistance Program (SPAP) claims. The actual amount of the expected recoveries will not be known until the reconciliation process is completed. The anticipated outcome of the reconciliation is that CMS anticipates the recovery of funds from the Part D plans.

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Medicaid benefits payable of $19,182 million ($19,786 million in FY 2005) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to HHS as of September 30, 2006. An estimated SCHIP benefits payable of $284 million has been recorded for the net Federal share of expenses that have been incurred by the States but not yet reported to HHS as of September 30, 2006. No such SCHIP accrual was recorded at September 30, 2005 because management deemed the estimate immaterial.

The liability for Katrina relief waivers of $704 million consists of $543 million in actual services rendered but not paid plus a $161 million estimate for services incurred but not paid, as of September 30, 2006. HHS has this authority under an approved Multi-State Section 1115 Demonstration Project of Public Law 109-171, Subtitle C.

Medicaid audit and program disallowances of $319 million in FY 2005 were contingent liabilities established as a result of Medicaid audit and program disallowances that were being appealed by the States. In all cases, the funds were returned to HHS. The HHS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment are deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There were also outstanding reviews of the State expenditures in which a final determination was not made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid & State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMSO. The outcome of these reviews is that HHS could be owed funds.

Note 13. Federal Employee and Veterans' Benefits

HHS' Federal Employee and Veterans' Benefits at September 30, 2006 and 2005, are summarized below. These liabilities are not covered by budgetary resources.

(Dollars in Millions)	2006	2005
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$6,583	$6,287
PHS Commissioned Corp Post-retirement Health Benefits	680	627
Workers' Compensation Benefits (Actuarial FECA Liability)	269	269
Total, Federal Employee and Veterans' Benefits	$7,532	$7,183

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Public Health Service Commissioned Corps: HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System for approximately 5,908 active duty officers and 5,275 retiree annuitants and 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, 2006, the actuarial present value of accumulated plan pension benefits was $6,583 million, of which $616 million was not vested, and the liability for medical benefits was actuarially determined to be $680 million.

Significant assumptions used by the actuary in its reports on the pension and medical programs as of September 30, 2006, were as follows:

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

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

The following shows key valuation results as of September 30, 2006 and 2005, in conformance with the actuarial reporting standards set forth in the Statement of Federal Financial Accounting Standards No. 5, *Accounting for Liabilities of the Federal Government*.

(Dollars in Millions)	2006	2005
SFFAS 5 Expense		
(a) Normal Cost	$ 156	$ 154
(b) Interest Cost	425	423
(c) Ongoing Cost (a & b)	581	577
(d) Prior Service Cost & (Gains)/Losses	34	(294)
(e) Total Expense	$ 615	$ 283

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

The liability utilizes historical benefit payment patterns related to a specific incurred period to predict the ultimate payment related to that period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the OMB's

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economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in FY 2006 and 2005 appear below.

FY 2006	FY 2005
5.170% in Year 1	4.528% in Year 1
5.313% in Year 2 and thereafter	5.020% in Year 2 and thereafter

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

FY	COLA	CPIM
2006	3.50%	4.00%
2007	3.13%	4.01%
2008	2.40%	4.01%
2009	2.40%	4.01%
2010+	2.43%	4.09%

Note 14. Accrued Grant Liability

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

At September 30, the OPDIVs record the liability based on the estimated accrual for unreported grantees' expenses. If the amount of the collective OPDIV advances outstanding exceeds the amount of the collective estimated expenses, HHS reports the difference as "Advances to Grantees." If the amount of the estimated expenses exceeds the amount of the collective advances outstanding, HHS reports the difference as "Accrued Grant Liability."

HHS' net grant advances (liability) at September 30, 2006 and 2005, are summarized below:

	2006	2005
Grant Advances Outstanding (before year-end grant accrual)	$ 15,590	$ 15,491
Less: Estimated Accrual for Amounts Due to Grantees	(19,423)	(19,274)
Net Grant Liability	$ (3,833)	$ (3,783)

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Note 15. Other Liabilities

HHS' other liabilities at September 30, 2006 and 2005 are summarized below:

(Dollars in Millions) 2006	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	480	-	480	746	-	746
Contingent Liabilities	-	34	34	-	1,601	1,601
Capital Lease Liability	-	83	83	27	9	36
Custodial Liabilities	-	409	409	-	10	10
Vaccine Injury Compensation Program	-	-	-	-	221	221
Environmental and Disposal Costs	-	-	-	1	36	37
Other	471		471	204	12	216
Combined OPDIV Totals	951	526	1,477	978	1,889	2,867
Less: Intra-OPDIV Eliminations	(365)	-	(365)	-	-	-
Consolidated OPDIV Totals	586	526	1,112	978	1,889	2,867
Less: Inter-OPDIV Eliminations	(157)	-	(157)	-	-	-
Consolidated HHS Totals	$ 429	$ 526	$ 955	$ 978	$ 1,889	$ 2,867

(Dollars in Millions) 2005	Intragovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ -	$ -	$ -	$ 15	$ -	$ 15
Deferred Revenue	475	-	475	552	-	552
Contingent Liabilities	-	-	-	-	2,266	2,266
Capital Lease Liability	-	86	86	31	5	36
Custodial Liabilities	-	84	84	-	5	5
Vaccine Injury Compensation Program	-	-	-	-	265	265
Environmental and Disposal Costs	-	-	-	2	31	33
Other	806	(1)	805	115	9	124
Combined OPDIV Totals	1,281	169	1,450	715	2,581	3,296
Less: Intra-OPDIV Eliminations	(366)	-	(366)	-	-	-
Consolidated OPDIV Totals	915	169	1,084	715	2,581	3,296
Less: Inter-OPDIV Eliminations	(92)	-	(92)	-	-	-
Consolidated HHS Totals	$ 823	$ 169	$ 992	$ 715	$ 2,581	$ 3,296

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

Deferred Revenue:
The Centers for Medicare and Medicaid Services routinely receive premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill. CMS accounts for $364 million of the deferred revenue with the public.

In addition, the Food and Drug Administration collects fees in relation to its various user fee appropriations. FDA accounts for $241 million of the deferred revenue with the public for the portion of the fees collected during current fiscal year that should be applied to the next fiscal year. The Indian Health Service accounts for $169 million of the intragovernmental deferred revenue for construction-in-process projects primarily under the Contribution, Indian Health Facilities fund, and $89 million of the deferred revenue with the public for the Tribal Buybacks. The Substance Abuse and Mental Health Services Administration accounts for $139 million intragovernmental deferred revenue for interagency agreement with another Federal agency to award and administer the Drug Free Communities program grants. The Vaccine Injury Compensation Program administered by the Health Resources and Services Administration accounts for $29 million in intragovernmental deferred revenue arising from the provision of goods and services by the program. The National Institutes of Health accounts for $104 million of the intragovernmental deferred revenue and $51 million deferred revenue with the public for unearned Cooperative Research and Development Agreement (CRADA) revenue.

Other Intragovernmental Liabilities:
Other Intragovernmental Liabilities of $955 million are comprised of $434 million, of which CMS owes to other Federal entities, primarily to the Department of the Treasury ($333 million at September 30, 2006). The CMS' payable to Treasury is a result of the receivables from the beneficiaries and Medicare contractors. The CMS owes other Federal entities $100 million for services performed through interagency agreements.

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

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sites and the National Institutes of Health ground water remediation project in accordance with applicable laws and regulations.

Note 16. Leases
Capital Leases:
HHS has entered into various capital leases with Native American and Alaskan Native tribes and with the General Services Administration (GSA) for office and warehouse space. Lease terms vary from 1 to 20 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments.

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

In FY 2005, the National Institutes of Health identified certain operating leases that do not have cancellation clauses and the obligation for the full term of the lease was not recorded. GSA issued a policy clarification for delegations of lease acquisition authority dated July 7, 2006, stating that leases meeting the criteria for operating leases were required to cover the annual lease payments only with budget authority.

A Summary of Net Assets under Capital Lease and Future Minimum Lease Payments at September 30, 2006 and 2005 is presented in the schedules that follow:

(Dollars in Millions)	2006	2005
Summary of Net Assets Under Capital Lease		
Land and Building	$ 140	$ 140
Machinery and Equipment	1	2
Other	-	-
Subtotal	$ 141	$ 142
Less: Accumulated Amortization	(38)	(32)
Assets Under Capital Lease	$ 103	$ 110

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(Dollars in Millions)	2006 Capital Leases	2006 Operating Lease	2005 Capital Leases	2005 Operating Lease
Future Minimum Lease Payments				
2007	$ 12	$ 319	$ 12	$ 322
2008	12	333	12	342
2009	13	333	12	348
2010	13	285	13	355
2011	11	253	13	340
Later Years	137	859	149	1,064
Total Minimum Lease Payments	$ 198	$ 2,382	$ 211	$ 2,771
Less: Imputed Interest	(79)		(89)	
Total Capital Lease Liability	$ 119		$ 122	

Note 17. Consolidated Gross Cost and Earned Revenue by Budget Function Classification

Intragovernmental transactions are between Federal entities meaning both the buyer and seller are Federal. Exchange revenue with the public is a transaction when the buyer of the goods or services is a non-Federal entity and the seller is Federal.

If a Federal entity purchases goods or services from another Federal entity and sells them to the public, the exchange revenue would be classified as "with the public" but the related costs would be classified as "intragovernmental." The purpose of the classifications is to enable the Federal Government to provide consolidated financial statements, and not to match public and intragovernmental revenue with costs that are incurred to produce public and intragovernmental revenue. HHS' consolidated gross cost and exchange revenue by budget functional classification for the years ended September 30, 2006 and 2005 are summarized below:

(Dollars in Millions)	2006 Education Training and Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals	2005 HHS Consolidated Totals
Intragovernmental								
Gross Cost	$ 166	$ 4,146	$ 695	$ 26	$ 5,033	$ (1,713)	$ 3,320	$ 3,535
Less: Earned Revenue	(21)	(2,773)	(8)	(8)	(2,810)	1,709	(1,101)	(1,085)
Net Cost, Intragovernmental	$ 145	$ 1,373	$ 687	$ 18	$ 2,223	$ (4)	$ 2,219	$ 2,450
With the Public								
Gross Cost	$ 12,068	$238,604	$ 386,229	$ 36,269	$ 673,170	$ -	$ 673,170	$ 618,463
Less: Earned Revenue	-	(1,505)	(49,947)	-	(51,452)	-	(51,452)	(39,593)
Net Cost, With the Public	$ 12,068	$ 237,099	$336,282	$36,269	$ 621,718	$ -	$ 621,718	$ 578,870
Totals								
Gross Cost	$ 12,234	$ 242,750	$386,924	$36,295	$ 678,203	$ (1,713)	$ 676,490	$ 621,998
Less: Earned Revenue	(21)	(4,278)	(49,955)	(8)	(54,262)	1,709	(52,553)	(40,678)
Net Cost of Operations	$ 12,213	$ 238,472	$ 336,969	$36,287	$ 623,941	$ (4)	$ 623,937	$ 581,320

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Note 18. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $53 billion and $41 billion for the years ended September 30, 2006, and 2005, respectively. The HHS' exchange revenue primarily consists of Medicare premiums collected from beneficiaries.

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

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

Note 19. Prior Period Adjustments

In FY 2005, prior period adjustments of $32 million were reported to correct errors and accounting changes with retroactive effect. HHS included prior period adjustments in the calculation of the net change in cumulative results of operations and unexpended appropriations. The FY 2005 adjustments were related to IHS' accrued unfunded payroll, the NIH's royalty activity, and the Office of the Secretary's stockpile transfer.

Note 20. Custodial Activity

The Administration for Children and Families receives monies from the Internal Revenue Service for outlay to the States for child support. These monies represent delinquent child support payments withheld from Federal tax refunds. Receipts are transferred to HHS appropriation 75X6234 to cover outlays. During FY 2006, receipts amounted to $1,571 million ($1,573 million for FY 2005) and outlays amounted to $1,556 million ($1,562 million for FY 2005).

The FDA custodial activity involves collections of civil monetary penalties (CMP) assessed by the Department of Justice on behalf of FDA. Penalties are assessed for violations in areas such as illegally manufactured, marketed, and distributed animal feeds and drug products. Total CMP collections in FY 2006 were $24.8 million ($4.7 million for FY 2005). CMP collections are immediately forwarded to the Department of the Treasury and cannot be used for FDA operations.

The Centers for Disease Control and Prevention custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status. Total

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custodial liabilities for FY 2006 and FY 2005 were $3.6 million and $84 thousand, respectively. CDC custodial collections are also forwarded to the Department of the Treasury and cannot be used for CDC operations.

Note 21. Federal Matching Contribution
Supplemental Medical Insurance 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 $78.20 from October 2005 through December 2005 and $88.50 from January 2006 through September 2006. Premiums collected from beneficiaries totaled $41.6 billion in FY 2006 ($35.9 billion in FY 2005) and were matched by $129.1 billion ($113.5 billion in FY 2005) contribution from the Federal Government.

Note 22. 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 15, Other Liabilities. With 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. 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 one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been cancelled pursuant to the National Defense Authorization Act of FY 1991 (*Public Law 101-150*). The total payments related to cancelled appropriations are estimated at $1,009 million and $1,136 million as of September 30, 2006 and 2005, respectively.

Contingent Liabilities:
The HHS is an agency in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. The HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined.

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The Medicaid amount for $1,126 million consists of Medicaid audit and program disallowances of $419 million and $707 million for reimbursement of state plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. The CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid and State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMSO. The outcome of these reviews is that CMS could be owed funds.

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

The CMS expects that as of September 30, 2006, it is reasonably possible that a contingent liability could be owed to States in an estimated amount as much as $1,641 million ($1,648 million in FY 2005), for unasserted claims arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. In FY 2005, CMS believed this contingent liability was probable, and therefore, recorded it as a liability in the financial statements. However, because no states have filed any claims since CMS first disclosed this issue, no liability has been recorded for FY 2006.

Vaccine Injury Compensation Program (VICP):
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $221 million VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2006.

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2005, there were 5,737 PRRB cases (5,580 in FY 2005) under appeal. A total of 2,422 new cases (2,301 in FY 2005) were filed in FY 2006. The PRRB rendered decisions on 85 cases (72 in FY 2005) in FY 2006 and 2,188 additional cases (2,072 in FY 2005) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 85 cases that were decided in FY 2006, a reasonable liability estimate cannot be projected for the value of the 5,886 (5,737 in FY 2005) cases remaining on appeal as of September 30, 2006. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

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Note 23. Apportionment Categories of Obligations Incurred
Obligations incurred by apportionment categories at September 30, 2006 and 2005, are summarized below:

	2006		
(Dollars in Millions)	Direct	Reimbursable	Totals
Category A	$ 125,641	$ 7,340	$ 132,981
Category B	388,707	431	389,138
Exempt from Apportionment	362,784	-	362,784
Total Obligations Incurred	$ 877,132	$ 7,771	$ 884,903

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

Obligations incurred consist of expended authority and the change in undelivered orders. Current system limitations prevent CMS from reporting the recoveries of prior year obligations. The OMB has exempted CMS from the Circular No. A-11 requirement to report the refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that CMS report all Medicare cash collections as offsetting receipts beginning in FY 2005.

Note 24. Legal Arrangements Affecting Use of Unobligated Balances
Unobligated balances consist of appropriated funds, revolving funds, management funds, trust funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. Annual appropriations are available for new obligations in the year the appropriation was received and for adjustments to valid obligations for 5 subsequent years. Revolving funds are no-year funds available until expended. The National Institutes of Health Management Fund is available for 2 fiscal years. The trust funds are also no-year funds without time limits. The CRADA funds are available for the performance of the contractual agreement.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is reported as Temporarily Not Available Pursuant to Public Law in the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and

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currently become available for obligation as needed. The entire trust fund balances in the amount of $292,426 million as of September 30, 2006 ($258,025 million in FY 2005) are included in Investments on the Balance Sheet.

The FDA received $168 million in funding in FY 2002 to remain available until expended, to support counter-terrorism projects that recognize the important role FDA plays in protecting the public health. The attacks of September 11, 2001, and subsequent national events resulted in an accelerated and intensified need for attention to activities related to counter-terrorism. The amount obligated for counter-terrorism projects through FY 2006 was approximately $167.7 million.

Note 25. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The SFFAS No. 7, *Accounting for Revenue and Other Financing Sources*, requires explanations for 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 referred to as the *President's Budget*. Paragraph 77 of the SFFAS No. 7 requires 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 Statement of Budgetary Resources.

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 2008 *President's Budget*, with actual amounts for FY 2006, has not yet been published, and, therefore, no comparisons can be made between FY 2006 amounts presented in the SBR with amounts reported in the "Actual" column of the *President's Budget*. The FY 2008 *President's Budget* is expected to be released in February 2007, and may be obtained from the Office of Management and Budget website http://www.whitehouse.gov/omb/budget or the Government Printing Office.

The *Budget of the United States Government, FY 2007 – Appendix* was used as the reference for the HHS total budgetary resources amount. Information in the "Federal Programs by Agency and Account" in the FY 2007 Analytical Perspectives volume of the *Budget of the United States Government* was used as the reference for the net outlays (less offsetting receipts) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2005.

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The prior year September 30, 2005, reconciliation is disclosed in the following schedule:

(Dollars in Millions)	2005			
	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$ 793,842	$ 775,635	$ 167,026	$ 581,294
Unobligated Balances – Not Available	(5,845)	-	-	-
Other	1,249	(261)	4	285
Budget of the U.S. Government	$ 789,246	$ 775,374	$ 167,030	$ 581,579

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the SBR and not in the *President's Budget* is the budgetary resources that were not available. The unobligated balances – not available line in the above schedule includes expired authority, recoveries, and other amounts included in the SBR that are not included in the *President's Budget*. The "Other" line in the schedule includes gift and donations, offsetting collections, reimbursable items and timing differences between the SBR and the *President's Budget*.

The Other Adjustments Line for Budgetary Resources included an increase of $1,920 million for the amounts reported in the President's Budget for the CMS to fund the Vaccines for Children program; these funds were subsequently transferred to the CDC and the Department of Treasury (Treasury). The CMS reported a decrease of $69 million for offsetting receipts. CDC reported offsetting receipts of $1.2 million and gifts and donations of $8 million.

The Other Adjustments Line for Obligations Incurred included an increase by CMS of $1,864 million for the obligations for the Vaccines for Children program reported in the President's Budget, offset by amounts reported by CDC and Treasury. The CMS also reported a decrease of $85 million for expired accounts.

The Other Adjustments Line for Net Outlays included an increase to net outlays for CMS in the amount of $1,659 million for the amounts reported in the President's Budget for CMS for the Vaccines for Children program subsequently reported by the CDC and Treasury. The CDC's outlays for the Vaccines for Children program were $1,302 million.

Note 26. 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 include 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.

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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 "Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods" which includes items such as accrued annual leave to reconcile budgetary resources to net cost.

Note 27. Permanent Indefinite Appropriations
The HHS permanent indefinite appropriations are open-ended; that is, the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

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

75 0170 (fiscal year) HHS Accrual Contribution to the Uniformed Services Retiree Health Care Fund, Office of the Assistant Secretary for Health
75 0340 (fiscal year) Health Education Assistance Loans Program
75X0350 (no year) Health Centers Loan Program, HRSA
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 Prof. Grad. Student Loan Insurance Fund, Liquidating Account
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) FDA Unconditional Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8249 (no year) Unconditional Gift Fund, HRSA
75X8250 (no year) Gifts and Donations, CDC
75X8253 (no year) NIH Conditional Gift Fund
75X8254 (no year) Conditional Gift Fund, HRSA
75X8307 (no year) Transitional Drug Assistance, CMS
75X8308 (no year) Medicare Prescription Drug Account, CMS
75X8510 (no year) Administration on Aging Gift Fund
75X8511 (no year) Indian Health Service Gift Fund
75X8512 (no year) AHRQ Gift Fund

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75X8513 (no year) SAMHSA Gift Fund
75X8514 (no year) OS Gift Fund
75X8888 (no year) Patients Benefit Fund, NIH
75X8889 (no year) Patients Benefit Fund, HRSA
7520X8004 (no year) Federal Supplementary Medical Insurance Trust Fund, CMS
7520X8005 (no year) Federal Hospital Insurance Trust Fund, CMS
7520X8175 (no year) Vaccine Injury Compensation Trust Fund, HRSA

Note 28. Adjustments to Beginning Balance of Budgetary Resources
In FY 2005, $164 million was reported as a beginning balance adjustment to properly reflect drug industry fees collected in advance by the Food and Drug Administration at the end of FY 2004.

Note 29. Undelivered Orders at the End of the Period
At the end of the period, HHS reported $76,429 million of budgetary resources obligated for undelivered orders for FY 2006 and $74,329 million for FY 2005.

Note 30. Earmarked Funds
Medicare is the largest earmarked fund group managed by the Department; therefore, Medicare financial data is presented on an individual basis with a separate column in the schedule below.

The HHS has designated as earmarked funds the Medicare HI and SMI trust funds, which also include the Payments to the Health Care Trust Funds appropriation and the Health Care Fraud and Abuse Control Account. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI trust funds.

The Medicare programs include: (a) Medicare Hospital Insurance (HI) Trust Fund, (b) Medicare Supplementary Medical Insurance (SMI) Trust Fund, (c) Medicare Prescription Drug Benefit – Part D, and (d) Medicare Integrity Program (MIP). See Note 1 for a description of each fund's purpose and how HHS accounts for and reports the fund.

The Social Security Act provides for payments to the HI and SMI trust funds (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). The Medicare Modernization Act of 2003 prescribes that funds covering the Medicare Prescription Drug Benefit, retiree drug coverage, reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to SMI. A transfer of general funds to the HI trust fund is made in amounts equal to Self-Employment Contribution Act tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries.

There were no legislative changes that significantly changed the purpose of or redirected a significant portion of an earmarked fund during this reporting period.

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Earmarked Funds (In Millions)	Medicare Earmarked Fund	Other Earmarked Funds	Eliminations	Total Earmarked Funds
Balance Sheet as of September 30, 2006				
Assets				
Fund balance with Treasury	$ 28,726	$ 820	$ -	$ 29,546
Investments	339,545	2,431	-	341,976
Other Assets	46,484	42	(42,637)	3,889
Total Assets	$ 414,755	$ 3,293	$ (42,637)	$ 375,411
Entitlement Benefits Due and Payable	$ 40,824	$ -	$ -	$ 40,824
Other Liabilities	44,420	674	(42,637)	2,457
Total Liabilities	$ 85,244	$ 674	$ (42,637)	$ 43,281
Unexpended Appropriations	$ 27,658	$ 7	$ -	$ 27,665
Cumulative Results of Operations	301,853	2,612	-	304,465
Total Liabilities and Net Position	$ 414,755	$ 3,293	$ (42,637)	$ 375,411
Statement of Net Cost For the Period Ended September 30, 2006				
Gross Program Costs	$ 386,924	$ 199	$ -	$ 387,123
Less: Earned Revenues	49,955	512	-	50,467
Net Cost of Operations	$ 336,969	$ (313)	$ -	$ 336,656
Statement of Changes in Net Position For the Period Ended September 30, 2006				
Net Position Beginning of Period	$ 276,020	$ 2,342	$ -	$ 278,362
Non-Exchange Revenue	197,843	155	116	198,114
All Other Financing Sources	192,617	(191)	(116)	192,310
Net Cost of Operations	(336,969)	313	-	(336,656)
Change in Net Position	53,491	277	-	53,768
Net Position End of Period	$ 329,511	$ 2,619	$ -	$ 332,130

The list below includes the Treasury fund symbols that are "Other Earmarked Funds":

75X8510 (no year) Administration on Aging Gift Fund
75X8512 (no year) Agency for Healthcare Research and Quality Gift Fund
75X0943 (no year) Disease Control, Rsrch, & Trning, CDC (partial – user fee portion only)
75 0943 (fiscal year) Disease Control, Rsrch, & Trning, CDC (partial – multi-year royalties)
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X8250 (no year) Gifts and Donations, CDC
20X8145 (no year) Allocation Transfer from EPA Hazardous Superfund CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8247 (no year) Food and Drug Administration Unconditional Gift Fund
75X0600 (no year) User Fee Act(s), FDA
75X4309 (no year) Revolving Fund for Certification and Other Services, FDA

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75X8249 (no year) Unconditional Gift Fund, HRSA
75X8254 (no year) Conditional Gift Fund, HRSA
75X8889 (no year) Patients Benefit Fund, HRSA
20X8175 (no year) Vaccine Injury Compensation Trust Fund HRSA
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8511 (no year) IHS Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8253 (no year) NIH Conditional Gift Fund
75X8888 (no year) Patients Benefit Fund, NIH
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75 3966 (fiscal year) Royalties, NIH
75X8513 (fiscal year) SAMHSA Gift Fund
75X8514 (no year) Office of the Secretary Gift Fund

Note 31. Statement of Social Insurance Disclosures

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions.

Actuarial present values are computed for the year shown and over the 75-year projection period beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. 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. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future cost are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, or those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or

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both. Since the projection period consists of 75 years, it covers virtually all of the current participants' working and retirement years.

The SOSI sets forth, for each of these three groups, the projected actuarial present value of all future HI (Part A) and SMI (Parts B and D) expenditures and all future non-interest income for the next 75 years. The SOSI also presents the net present value of future net cash flows for each fund, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The existence of a large actuarial deficit for the HI trust fund indicates that, under these assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures over the next 75 years. 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.

In addition to the actuarial present value of estimated future excess of income (excluding interest) over cost, shown in the basic statement, for the open group of participants, it is possible to make an analogous calculation for the "closed group" of participants. The "closed group" of participants consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained age 15 through 64. In order to calculate the actuarial net present value of the excess of future income over future costs for the closed group, one could subtract the actuarial present value of estimated future costs for or on behalf of current participants from the actuarial present value of future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in the treatment of medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors, and such changes are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under current law. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care cost, wages and the consumer price index (CPI), fertility rates, mortality 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. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

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The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included on the table below. The assumptions underlying the SOSI actuarial projections, and the projections themselves, are drawn from the Social Security and Medicare Trustees Reports for 2006. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions.

Medicare and Economic and Demographic Assumptions

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2006	2.03	1,075,000	848.9	1.2	4.1	2.9	3.4	4.7	8.6	—	1.4
2010	2.03	1,000,000	829.2	1.5	4.3	2.8	2.6	4.7	4.1	7.9	3.1
2020	2.01	950,000	767.1	0.9	3.7	2.8	2.1	4.4	4.5	6.6	2.9
2030	2.00	900,000	707.4	1.1	3.9	2.8	1.9	5.8	5.6	5.3	2.9
2040	2.00	900,000	654.5	1.1	3.9	2.8	2.0	5.8	5.3	5.2	2.9
2050	2.00	900,000	608.0	1.1	3.9	2.8	2.0	4.9	4.8	4.9	2.9
2060	2.00	900,000	566.9	1.1	3.9	2.8	1.9	4.6	4.7	4.6	2.9
2070	2.00	900,000	530.3	1.1	3.9	2.8	2.0	4.5	4.4	4.4	2.9
2080	2.00	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that populations were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage increases in wages and the CPI.
[5]Average annual wage in covered employment.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is new (having begun operations in January 2006), and very little actual program data is available. The actual 2006 bid submissions by the private plans offering this coverage, together with preliminary data on beneficiary enrollment, has been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Note 32. SMI Part B Physician Update Factor

The projected Part B expenditure growth reflected in the accompanying SOSI is significantly reduced as a result of the structure of physician payment updates under current law. In the absence of legislation, this structure would result in multiple years of significant reductions in physician payments, totaling an estimated 37 percent over the next 9 years. Reductions of this magnitude are not feasible and such reductions are very unlikely to occur fully in practice. For example, Congress has overridden scheduled negative updates for each of the last 4 years. However, since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. Consequently, the projected actuarial present values of Part B expenditure shown in the accompanying SOSI is likely understated.

The potential magnitude of the understatement of Part B expenditures due to the physician payment mechanism, can be illustrated using two hypothetical examples of changes to current law. These examples were developed by management for illustrative purposes only; the calculations have not been audited; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation on physician payments under Medicare and of the broad range of uncertainty associated with such impacts. Under current law, the projected 75-year present value of future Part B expenditures is $17.6 trillion. If Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.3 trillion. Alternatively, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $24.4 trillion.

The extent to which actual future Part B costs could exceed the projected current-law amounts due to physician payments, depends on both the level of physician payment updates that might be legislated and on whether Congress would pass further provisions to help offset such costs (as it did, for example, in the Deficit Reduction Act). As noted, these examples only reflect hypothetical changes to physician payments. It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these would likely be designed to reduce costs in an effort to make the program

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more affordable. In practice, it is not possible to anticipate what actions Congress might take, either in the near term or over longer periods.

Note 33. Stewardship PP&E
The HHS assets regardless of their status are used to support the day-to-day operations of providing healthcare to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist. For stewardship reporting purposes, the HHS identifies two types of assets: Heritage and Indian Trust Lands.

Heritage assets are PP&E that are historically, architecturally, or culturally significant. This category includes:

- Buildings Located in a Historic District or Included with a National Landmark
- Buildings Determined to be Historic in Nature
- Building Submitted to Tribal Historic Preservation /State Historic Preservation Office for Determination
- Buildings Having Some Potential Historic Eligibility Criteria

Indian Trust lands are those lands that do not meet the definition of Stewardship land (i.e., land other than that acquired for or used in connection with general (capitalized) PP&E), but have always been held by the U. S. Government as separate and distinct, because of the Government's long-term trust responsibility. The U. S. Government holds Indian land in trust upon which the Indian Health Service has built health care facilities. All Trust lands, when no longer needed by IHS in connection with its general use PP&E, must be returned to the Department of the Interior's Bureau of Indian Affairs, for continuing trust responsibilities and oversight.

Currently, HHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. Indian Trust land balances are removed from the IHS FY 2006 Balance Sheet, and reported as Stewardship Assets - Indian Trust Lands.

The Required Supplementary Information (RSI) provides additional information for Stewardship PP&E.